Intimate Encounters: Men Negotiating Sexuality When Working as Midwives

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Abstract

This paper explores how men in midwifery negotiate sexuality and gender when providing intimate care (IC). Midwifery has long positioned itself as a mono-gendered profession protecting cisgender women from male encroachment. Men were admitted to midwifery in the United Kingdom (UK) in 1983 and our study is the first in-depth qualitative account of their experiences. We present empirical findings from an interpretative phenomenological analysis of 15 interviews with men who work as midwives in the UK, examined through Ahmed's concept of Orientations to reveal how men disrupt lines predicated on cisheteronormative caregiver interactions. Orientations accounts for their bodily reactions and how they viscerally experience and manage their gender. Through the use of vignettes, we show how men recognise that IC creates boundaries to their acceptability, how they reconfigure these boundaries to render their IC less transgressive, and how they process the conflict they experience when their IC is at risk of rejection. By working with the concept of Orientations we make a key contribution to both the fields of midwifery and sexuality studies by showing how sexuality becomes visible in caregiver interactions and likely shapes the experiences of men in midwifery and other IC-based professions.

Keywords: Intimate care, male midwife, Orientations

Introduction

Midwifery is one of the oldest recorded occupations and overwhelmingly mono-gendered. Historically only women who had given birth could be midwives because this embodied experience was necessary for their practice (Pendleton 2019). Because midwives are required to provide intimate care (IC), they have acted as gatekeepers protecting birthing people – always presumed to be cisgender women – from the risk of 'pollution' when examined by men (Donnison 1988). Thus, midwifery became understood as a profession delivered by women to protect other women, framing midwifery in binary opposition to men and enshrined in its nomenclature (meaning 'with woman' (Pendleton 2021). This interpellates a fiercely defended cisheteronormativity into its language and interactions with all stakeholders (Pezaro et al. 2023). Accordingly, when we refer to men and women we mean cisgender people to reflect understandings of gender in the existing literature and articulated by participants in our study, despite queer and trans people existing as both birthing people and midwives.

Since 1902, midwifery in the United Kingdom (UK) has been a distinct profession evolving with a high degree of autonomy which remains highly prized (Zarbiv and Ellen 2025). In contrast to many nations where birth has become the preserve of obstetricians, UK midwives continue to hold a privileged position as the default care providers. Men's admission to the profession in 1983 was met with fierce opposition from professional bodies but nevertheless enacted as part of legislation against sex discrimination in employment (McKenna 1991). Connell (2009), via Acker (1990), argues that the neoliberal movement towards equality of opportunity at work happening in Western nations at this time was based on a principle of de-gendering organisations to place the emphasis on individual skills. Similarly the driver that opened the door to men in midwifery was a by-product of seemingly gender neutral legislation.

Cisgender men are the most significant gender minority at 0.3% of UK midwives (Sannomiya et al. 2019). In this paper we argue that their presence provides a unique perspective on how sexuality is made visible and regulated in organisational spaces. We start by making the case that IC is the nexus where gender and sexuality converge to dictate the experiences of men and how midwifery, as distinct from nursing, presents unique challenges for them. We then argue that Ahmed's theory of Orientations (2006b) can account for bodily interactions in our study because it makes sexuality visible and explains how it is viscerally experienced and managed by men working as midwives.

Following the methodology section we present key vignettes from interviews with 15 men who are midwives and show, via Orientations, how participants recognise that IC creates boundaries to their acceptability, how they negotiate them to render their IC less transgressive, and the internal conflict they experience when their IC risks being rejected. As the first in-depth empirical study of men in midwifery to critically analyse the role of sexuality in shaping their experiences, this paper makes an important contribution to midwifery and healthcare studies more widely. Existing literature that engages with Ahmed's Orientations focus on sexuality as an identity – our paper extends this by accounting for embodied experiences beyond those of people with marginalised sexualities and gender identities. Specifically, we show how cisheteronormativity is constructed and maintained in institutions through people's orientations to one another, regardless of their sexual orientation. Accordingly our work makes an important and novel contribution to sexuality studies which is absent from other writings on midwifery.

Intimate Care

The continued gendered segregation in midwifery centres on the provision of IC. Within midwifery, birth has been described as sexual and sensuous (Buckley 2010) because of hormonal activity which provokes disinhibited behaviour normally displayed with trusted sexual partners. IC and physical proximity are key elements of midwifery which work in synergy with birth physiology, relying on the birthing person feeling psychologically and physically safe in order to unfold effectively. Within Europe, the taboo surrounding men working as midwives emerged because it was believed that only cisgender women within heterosexual relationships could conceive and give birth (Pendleton 2021). It was argued that exposure of genitals to members of the opposite sex would result in a loss of modesty for parturients, with concomitant accusations of perversion and predation by male birth attendants (Donnison 1988). IC by female nurses was not regarded as problematic because women were not seen as having 'the power and status to exercise exploitation' (Chiarella and Adrian 2014). Vaginal examinations (VEs), a key component of intrapartum care, may be acceptable as a clinical procedure by female midwives on other women in a relationship traditionally characterised as altruistic and non-hierarchical (Bradfield et al. 2018). Conversely, power is attributed to men in this setting via sex-role theory which sees them adopting sex appropriate behaviours to perpetuate their privileged status over women (Wedgwood 2009).

Despite the rich potential for exploring how IC is navigated by men in midwifery, it has attracted little empirical enquiry since men attained the right to employment in the field. The inverse is true for nursing where literature shows that male nurses frequently fear being alone with women in case of accusations of inappropriate touching, eliciting feelings of anxiety and embarrassment (Keogh and Gleeson 2006). Gay male nurses may experience internalised homophobia, hiding their sexuality in heterosexist environments (Harding 2007), whilst others experience anxiety when working with children in case they are accused of paedophilia (Kellett, Gregory and Evans 2014). Thus there is fear not only of being associated with sexuality generally when delivering IC, but of accusations of criminal and abusive sexuality specifically.

Mokdad and Christensen (2021) analysed posts on parenting websites and found that IC by men continues to be seen as problematic. Most contributors felt angry or embarrassed at the prospect of, and therefore refused, IC by men, but conversely were pragmatic about IC with a male doctor. The distinction centred on whether the care was perceived as 'technical or intimate.' This perpetuates the notion that men are essentially unsuited to IC due to their association with a techno-rational approach to healthcare (Evans 2002). Furthermore, what is perceived as acceptable when a patient is sick diminishes as they move towards wellness, and the degree of intimacy is renegotiated as the patient recovers and can care for themselves. This is particularly pertinent for men in midwifery which supports a physiological life event – usually the continuation of a sexual act – for a person who is likely at the peak of their physical health. Making sexuality – the recognition of oneself as a sexual being and not limited to behaviour, attraction or identity (Ellis, Riggs and Peel 2020) – visible in midwifery can inform curricula, policy, and training because it supports midwives to better understand gendered power dynamics when interacting with service users and the facilitation of fully informed consent when providing IC.

Orientations

Research on the experiences of men in healthcare has largely focused on gendered workplace structures via Connell's work on masculinities (2009) (see Cottingham 2019, Simpson 2004). Whilst masculinities are key to exposing how power and privilege direct men's behaviours, Connell recognises its limitations in not adequately accommodating the role of social embodiment in empirical studies exploring hegemonic masculinity (Connell and Messerschmidt 2005), and specifically how masculinities interact with sexuality (Wedgwood 2009). Cottingham, Johnson and Taylor (2016) have begun this work by exploring the heteronormative labour required of men of any sexuality in nursing when performing IC. They divide this into discursive, cognitive, and emotional labour to manage the institutionalised heteronormativity embedded within healthcare which positions men performing IC as a sexual threat. However, their work cannot account for the embodied and visceral responses of the men in our study and accordingly, we turned to Ahmed to understand how sexuality is made visible and experienced within midwifery.

Ahmed argues that space has a phenomenality to it because its existence 'is dependent on bodily inhabitance' (2006b, 6). She questions how the orientating device of sexualities (contained within the term 'sexual orientation') serves phenomenological enquiry to understand how bodies come to inhabit certain spaces. Over time sexual orientation has become foregrounded as an identity whilst its directionality has receded. Returning it to a metaphor, Ahmed questions what happens when its directionality is brought back into view, positing that spaces dictate how bodies behave, moving them along lines created by repetition over time. These lines can be physical but also metaphorical, intellectual, and visual and are invisible until they are disrupted by unfamiliar bodies. Registering things as unfamiliar is disorientating and requires work – or reorientation – to regain a sense of being at home in certain spaces.

By Ahmed's own account Orientations is only a model for how bodies 'become orientated by how they take up space and time' (p.5). Much of the work taking up Orientations has focussed on LGBTQIA+ people, combining directionality with identity in using the word 'orientation' in order to understand sexuality. Goldberg, Ryan and Sawchyn (2009) cite this as helpful in understanding the experiences of lesbian birthing couples and argue that midwives must orientate away from the heteronormativity underpinning their profession to make spaces safe for lesbian service users. Heyes, Dean and Golderg (2016) have used Orientations to explore experiences of queer healthcare users and nurses navigating heteronormative organisations. Their analysis shows how these spaces compel queer service users to feel uncomfortable when they cannot follow the trajectories laid down for straight service users – for example a female partner attending an antenatal class, because only men are recognised as legitimate secondary parental figures.

Vitry (2020) posits that spaces themselves dictate not only which bodies are allowed in the workplace, but also how those bodies act once there. They give the example of queer bodies' alienation in workspaces because lines of economic power are laid down by those deciding who is hired and whose complaints get heard. Similarly Linander et al. (2019) interviewed trans people and use Orientations to understand the physical exhaustion incurred through straightening devices in cisgender spaces. Siverskog and Bromseth (2019) show that the reverse is also true when LGBTQIA+ adults reorient themselves towards chosen families in order to feel at home. Whilst these papers explore how queer bodies specifically navigate lines in cisheteronormative spaces, they provide useful starting points to consider the

participants in our study who did not consistently foreground their sexuality as an identity, queer or otherwise. Considering our findings in conversation with Orientations allows us to see how sexuality is summoned, constructed, and – crucially – experienced through interaction, so as to become a dynamic field of action.

Methods

This paper emerges from a larger interpretative phenomenological analysis (IPA) study of 15 men who work as midwives in the UK. Because there was no preexisting substantive qualitative research on this phenomenon, the research question was inductive: namely, 'what are the experiences of men who work as midwives?' Phenomenology seeks to describe the essence of someone's lived experience stripped of superimposed theories and prejudices. IPA, however, draws on Heideggerian philosophy in not attempting to transcend embodied experiences (Smith, Flowers and Larkin 2022) but to hear people's interpretations of phenomena because this is a cardinal quality of what it means to be human. This is important to avoid a descriptive or discursive approach which adds additional scrutiny to men who are already hypervisible in their everyday work and objectified through journalistic fascination. IPA returns agency to participants by providing accounts rich with their individual voices which are largely absent in existing literature. Rather than only seeing points of convergence between participants, IPA's idiographic approach gives equal emphasis to points of divergence, illustrated by verbatim quotes mitigating the reductive gender essentialism that has characterised midwifery to date (Pezaro et al. 2024).

This study received approval from the University of Northampton Ethics Committee (ID: ETH1920-0149), and recruitment took place via an article published by the Royal College of Midwives inviting anyone who identified as a man and was a midwife to participate. 12 men were recruited initially with a further three via snowball sampling. Demographic questionnaires showed that all were cisgender men, six were gay, two bisexual and seven straight. For comparison, 57% of men in midwifery identify as straight (NMC 2020a) whilst 0.4% of midwives do not identify with the sex they were assigned at birth (NMC 2020b). A participant information sheet outlined the aims of the study and after participants had provided written consent, interviews were conducted online lasting on average 90 minutes. Following transcription, confidentiality was achieved by replacing names with pseudonyms and redacting identifying details. Participants were invited to remove any parts of transcripts that they no longer wished to be made public. A challenge was the small potential sample size with only 165 men currently registered as midwives in the UK. To minimise the risk of jigsaw identification, limited demographic information is included and specifics such as age, length of service, or geographical location are avoided.

Each interview was analysed separately, with exploratory notes documenting semantic content and explicit meaning alongside repeated phrases, images and references. These were organised into 'experiential statements' capturing a 'concise and pithy summary' of iterations of the phenomenon (Smith, Flowers and Larkin 2022, 87). These were reviewed and clustered into personal experiential themes (PETs) summarising the key meaning-making of the phenomenon and then repeated across all 15 interviews. PETs were considered alongside each other to see how combined they created new understandings or reaffirmed what had been understood individually. This resulted in three group experiential themes (GETs) emphasising both commonalities across participants and contrasting narratives to show unique experiences of the shared phenomenon. Analysis was conducted without

predetermined theoretical lenses to privilege the participants' experiential accounts. Theory in IPA is typically reintroduced in a separate 'discussion' section, but we choose to present it in dialogue with the participants' words. Reflexivity was informed by the use of the COREQ guidelines (Tong, Sainsbury and Craig 2007) throughout all stages of the research. In particular, this allowed the first author to capitalise on his emic and etic experiences as both researcher and midwife. This makes transparent IPA's double hermeneutic process – with the researchers making sense of the participant making sense of the phenomenon – to reveal an additional layer of meaning not available to participants because they are immersed in it.

One GET explored the participants' relationship with gender when becoming a midwife; the second GET their experiences of being a discrete minority group. In this paper we centre the GET where, through discussing their experiences of working as midwives providing care for cisheterosexual birthing couples, the participants come to recognise that they bring an unanticipated, unwanted and unhelpful sexuality into the birthing room.

Findings & Discussion

Transgressing and reconfiguring boundary lines

Awareness of sexuality within professional spaces occurs through moments of disruption. Early in his career Adam worked with a colleague supporting breastfeeding:

> I remember working with the parentcraft sister… [she went] behind the curtain, barely spoke to the woman, opened her nightie, grabbed her breast, grabbed the baby, put the two together and basically forced the baby to breastfeed… I thought, 'Oh my God, I can't possibly do this! …There are clearly certain things that my female colleagues do... that there's absolutely no way that I can do!'

As Goldberg, Ryan and Sawchyn (2009) point out, heterosexuality can be perpetuated as hegemonic by relegating sexuality, as an orientation rather than an identity, to private spaces, thus making its regulatory power invisible in everyday interactions. This can be seen through Adam's observations because of an unspoken assumption that women touching other women's secondary sexual organs in the postnatal ward is not regarded as sexual. The orientation of Adam's body towards the breastfeeding woman was queer because it could not 'line up' (Ahmed 2006b, 107) with how women are sanctioned to turn to other women. Adam juxtaposed the positioning of a woman touching another woman's breasts as unproblematic against the impossibility of him doing the same. He highlighted the female midwife's mechanistic way of facilitating breastfeeding and repeated 'no way' to emphasise his shock when considering he may need to do likewise to function as a midwife. He offered a more explicit example of becoming conscious of his sexuality later in his career:

> A woman was transitioning into more active labour, and was becoming really warm so had started [removing clothes…] and just put her arms around me, completely naked… and her partner walks into the room... you're looking at his face and you're trying to make that expression, to say, '…This is nothing other than... I'm completely oblivious to the fact that your...'

Here, a woman seeking support whilst naked became loaded with risk should it be perceived as sexual by the partner. Adam's priority was to communicate that he was 'oblivious' to the woman's nudity, in so doing betrayed the fact that he was acutely aware of it. The need to communicate this non-verbally so that the woman remained unaware of these dynamics reinforced Adam's hyper-awareness of how his being in the room disrupted accepted sexual dynamics and forced his gaze to be reoriented towards the partner rather than focusing on the woman's needs. Sexuality must be both acknowledged and suppressed. Adam did not attribute an awareness of sexuality to women in their interactions with caregivers. In fact, the voices of service users were markedly absent in all of the interviews, revealing how omnipresent structural lines of sexuality operated to reinforce heteronormativity and how little agency service users were afforded in regulating it. Rather, it was the participants who self-imposed the policing of these imagined boundary lines, and their awareness was amplified by the presence and reactions (both real and anticipated) of the women's partners.

Boundary lines were also perceived through the eyes of midwives who were women. Mike, as a student, offered his hand to a woman:

> Without thinking I just said, 'There's a hand here… you can squeeze me as hard as you can, you can't break me, I'm made of strong stuff!' ...And tried to just provide that reassurance without taking into consideration… how that might make not only the woman feel but also maybe her partner.

The midwife he was working with cautioned him that:

> … in other people's minds there is a difference between a man offering a hand and a woman offering a hand.

He recalled feeling 'embarrassed' that he did something perceived as 'inappropriate,' due to a woman's hand representing comfort and a man's hand signalling an intimacy beyond reassurance. He then modified his approach:

> What I choose to do is… I will just offer it and say, 'My hand is here if you need it.' It's more of a diplomatic approach.

He moved from acting spontaneously to consciously, but the content of his words to the service user did not change significantly. It is his rationalisation to himself of how he worked more cautiously that offered him protection from further feelings of inappropriateness. He understood by the censure of his mentor that he was queering the lines of connection which were unproblematic when enacted by a male birth partner or a female midwife. Mike was disorientated and had to reorient himself to become at home in such spaces. When faced with the same situation again, he left his hand available but not touching – the bodily connection could be made but must be directed by the woman towards Mike to be acceptable.

Experienced midwives still described being stopped on their journeys and having to reorientate themselves. For Alan, such a moment of disruption came when he performed a VE in the presence of a woman's partner:

> I'm sat on the bed, and I shut my eyes, and I'm looking up to the corner of the room, and I'm trying to get in my head and visualise... where's the sagittal suture[1]... And this fella sat there and said, 'You must fucking love your job!' Seriously, the woman's partner! And it just stopped me.

Once again, it was the partner's presence that forced Alan to confront the unwanted sexuality he brought into the room, challenging him to consider how a clinical procedure might be perceived as sexualised by others. This disrupted Alan's ability to carry out IC. For Ahmed, time is an important part of acquiring an orientation by allowing people to feel they belong in spaces.

These examples show the recurring moments when the legitimacy of men to follow lines laid down before them in midwifery is called into question, forcing them to stop and turn towards the person arresting them. Each time they are stopped the line becomes more visible, and each time their legitimacy is questioned they must reorient themselves. Ahmed tells us that to 'acquire a direction takes time' (2006b, 20), but to be stopped in time equally forces a body to take a new direction when the line available to others is blocked. The constant vigilance following their disruption of invisible boundary lines forced the participants to identify and manage their sexuality in the provision of IC.

Participants talked about an 'added level of '"differentness"' that they brought into a room, causing them to consciously manage the delivery of IC. The powerful imagery of someone walking into a room, donning a pair of gloves and conducting a VE without any preliminary discussion was repeated across multiple participants' accounts. James stated:

> Certain midwives would just come into the room… put on a pair of gloves and stick their fingers into the woman's vagina without even gaining any form of consent…

The participants perceived this behaviour by midwives who were women and obstetricians of any gender as accepted without challenge by service users, but they all strongly rejected it as unacceptable. Rather than assuming the right to access women's bodies, Jake explained how he would act differently to render the space safe:

> Exposing a woman's body to the room is something that I witnessed both medical colleagues particularly, but also other midwives, not very sensitive to making sure the space felt safe …. I would take a lot of time to make sure the environment was prepared correctly.

Giovanni similarly acknowledged that keeping other people out of the space was important, but also that his presence within it could be what rendered it unsafe to some service users:

> When they come into the room it's very important for me to shut the door and make sure that people feel secure, so they're always close to the door and I'm away from it so… if they needed to, they can escape.

[1] This procedure involves inserting two fingers into the vagina to feel the suture lines and fontanelles between the bones on the fetal skull, allowing the midwife to determine the foetus' position.

A tension exists between reassuring service users that, like their female colleagues, they had the skills to examine women's bodies, whilst also anticipating the threat their presence could bring. James described midwives performing VEs without challenge from service users as an 'assault.' Outside of the birthing room this behaviour would be shocking, but within that space it has become normalised, because the social and sexual significance of digital vaginal penetration is not routinely acknowledged either by female midwifes (Kingma 2021) or birthing people (Shabot 2021). When the male-bodied midwife enters the room, the reverse is true and a disorientation takes place; he must then reorient himself to make the situation acceptable. Jake did this by closing the door, whereas Giovanni ensured that the woman was closest to and his body furthest from the door, so that she could 'escape.' For Ahmed, 'the starting point for orientation is the point from which the world unfolds' (8). The door becomes this threshold, a familiar point of arrival and departure and now an important orienting device. By being in the room, the participants brought sexuality into it. By changing how bodies are oriented in relation to the door, or whether the door is open or closed, they could reconfigure the lines laid down to recreate a sense of safety for both them and the women.

Highlighting and minimising sexuality

The most explicit discussion around sexuality occured in Karl's interview:

> I think being a gay man helps. Because... women don't find you so much of a threat…. I sometimes use it to my favour… I camp it up… If someone said, 'You've got lovely Karl looking after you'... they're like, 'Karl! Oh my God, a man...' And then I walk in… Instantly they're like, 'Phew! He's gay!' Which is terrible but that's how I imagine the women being.

He acknowledged that it shouldn't be necessary for him or the families he cared for to go through this process ('terrible') whilst also making his sexuality visible through behaviour stereotypically attributed to feminine-presenting gay men. Benjamin echoed Karl when talking of needing to 'signal' his sexuality, but again, not because of something said by a service user or a partner. He used the identical words 'camp it up' to negate being perceived as straight and therefore as 'threatening' by the male partner:

> I've been into a room and the guy has been... wary of the fact that there's another man in the room. So sometimes you just have to camp it up a bit so that, 'I'm not there to threaten your position. You are the man in the relationship.' ...if I'm talking to the guy, I'll switch from 'mate' to 'hon.'[2] It's just little signals of, 'I'm not… here to threaten, I need to do this because it's medically important, not because I'm trying to see your partner's vagina.'

Other participants also acknowledged that their sexuality was of interest to service users; there were almost identical comments in three different interviews:

> They've asked me if I've got children and if I'm married? (Joseph)

[2] Hon as used here is an abbreviation of 'honey' and a familiar term of endearment used by gay men.

> ‘Have you got children?’ And I would say, ‘Yes!’... As soon as you say you’re married with children they make the assumption that you’re married to a female. (Ken)
>
> They ask about my family then you say, ‘Wife, four children.’ ‘Oh, OK, so you’re not gay then?’ (Alan)

All recognised the pretext for the questions but their responses did not reveal whether they were gay or straight. Service users tried to establish caregivers’ sexuality to feel at ease, but participants retained the agency to withhold (or strategically highlight, as above) their sexuality to make it easier to do their work.

Joseph outright rejected the significance of sexuality in his work, manifesting in repeated discussion of limiting his involvement with IC. He talked about needing to ‘exit’ quickly from episodes of care and used the word ‘minimise’ throughout. He described assisting a junior midwife with suturing a woman’s perineum torn in childbirth:

> I say, ‘I’m Joseph, I’m the midwife that’s running the shift today, don’t worry... I promise you’ll never see me again! Do you mind if I have a look at what’s going on down below?’ … I try to minimise my involvement.

He repeatedly moved from specific examples to more generalised statements, seeking to distance his involvement with IC and redirect the gaze back to the women and partners rather than himself:

> It’s not what I’m doing that’s important... Usually there’s a baby, happily screaming its head [off], or, you know, the mother or the parents have that baby and it’s almost like, we’re not the focus?

The anxiety of being perceived as threatening sat with the caregiver and is something all participants anticipated and worked to diminish using multiple strategies. The experiences of Giovanni, however, diverged from other accounts. He provided an example of when his sexuality was used by a colleague to reassure a service user that Giovanni posed no danger. The service user had made ‘allegations of a sexual nature’ following Giovanni’s clinical assessment and the senior midwife responded by telling her that Giovanni was gay:

> I think in an attempt to calm things down she felt that by disclosing my sexuality the whole thing will stop.

In fact, it had the desired effect:

> The woman was like, ‘Oh sorry, I didn’t mean to, I didn’t really say that…’ And the whole dynamic changed, and she didn’t want anything else to be done about it.

Contrary to Karl and Benjamin’s performances of their sexuality, Giovanni was unhappy that his sexuality had been mobilised to combat the threat that he represented. He felt that it ‘shouldn’t have been… part of the discussion,’:

> Yeah, just really interesting, that… in an attempt to help me, personal information about yourself that nobody needed to know about just became the centre of a discussion.

Through being interviewed, participants came to understand that while sexuality was not always explicitly acknowledged, it was frequently tacitly managed by themselves or by colleagues on their behalf. These behaviours all appear predicated on the assumption that any sexuality they brought into the room was potentially predatory, foreclosing the possibility of benign male heterosexual sexuality. The invisible but regulating power of sexuality within midwifery was revealed when participants realised they were perceived as sexual beings first, before being understood as caregivers. Ahmed recalls Rich's (2004) concept of compulsory heterosexuality which sees heterosexuality as structural rather than individual, and as one of the many ways in which a social order privileging men and upholding patriarchy is enacted. She reminds us that heterosexuality is not simply an orientation between two people, but rather something that 'we are oriented around, even if it disappears from view' and thus a 'compulsory orientation' (2006a, 84) in most spaces. Considering heterosexuality as such is essential for understanding how sexuality becomes embedded in seemingly non-sexual aspects of social life, such as the midwifery workplace.

Compulsory heterosexuality also marginalises all other sexualities. Karl and Benjamin strategically signalled that they were gay to undermine the threat that their maleness, or male sexuality, represented. However, this was not consistent and there was ambivalence about how appropriate it was to acknowledge any sexuality at all. Giovanni did not want his sexual orientation to be part of any discussion with service users whilst other participants were oblique in their answers to service users to keep their sexual orientation private. This confusion illustrates the invisible but regulatory force of sexuality in midwifery, suggesting it is the presence of men which queers the straight lines that have been set down in this context.

Experiencing (the risk of) rejection

Deciding how to exploit or negate the presence of sexuality in the birthing room was predicated on the risk of IC being rejected. Ken began by saying that rejection was 'few and far between.' As the interview progressed, he moved from saying women accepted him to explaining how he took steps to make himself acceptable:

> If you just sat down with them… and just started chatting to them normally, they would often forget and just let you carry on… Some wouldn't be keen on me being in the room at all, or there'd be others that were really happy because… they thought, 'You're a man, you're more experienced, you've got authority!'… If you got them on your side, then usually it just flowed.

The imagery is of being able to neutralise ('forget') the threat of his sexuality by engaging in conversation ('get them on side') prior to any clinical encounter. The authority represented by being a man can also take precedence over any threat of sexuality. The care of female midwives is exempt from the taint of sexuality, reflected in the negligible attention given in the literature to experiences of lesbian midwives (Mander and Page 2012). Studies of women in nursing represent their sexuality as either asexual or constructed in relation to men (Jinks and Bradley 2004), in contrast to the heightened visibility experienced by men who are nurses,

frequently portrayed in the media as bringing an undesirable or threatening sexuality to the workplace (Weaver et al. 2014). Sexuality thus hides in plain sight until exposed by men's presence. The men need to work to reorient themselves within the space, to make their presence acceptable enough to deliver IC. For example Ken extended the lines that can accommodate his presence verbally, in order to get women and their partners 'on side.'

All participants acknowledged that women declining IC is a constant possibility and an occasional reality. On a busy shift Ibrahim triaged a woman in advanced labour:

> I realise she's about to deliver. The husband asked me, 'Can you leave now?' I said, 'No, I can't because… your wife would deliver without any health professional…' He walked out shouting for… women to come in, and nobody was answering. He came back and said, 'Can you leave please?' I said, 'Did you find someone?' 'No, but I want you to leave. I don't want a man to deliver my baby.' And I said to him, 'There's no one here, I cannot leave this woman.'

In common with other accounts, it was the man who declined IC on behalf of his partner. The woman's perspective was again noticeably absent, but here Ibrahim brought her into the narrative:

> I can see that the wife wanted to say yes, but it was a bit of difficult... because if a husband said no and she said yes, it will be a problem between them…. She was looking at me like begging with the eye contact that, 'Please see me, don't leave me!'

To the woman Ibrahim represented safety not sexuality, but the reverse was true for her partner. Alan had a similar encounter but with the opposite reaction from the woman:

> She was obviously in very advanced labour, very distressed, couldn't speak a word of English… And her partner said, 'What are you doing?' And I said, 'We need to see what the baby is doing, we could do with a vaginal examination.' And she's looking at me… horrified… but he said, 'Just do it! I give you permission…' I said, 'No!'

They were both at the centre of competing gazes, perceived simultaneously as both a threat and a source of safety, and negotiating how to act ethically as a midwife and a man delivering IC.

Ahmed (2006b) argues that disorientation occurs when we become embodied by encountering ourselves through the objectifying gaze of others, pulling us out of subjectivity and forcing us to consider ourselves in relation to other bodies in spaces. When Adam performed IC, he turned to look at the woman's partner, 'trying to make that expression' to signal he is oblivious to the woman's nudity. When Alan did it, he directed his gaze 'up to the corner of the room', but the woman's partner pulled his gaze back into line with his when he said, 'You must fucking love your job!' Joseph told service users not to worry because 'you'll never see me again,' emphasising the transitoriness of his disruptive presence. The most striking lines of sight appeared for Ibrahim and Alan when birth was imminent. The service user begged with eye contact for Ibrahim to stay and deliver her baby. Conversely, Alan found the service user 'looking at me… like's she's horrified.' The gaze is a powerful orientation strategy, signalling when sexuality is not allowed in the room.

Conclusion

We began this paper by arguing that the exclusion of men from working as midwives came about because of the need to provide IC, a component of the job which cannot be delegated and brings a challenging sexual dynamic into the caregiving interaction. The taboo around men working as midwives is predicated on an understanding that all midwives and all people accessing midwifery services are – at least until recently – cisgender women, in order to provide a safe space from interactions with men positioned as predatory. Thus, an implicit binary cisheteronormativity structures interactions within the birthing space and is disrupted by the introduction of men working as midwives, but this also provides a unique site to explore how gender and sexuality combined must be negotiated within organisations. This paper, as the first in-depth qualitative study of men in midwifery, makes a novel contribution to the wider empirical evidence of men working in gender incongruent professions by making sexuality its explicit focus.

We presented vignettes from interviews with 15 men, showing them making meaning from interactions with female midwives, parturient women, and male partners. Introducing the concept of Orientations makes visible how their embodied presence conjures up a sexuality that does not exist for midwives who are women or for medics of any gender. Through the lens of Orientations, spaces become fields of action where the regulatory gaze of others cause men who are midwives to stop, determining where to place their bodies to make their presence and actions acceptable despite the sexuality they bring into the room. Our work makes an important contribution to the existing corpus of empirical studies working with Ahmed's theory to show the regulatory effect of organisational spaces on the construction of sexuality. Unlike previous studies, we extend it to show that it is not only non-normative LGTQIA+ sexualities that are disoriented, but Orientations can also make *normative* sexuality visible in heteronormative spaces. By focussing instead on orientations contained within spaces, the lines laid down by repetitive actions, we can move beyond accounts of gender and sexuality which require knowledge of whether individual identities are queer and consider instead how all bodies may be queered (i.e. disoriented and forced to reorient) through space itself – considered here itself an active agent in enforcing cisheteronormativity.

Orientations makes visible the regulatory power of heterosexuality within midwifery via men who work as midwives and unwittingly disrupt this framework, finding themselves queering established lines even when they themselves do not identify as queer. Orientations can therefore illustrate how sexuality and gender shape the experiences of those with the most privilege, cisgender men. Our empirical study, via Orientations, illustrates that considering how sexuality directs men's experiences of working as midwives can help us understand the complexity of their experiences, as well as offering a novel contribution to wider understandings of the negotiation of sexuality in organisational spaces. Our work therefore importantly makes visible how gender and sexuality are not just individual identities but also embodied experiences for people who do not otherwise have to routinely acknowledge their everyday role. To borrow from Vitry (2020), shifting the focus away from considering *which* bodies are allowed in spaces towards centring spaces as dynamic operational fields allows us to see *how* bodies negotiate occupying them.

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Conflict of interest

The authors have no competing interests to declare.

Data availability statement

The participants in this study did not give consent for their interview transcipts to be shared publically as a dataset so supporting data is not available.

AI use

Microsoft 365 Copilot (version number: bizchat.20260210.47.1) was used to help reduce the abstract's word count. AI tools were not used in the writing of the paper.

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