TRIALS of LABOUR

The Re-emergence of Midwifery

Diana Korbek

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Trials of Labour
The Re-emergence of Midwifery
Brian Burtch

Trials of Labour

The Re-emergence of Midwifery

BRIAN BURTCH

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To Leora, Aymer, and Doreen Burtch
and
in memory of Diane Corkum, James Brown,
and the Gordons

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CHAPTER ONE

The Midwifery Movement in Canada

Midwives were in demand among the settlers in Nova Scotia, for in 1755 a request came from Colonel Sutherland, in command at Lunenberg, for "two proper persons to reside there as midwives at a salary of two pounds a year, as the inhabitants were losing so many of their children."

Cited in Jan Gibbon and Mary Matthewson,
Three Centuries of Canadian Nursing

THE PROPER PERSON

Historically, midwives have been the traditional caregivers at births. Today, midwives attend the majority of births worldwide. They are established as an integral part of maternity and infant care in virtually every country in the world. In twentieth-century Canada, however, midwives nearly disappeared as "feminine networks" lost ground to the developing science of obstetrics (Mitchinson 1991, 164). The importance of midwifery was recognized in earlier times in Canada. Colonel Sutherland's request for midwives in eighteenth-century Nova Scotia reflects their importance. Midwives were active for thousands of years among the first peoples of North America, and were an esteemed part of settlements in America (Edwards and Waldorf 1984, 148) and colonial Canada, providing childbirth attendance and healing. A number of documents attest to the importance of lay midwives in coastal settlements in British Columbia and Newfoundland, the prairie region, and in urban centres during the eighteenth and nineteenth centuries (Benoit 1991, Biggs 1983).

The place of the community midwife in Canada has changed dramatically. With the very recent exceptions of Ontario and Alberta, Canada is alone among industrialized nations in not providing a distinct legal status for practising midwives. Once respected and

sought after as a resource for settlers, community midwives in Canada have in recent years been subject to prosecution or other formal proceedings (such as coroner's inquests or inquiries). Whether one sees the Canadian midwife's status as *alegal* (having no clear status in law) or *illegal*, the past two decades of the midwifery movement in Canada confirm that midwives are liable to be charged with practising midwifery (or medicine) without a licence. Criminal prosecution of community midwives has also been carried out. Even where such formal prosecution is not launched, there have been numerous coroner's inquests and inquiries into midwifery practice, usually after infant deaths.

In this book I will examine the ways in which the midwife's role has been transformed throughout Canada. This transformation has been threefold: first, campaigns against midwifery practice have led to the near-eradication of the lay midwife; second, birth and pregnancy have been redefined as medical events, requiring the supervision of physicians and nurses and the virtually routine application of technological aids; third, midwifery was the subject of a complex series of responses in law and state policy, leaving only a limited footing for establishing midwifery as a self-regulating profession in Canada and the United States.

Trials of Labour traces the difficulties faced by midwives and their supporters in questioning the domination of birth care by physicians and nurses and the nearly complete management of labour, delivery, and early post-partum care in hospital settings. Yet this is not simply a story of victimization writ large: Canadian midwives have to date avoided criminal conviction, continue to lobby for legal recognition, and attend births even though midwifery is not clearly recognized in law. Nevertheless, it is ironic that midwives – who are entrenched in most other countries – have received a generally dismissive and sometimes hostile reaction from the dominant health professions and government bodies responsible for justice and health care. In the media and the courts, and in debates over birth care, midwives in Canada are often on a form of trial, their competence called into question and their motivations and practices subject to distortion.

Midwives seek to restore a sense of intimacy and community throughout the birth process. In this they face limitations, not all of them traceable to official resistance. Dramatic changes have occurred in family structures and communities in Canada and on a global scale. The family as the locus of childbirth and child-rearing has become diffuse, with institutions such as the hospital, the school, and child-care centres taking more responsibility and control. The sense of community has also been altered, particularly in terms of a community of women. Historically, women formed communities of

interest that included pregnancy, childbirth, and health care (Ehrenreich and English 1973; Oakley 1976, 17–58). These communities thrived well into this century in some regions of Canada. Outport villages in Newfoundland are one example of the importance of midwives and the community of women (Benoit 1991). Kitzinger (1978: 125–6) adds that midwives in peasant societies had high prestige and considerable power as birth attendants, and for presiding over the forces of fertility. Structural changes in midwifery, families, and communities are thus central to an understanding of midwifery practice in health care systems.

The professionalization of midwifery – such that pregnant women are made into clients, and served by midwives, nurses, and physicians – is a major force shaping the midwifery movement. In a sense, while this ideology of professionalism is a barrier to midwifery, it has also given life to the modern midwifery movement. Professional management of birth, enjoying a near-hegemonic status in North America (with approximately 99 per cent of births occurring in hospitals or clinics under professional management), has been subject to wide criticism for its depersonalized care and excessive intervention, and at times for the iatrogenic effects of medical or nursing supervision of birth. Illich (1977: 35–36) describes *clinical iatrogenesis* as "all clinical conditions for which remedies, physicians, or hospitals are the pathogens, or 'sickening' agents."

Criticism of obstetrical procedures ranges from a growing feminist literature that regards some procedures as reproducing the dominance of technology and professional needs over women's bodies and interests, to ongoing criticism from medical and nursing practitioners concerning high caesarean section rates and other forms of "technocratic interference in the process of childbirth" (Cohen and Estner 1983, 11). Concerns over morbidity associated with modern obstetrics in Canada and elsewhere have been expressed in the medical profession. Some physicians have involved themselves in support of midwifery: these include Cheryl Anderson, Kirsten Emmott, Bernd Wittmann, Gabor Mate, Murray Enkin (Canada), Marsden Wagner (World Health Organization), G.J. Kloosterman (Netherlands), and Wendy Savage (United Kingdom). This list is far from comprehensive, but highlights support for midwifery within the medical community. While acknowledging the importance of specialized interventions and various forms of monitoring for high-risk births and in the care of premature infants, these physicians see great value in restoring birth management to the care of midwives.

The midwifery debate in Canada is also discussed in the context of other health-care systems. This requires an appreciation of the political economy of health care. While the majority of births

worldwide are attended by midwives (Kitzinger 1988, 9), there are substantial disparities in resources and training of birth attendants among nations. In Canada, the United States, and the United Kingdom, over 90 per cent of births are attended by medically trained personnel, including midwives. Within these countries, disparities in care available to women and in infant mortality (especially among the poor) are evident. The promise of medically supervised births thus has its failings in practice, whether owing to an erosion of birth-related knowledge among expectant women, unnecessary interventions, or inadequate access by needy women to services such as prenatal care (see Mitford 1992, 219). In contrast, India, Malaysia, and several African countries report less than 30 per cent of births attended by such trained workers. Whereas many developing countries lack skilled birth care, in wealthier countries "growing disenchantment with modern medicine's approach to birth care is leading to a resurgence of midwifery" (Seager and Olson 1986, section 11).

DEFINITIONS OF MIDWIFERY

There are many definitions of midwifery. A generic definition of "midwifery" includes anyone, male or female, who assists a woman in childbirth, including certified nurse-midwives, community midwives, folk or lay midwives, neighbours and spouses who assist at birth, obstetricians, general practitioners, obstetrical nurses, and those compelled to assist at unexpected births (such as police officers and paramedics). A more restrictive definition of midwifery includes only female birth attendants. In this usage, "wife" (originally "wyfe," or woman) and "woman" are linked. There is some debate over whether the term "midwife" includes *all* women who are present with the mother at birth, or only "a woman by whose means the delivery is effected" (*Oxford English Dictionary*).

THERE IS CONSIDERABLE agreement that midwives form an occupational grouping; this means that occasional participants in birth are not correctly defined as midwives. The midwife is thus "any individual who, by choice, assists a woman in the process of delivering her baby, and who consciously assumes some degree of responsibility for the health and well-being of mother and child. This is the broadest possible definition, and includes trained nurse-midwives, traditional midwives or birth attendants in all cultures, as well as trained obstetricians. *It also includes men and women who together decide to deliver their child at home.* It excludes firemen, policemen, emergency service

personnel and random individuals who fortuitously deliver an occasional baby as the result of idiosyncratic circumstances" (Cobb 1981, 75, emphasis added).

Many midwives see midwifery as distinct from medical specialties and general practice. For them, this incorporation of midwifery and obstetrics is misleading. It obscures significant differences in practice and philosophy between midwives and other birth attendants. This is especially so in that it is thought that midwives should honour women's preferences in birth, and that midwives should establish a deep rapport with expectant mothers and families, partly through intensive prenatal care.

In Canada, two forms of midwifery practice were prominent in the 1970s and 1980s. As we will see later, these forms are no longer cut-and-dried: midwives increasingly are seeking multiple routes of entry to the midwifery profession. The first was community or independent midwifery, associated primarily with home birth, as well as labour coaching in hospital, prenatal classes, and lobbying government to restore midwifery. The second form was more closely associated with obstetrical nursing, termed *nurse-midwifery*. Advocates of the nurse-midwife pointed to the versatility, training, and public appeal of birth attendants who were also qualified as nurses.

Community midwives in Canada have an uncertain and precarious status in law. They may be disadvantaged without the established professional and legal protections accorded physicians and nurses. Community midwives prize continuity of care with their clients, from regular prenatal visits (usually of longer duration that that of general practitioners), care through labour and delivery, and follow-up via post-partum visits with the mother and family. By the early 1980s in British Columbia, however, most community midwives were not licensed midwives, nor did they have access to formal training. Community midwives were thus largely self-taught, referring to available texts and other materials, as well as apprenticing with other, more experienced midwives. Since the early 1980s, with the advent of a midwifery school in Vancouver, many of these community midwives have completed an academic and clinical program in midwifery, and have been accredited as midwives through Washington state. This accreditation means that the midwives can practise in Washington state or in other jurisdictions with reciprocity. Initially, British Columbia did not provide reciprocity, so the midwives could not establish lawful practices in the province.

The term "community midwife" is more popular than "lay midwife." "Lay midwife" is thought to connote inferiority and dangerousness. Many community midwives have nursing training, hospital

experience, and accreditation. Unlike obstetrical nurses, who practise in hospital settings or other accredited sites, community midwives in British Columbia practise for the most part out-of-hospital. This practice includes primary prenatal and postnatal care and assistance with home births. Community midwives may also provide birth control counselling, advice on breastfeeding, prenatal classes, and labour coaching in hospital. Community midwives, once thriving in various parts of Canada, have generally been discouraged from practice. In Vancouver, for example, approximately twenty community midwives in 1980 and fifteen in 1993 were known to be practising, despite significant population growth in greater Vancouver.

A nurse-midwife is a birth attendant who has completed nursing training, is registered with the local (or national, state, or provincial) nursing association, and has completed additional midwifery training in an accredited program. The term "nurse-midwifery" is to a large extent an Americanism. In many other jurisdictions, midwifery is not seen as a hyphenated profession. Some argue that nurse-midwifery keeps midwives on a lower rung of the hierarchy and under physician control of one form or another. Supporters of the concept point to the legacy of nursing care, and to considerable evidence that nurse-midwives have earned the trust of the women they care for. The sphere of practice of certified nurse-midwives (CNMS) can be very broad. Nurse-midwifery may involve continuity of care beyond attendance at labour and delivery:

> [The certified nurse-midwife] might be employed by a hospital, by a medical center, by an affiliated community-based maternal and child health service, or by an obstetrician-midwife group practice. She manages the complete maternity care for mothers with an essentially normal course of pregnancy. She always functions with readily available medical consultation should any sudden medical complications arise. Today's modern midwife is prepared to function in all areas of [a] woman's health maintenance concerned with reproductive processes, including family planning and childbirth. Perinatal care and newborn health management are integral parts of midwifery practice (Lang 1979, 145).

Lang's definition encapsulates several major themes concerning the redefinition of midwifery in contemporary medical care. First, the CNM is often not an independent practitioner working out of her home or private office. She usually works as an employee or a partner in a practice. Levy and his associates (1971, 51) reported that "nurse-midwives are never independent practitioners; they always function within the framework of a physician-directed health service." This

assumption of the subordination of nursing deserves critical scrutiny, for it underestimates the role of the nursing profession in maternity and infant care. A second theme is that non-medical personnel (such as lay midwives) are excluded from the CNM's network of collaborating birth attendants. Third, the premise of "readily available" medical consultation obscures the very tangible conflicts between the sphere of practice of nurse-midwives and that of other birth attendants. Rooks and Fischman (1980, 990) saw nursing training as an integral part of the development of American midwifery. The International Federation of Gynaecology and Obstetrics (FIGO), together with the International Confederation of Midwives (ICM), formulated a widely accepted definition of midwifery that encompasses nurse-midwifery and other forms of midwifery (see Phaff et al. 1975, 2).

> A midwife is a person who, having been regularly admitted to a midwifery education program, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventive measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency services in the absence of medical help.
>
> She has an important task in health counselling and education, not only for the women but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practice in hospitals, clinics, health units, domiciliary conditions or any other service.

This broad definition of the midwife's role has been accepted in many countries. The potentially wide sphere of practice for midwives contrasts with the artificial division of Canadian midwives into the more independent but illegal practice of community midwifery or the hospital-based employment of nurses trained in midwifery. In fact, there is a considerable blurring of these two kinds of midwifery, such that the generic term *midwife* is now widely used in Canada. "Midwife" is a stand-alone term in most other nations.

Obstetrical nurses are legal practitioners under the British Columbia Registered Nurses Act. Nevertheless, their legal status has been accompanied by the containment of midwifery skills within

many obstetrical settings. As discussed in chapter two, the FIGO/ICM definition may be compromised when midwifery services are implemented so as to restrict what midwives can legitimately do as caregivers. For a critique of the doctrine that midwives *must* be nurses, see Flint (1986a).

The contrived distinction of nurses versus midwives has been questioned by the midwifery movement in Canada, the United States, and other countries. The midwifery movement in North America draws on community midwives, nurses and nurse-midwives, and supporters of midwifery. While there is some disagreement over the proper sphere of midwifery practice in Canada, those active in the movement have generally held fast to the principle that midwifery ought to be legalized. This would mean that midwives would no longer be singled out as objects of highly publicized, expensive legal proceedings. The midwifery movement also espouses public education, holding that there is support among the public for midwifery attendance. "Midwife" is thus seen as a more inclusive term, to be applied to those who are expert in the management of normal childbirth, and to those who assist in high-risk management supervised by medical specialists. The movement to bolster midwifery in Canada thus draws on a range of practitioners and supporters, and seeks to establish means of certification, training, guidelines for practice, and a more collegial relationship with other practitioners.

THE MIDWIFERY CONTROVERSY

The modern controversy over reinstating midwifery services in Canada is best understood in the light of conventional research surrounding maternity and infant care and a growing body of critical literature addressing the nature of power and control in health services and social life generally. In this book I will provide an argument in support of the reinstatement of midwifery in Canada, an argument that is well supported through conventional studies of birthing services. The hegemonic powers of the medical profession and formal state powers (in legislation and social policy) have generally served to curb and weaken initiatives for the reinstatement of midwifery services across Canada. The short history of the modern midwifery movement in Canada confirms the potential danger of compromising midwifery by granting it legal status at the considerable price of imposing medical direction upon it.

Much contemporary research on childbirth has been medically oriented, addressing obstetrical techniques and birth outcomes. This approach is directed toward improved services for women in labour

and their infants. It is associated with considerable improvements in the management of high-risk pregnancies and methods of treating newborns suffering from low birth weight, genetic deformities, fetal alcohol syndrome, and the like. Technical discussions of the prevention and treatment of mortality and morbidity are central to this literature, along with a growing interest in health promotion for expectant mothers and infants. This literature is of course valuable, and arguably invaluable, in understanding the mechanics and problems associated with childbearing.

Other approaches to childbirth present a less clinical or technical portrait of childbirth. For instance, sociological studies of pregnancy and childbirth have shown interest in the history of birthing practices in North America and elsewhere and in cross-cultural variations in birth (Oakley 1980). A vast literature has emerged on the high rates of intervention in western obstetrics and ongoing work suggests that procedures could be modified such that morbidity might be lessened without compromising the well-being of mothers of infants. There has been little information on the self-regulation of birth attendants by professional associations such as colleges of physicians and surgeons and nursing colleges, or on the more direct involvement of the legal apparatus of the state. Framed within the research and clinical experience of modern medicine and nursing, North American perspectives on birth have recently broadened. This broadening includes an appreciation of other countries where midwifery is much more integrated with medicine and nursing. Proponents of this critical approach thus see midwifery and health promotion as cut from the same cloth. Midwives can promote public health and provide a valued service if the health system allows for qualified midwifery instruction and practice.

The anomalous situation of midwives in Canada – at best, alegal; at worst, subject to inquests, inquiries, trials, and penalties – stems from a complex mixture of medical ideology, repressive criminal legislation, and protective civil legislation in the form of medical acts. Those medical acts grant substantial powers to medical associations in the supervising of and intervening in the birth process. For midwives, the renewed interest in theories of the state in western capitalist societies provides a framework for understanding the resistance to re-establishing midwifery, and also charts directions that may lead to the broadening of options in maternity and infant care. Specifically, the central question is how state intervention in childbirth attendance in British Columbia has contributed to the outlaw status of the midwifery profession. These questions are discussed in more detail in chapter five.

Critical theory begins with the assumption that the state secures patterns of domination and subordination in Canada and elsewhere. The nature of domination encompasses patterns of male dominance over women (as employees and patients) within the medical and other spheres, the everyday power of professionals over non-professionals, and the spectrum of routine technological intervention in childbirth. State support for the medicalization of childbirth is historically rooted in a legal monopoly of practice for male physicians and surgeons. The monopoly status protected the interests of the then emergent, now dominant, medical profession. The exclusion of non-medical practitioners by the state thus enabled medical practices to develop with limited competition from "irregular" practitioners (Biggs 1983; Mitchinson 1991).

The midwifery movement, as a public interest force, challenges the assumption that the state has acted in the public interest by promoting a virtual monopoly for physicians and nurses in managing births. In its general non-responsiveness, or its active prosecution of midwives, the state has often been complicit in the historical takeover of birth attendance. As mentioned earlier, the takeover is almost complete: close to 100 per cent of births in North America involve hospital-based deliveries supervised by medical personnel (Arms 1977; Tonkin 1981).

Government officials are not presented as simply in league with medical interests in Canada. There is a degree of autonomy exercised by officials in reconsidering social policies. Conspiracy theories of the state and health professions oversimplify the complexity of the midwifery debate and the prospects for new policies for midwifery in Canada.

This book also examines the practices of community midwives. Reference is made to my study of 1,006 attempted home birth records in Canada (Burtch 1987a), along with other studies of modern midwifery practice in Canada and elsewhere. These studies lack the rigour of scientific experimentation (randomization, perfect matching of control samples). On balance, however, they suggest that qualified midwives can practise so as to reduce morbidity, with a minimum of interventions and to the considerable satisfaction of the women attended by them.

The specific apparatus of law in Canada is considered here. The thesis to be examined is that contemporary midwifery practice, whether undertaken by nurses trained in midwifery or by lay midwives, is substantially constrained by current legislation and legal practice. These constraints include the delineation of midwifery as an element of medical practice under the Medical Practitioners Act

in British Columbia. This has transformed midwifery from a local practice into an illegal act, thereby effectively transferring power from the midwives and their clients into the professional sphere of physicians and nurses. Other constraints include the powers of discipline and legal redress that physicians can employ against midwives, including the potential charge of practising medicine without a licence. There is also a greater likelihood that police and prosecutors will initiate criminal proceedings against non-medical birth attendants in the event of injury to the mother or child.

Midwives, among others, have objected to the assumption that preserving a monopoly status for doctors and nurses is in the public interest. A growing body of research is available in support of the argument that midwifery attendance is safe and appealing to parturient women. This finding is not fully established, owing partly to methodological problems in the existing literature. Nevertheless, if midwifery attendance appears comparable to or superior to obstetrical attendance, the question remains: why is midwifery excluded or marginalized while the profession of medicine is fostered? Legal barriers to midwifery practice support the professional interests of organized medicine, and at the same time contain more radical, feminist initiatives, including the questioning of power within a patriarchial medical system (Eisenstein 1981, 220). The movement to recognize midwives is not wholly a radical feminist initiative. It does, however, stem from the feminist critique of patriarchy in law and health care. Radical associations have been formed – for example, the Association of Radical Midwives. Other groups in England include the National Childbirth Trust and the Association for Improvements in the Maternity Services (Flint 1986, 238–40). The containment of midwives is sought not only through criminal prosecution or prosecution for the illegal practice of medicine, but more broadly through the power of legal ideology. Considerable power is invested in expert medical testimony, and in the expert application of due process principles in legal proceedings involving midwives. These beliefs tend to reproduce a trust in medical and nursing authority and in legal institutions, with midwives walking an uphill grade in seeking full recognition of their profession. The status of medical knowledge as the lodestar of birth management is to a large extent a result of the consolidation of occupational interests in prestige, income, control of patients, and considerable freedom from state or public scrutiny of professional practices. The central problem investigated in this study is illustrated through a specific instance of "statism." Statism is defined as the transfer of activities from particular organizations in civil society to state regulation (Asher 1981,

43–56). Miliband (1973, 1) speaks of the "vast inflation" of the power and activities of the state such that "more than ever before men now live in the shadow of the state."

Studies of statism highlight ways in which the ordinary activities of people are scrutinized, monitored, and sanctioned through the modern state. Panitch (1979, 10) illustrates this expanded role of the state through the subsidization of political parties' expenditures and influences on trade union activities. There is also a growing literature that is critical of the "commodification" of women's reproductive powers, and the profit orientation of many interest groups allied with birth supplies and technologies (Cox 1991; Mitford 1992).

In chapter two I argue that structuralist theorists of the state offer an incomplete framework in assessing the controls faced by midwives. Structuralist theories fail to take into account instances of sustained resistance to state control of social action. Structuralists question the separation between state agencies and non-state organizations favoured by Miliband, substituting a broader definition of the state. This connects formal state structures (the judiciary, the civil service, the police, the military) with ideological structures: political parties, the churches, trade unions, and specific interest groups, including the medical profession and related bodies (see Poulantzas 1978). The structuralist approach allows for distinct lines of authority between the professions, rival occupations, and state officials, as well as competing objectives among them. The initial encroachment of the state in permitting a monopoly status to medical practitioners in nineteenth-century Canada was largely instrumentalist (serving the interests of members of a dominant class). It was also tied to patriarchical ideology, and excluded, where possible, non-professionals (invariably women) from birth attendance. It has been established that the monopoly status of doctors in pioneer Canada was enforced "in the breach" in regions where doctors did not practise. In such cases, lay midwives were allowed to practise until medical and nursing personnel were present (Biggs 1983; Sigerist 1944).

The contemporary focus of this book, while linked with this instrumentalist framework, will address the complexity and vagaries of state enactments and occupational action through a critical framework, using insights from postmodernism, feminism, and the play of class forces best associated with neo-Marxism. A key point here is that structures of knowledge, once rooted in a specialist cadre and seemingly taken for granted, are increasingly subjected to new evidence, new ways of developing or even imagining legal rights, health care, and women's identities. To the extent that postmodernism has an "affirmative" character, new ways of thinking and action are

applied to such profound issues as human rights, peace, and sexual orientation: "The affirmative post-modernists encompass a more optimistic spirit than the skeptics, and they support a range of new political movements ... They encompass 'communities of resistance,' poor people's movements, and therapy groups. They bring together the oppressed, the mentally ill, citizens with disabilities, the homeless, and the generally disadvantaged" (Rosenau 1992, 144; see also Baum, 1990; Young 1990). Borrowing from Marxism, the contemporary state is not simply an instrument of a particular class or set of classes, nor is it a determined set of objective relations. Rather, the state maintains a degree of autonomy in initiating legal reforms and constraining the actions of dominant, privileged groupings. This feature, it is argued, reflects in part the vitality of struggles "from below." It is particularly important to incorporate a feminist critique of patriarchy – within the formal state apparatus, and within everyday cultural practices and beliefs in health care – in understanding the anomalous status of Canadian midwives and attempts elsewhere to limit midwives' autonomy in health care. Attention is also directed to initiatives by state personnel that influence reforms in social justice and changes in criminal justice policies (Ratner, McMullan, and Burtch 1987). The legal apparatus within the Canadian state is assessed in terms of its contradictions, including the tension between democratic freedoms and extensive state regulation of human interests.

The medicalization of maternal and child care is a process against which a number of related issues can be assessed. These include the nature of accommodation to, or resistance against, state regulation. Resistance and accommodation are evident in the occupations of obstetrical nursing and community midwifery in British Columbia and elsewhere. Both occupations seem to manifest degrees of accommodation. Obstetrical nursing has become more allied with medical practitioners as nurse-midwives have sought to be part of a functioning team. Community midwives seek an arm's-length relationship in their involvement with physicians and nurses. Community midwives in this sense challenge the hegemonic status of medical personnel in women's health care. There is some evidence that community midwifery practice is characterized by lower rates of interventions – episiotomies, medication, forceps deliveries, and electronic monitoring of labour – than hospital-based practice. This differentiation is linked with structural pressures on nurse-midwives to defer to physicians during labour and delivery procedures, to utilize hospital equipment and personnel, and the like. This is in turn linked with women's status and the state, especially the concept of

patriarchy – the historical exclusion of women from participation in public life, the barring of women from medical education (Strong-Boag 1979, 109–29; Backhouse 1991), and the gradual dichotomy of authority established between men (as doctors) and women (as patients or nurses), both subject to medical authority (Lorber 1975).

This study of midwifery in Canada addresses the contemporary debate on childbirth attendance and its regulation in a number of ways. Published studies of the history of midwifery and the advent of obstetrics are reviewed to place contemporary midwifery in a historical context (Anisef and Basson 1979; Bohme 1984). An empirical study of the practice of midwives in hospital programs and community midwives in British Columbia and Ontario is used to examine patterns of practice and legal intervention for midwives. The empirical study of home births and midwifery practice is divided into three parts. The first is a comprehensive documentary analysis of birth records and charts pertaining to attempted home births with community midwives. The researcher asked community midwives if they had compiled birth records or charts or had access to them. The researcher then requested access to these records to compare outcomes of midwifery attendance with obstetrical outcomes in British Columbia. This documentary analysis provides original data on various aspects of birth attendance and birth outcomes in the province. These findings are linked with other studies of birth attendance in Canada (for example, Benoit 1991; Tyson 1989). This study of attempted home births supports the finding of reduced morbidity for mothers and infants attended by midwives. It also explores how midwifery practice can empower pregnant women, families, and health-care practitioners.

Published accounts of a midwifery demonstration project at the Old Grace Hospital and the New Grace Hospital in Vancouver between 1981 and 1984 are also considered. In conjunction with physicians, four nurse-midwives provided prenatal care, attendance at labour, and postnatal care for 61 women (see Carty et al., 1984). The Grace project has not been developed as an entrenched service. My understanding is that, on average, ten women give birth under the auspices of the project every month. Some midwives view the service as providing an important service to too few women. And some would argue that midwives ought not to use waiting lists, or be unable to attend a wider clientele. In 1991, the Grace midwifery project was temporarily suspended when midwives active in the service became dissatisfied with artificial limitations on their work, including restrictions on the number of women served.

These two documentary analyses are combined with the information gleaned from in-depth interviews with samples of practising nurse-midwives and community midwives, as well as with other people concerned with maternity and infant care and pertinent legislation (defence attorneys and prosecutors, educators, and consumer advocates). These interviews provide a forum for midwives to speak about their work and about the future of midwifery.

Medical and nursing terminology is consolidated in the glossary. Reference is made throughout the book to specific research reports, such as articles on caesarean section rates, studies of induction procedures and episiotomies, electronic fetal monitoring, and evaluation studies of nurse-midwifery and community midwifery (Placek and Taffel 1980; Brendsel et al., 1979; Student Nurses Association 1979; Shenker et al., 1975). Reference was also made to standard medical and midwifery dictionaries and textbooks (da Cruz 1969; Myles 1975).

The results of the sociological approach – documentary analyses, interview data, and state theories – are interpreted in conjunction with research reports by nurses, physicians, midwives, and health-care researchers. The original research and the available literature are used to discuss how particular groups develop accounts of society and their contributions to a given society. I will examine contradictions in formal regulations of birth attendants and the role of the judiciary in rationalizing and sometimes rejecting legal actions (Cotterrell 1984, ch. 7; Burtch 1992, 124–9).

The study of the implications of legal prohibition begins with a consideration of the historical precursor to modern campaigns against midwives, the persecution of midwives in North America and Europe. It is then extended into a review of recent case law dealing with prosecution of midwives under the relevant legislation in British Columbia and other Canadian provinces.

It is expected that state suppression of midwifery, and current efforts to regulate the practice of midwifery, will illustrate features of the way in which structured patterns of authority and domination are mediated through the state apparatus in capitalist society. At the same time, it reveals the pressures for alternative approaches to childbirth and women's occupational freedom, the limited impact of those pressures on legislative enactments and professional policies (such as those concerning birthing practices), and the attempts of the state to contain those pressures through legal repression and ideological persuasion. The theoretical framework in which the above assumptions are explored involves the role of the state as "relatively

autonomous" of specific economic or other interest groups, such as organized medicine, and as responsive to countervailing pressures yet integral in the promotion of dominant interests as a whole.

The debate over midwifery practice in British Columbia and other Canadian jurisdictions can be identified as a fundamental dispute about the desirability of granting midwives independent legal status as birth attendants. This debate highlights the contradiction between (1) the ostensible "general interest" served by professional birth attendance, and (2) the radical tenet that legal regulation primarily serves dominant class interests while undermining women's rights to self-determination as mothers and as birth attendants. Specifically, the outlawing or marginalization of lay midwives as well as the subordinate status of certified nurse-midwives in the United States reflects a consolidation of professional occupational interest that is largely intact despite challenges to its hegemonic status (Starr 1983) This consolidation of interest is made possible through legal sanctions that may be directed toward birth attendants "poaching" on the medical monopoly: first, through civil actions against midwives; and second, through criminal prosecution of midwives in the event of injury or death to mothers or newborns (while criminal prosecution is largely eschewed in instances of injury or death occurring in hospital-situated, professionally attended births). There is a precedent in British Columbia in which a person attending a birth was convicted of practising midwifery without a licence (see chapter five).

The legal encumbrances on independent midwifery practice have been interpreted as protecting citizens from incompetent or dangerous birth attendants, and as a way of maintaining professional self-determination, status, and income. The British Columbia College of Physicians and Surgeons has the statutory power to register doctors for the practice of medicine and to restrict the practice of medicine and midwifery by other birth attendants. An exception to this general rule involves outpost nurses working in areas that have few or no doctors – the Northwest Territories, the Yukon, and remote areas in the province. Accordingly, the dominant method of birth attendance is for labour, delivery, and immediate post-delivery to be supervised by doctors, usually with the assistance of obstetrical nurses in maternity wings or maternity hospitals. Even where midwifery implementation is considered, it is often seen as requiring physician supervision in assessments of pregnant women and management of labour and delivery. For those advocating the medical model, it is unthinkable that midwives could be at the centre of things, and call in other expert assistance as needed.

There are nevertheless a number of problems with what appears to be a clear prohibition of midwifery practice. First, the definition of midwifery has not been clearly set out in law. Second, despite potential legal sanctions, up to 100 lay midwives attended births in British Columbia in 1980 (Schroeder 1980). There have been recommendations that the role of the certified nurse-midwife be expanded with respect to hospital-situated births (Registered Nurses Association of BC 1979). Third, there is a contradictory phenomenon of growing support for midwifery training, licensing, and practice on the one hand, and structural changes in obstetrical practice that seek to eliminate midwifery or to "medicalize" it on the other (Illich 1977; Crawford 1980). Fourth, the historical development of midwifery, the imposition of legal obligations to register births through provincial vital statistics acts, and the advent of physician-dominated childbirth in Canada are not understandable through direct reference to case law and statute law alone.

The legal status of midwifery in British Columbia is a critical feature of the growth and contraction of midwifery services. Attempts to prosecute midwives for criminal negligence, a crime with serious consequences for those convicted, including a possible life sentence for criminal negligence causing death (see Bourque 1980), have occurred in British Columbia and Nova Scotia. Legal interventions appear at two other levels: first, the ordering of coroner's inquests and hearings into midwife-assisted births, and, second, the continuing lobbying for legal recognition of practising midwives. Certainly, physicians and nurses are not strangers to the legal arena; however, they are usually faced with civil actions (by plaintiffs seeking damages for injuries, for example), but rarely with criminal prosecution.

The nature of midwifery practice is tied to legal regulation or prohibition in many North American jurisdictions. The abstract protections of law often founder when we consider how laws can be disabling for individuals, or how laws enable state authority (Ericson and Baranek 1982; Burtch 1992, 185). Arguments against legalizing midwifery almost always rest on the premise that midwifery practice is riskier than physician-supervised deliveries. Several research studies challenge this premise (Haire 1981; Levy et al. 1971; Scupholme 1982; Stewart and Clark 1982). These demonstration projects are bolstered by longer-term midwifery services such as the Frontier Nursing Service in Kentucky (Edwards and Waldorf 1984, 10–12). In chapter four, evidence is presented that skilled midwives can *lower* rates of maternal morbidity and of operative delivery (anaesthesia,

analgesia, forceps delivery, vacuum extraction, and caesarean section).

This book considers how the midwifery movement emerges and is sustained. Information is presented on patterns of recruitment and apprenticeship by lay midwives and nurse-midwives, on the practice of midwifery itself, on why midwives may discontinue practice indefinitely or temporarily, and on midwives' reflections on the optimal place of midwifery alongside obstetrical care. This information ties in with studies addressing women and the workforce (Marieskind 1980; Wilson 1986; Benoit 1988, 1991). This focus on women as workers is useful inasmuch as midwifery is overwhelmingly a female occupation. It is only recently that men have been admitted to midwifery training in Britain, for example. Considering the near-segregation of work along gender lines historically, it is not surprising that in 1979 only 4 of the 24,000 midwives in Britain were men (Plommer 1979). While there has been some increase in the number of male midwives practising in the United Kingdom, the profession remains essentially female (Lewis 1991). The nursing profession, also essentially a female occupation in many countries, continues to wrestle with its proper role in the hierarchy of health care. Having outlined many structural difficulties faced by nurses today, Salvage (1986, 84) sees something of a sea change occurring within nursing: "Many nurses believe that the old-style hierarchy no longer meets the needs of nurses or patients. It is acknowledged that patients want and should be able to participate in planning and carrying out their care and treatment ... with growing pressure from consumer groups and individuals, the health care professionals are having to rethink their old assumptions about being in charge and telling the patients what is best for him or her."

The theoretical linkage with work and occupations depends upon an understanding of the modern state. The assumption here is that historical and contemporary conflicts among birth attendants, as well as conflicts between these attendants and state authorities, are best understood with reference to the movement of the state into this aspect of health care. By taking criminal action against lay midwives, by transferring licensing powers to medical and nursing colleges, the state reinforces the dominance of medical attendance at birth while discouraging the growth of a more pluralistic birthing system.

THE STATE AND HEALTH CARE

A common problem in sociological research is a tendency toward an empiricism that divorces data from theory (Mills 1959; Menzies

1982, 1). This tendency promotes descriptive research and the pursuit of correlations without extensions into causal relationships among the variables under study. Policy-oriented research has tended toward descriptive and atheoretical analyses, in contrast to the growing critical literature on the state and health care (Twaddle 1982).

This study combines empirical research with a broader theoretical discussion of the contradictory relationship between health care, the state, and the public interest. The literature on state theories dramatizes the limits of pre-eminent liberal-pluralist theories of the state and the politics limiting the rule of law. Critical theories of the state, such as structuralist perspectives, emphasize the play of objective forces autonomously from human agency, and a recognition of the functions served by the state in meeting demands of accumulation of capital and the legitimacy of government and the professions.

A central difficulty with this research is the limited attention given to the state and health care. There have nevertheless been a number of recent articles and books addressing the pivotal role of the capitalist state in containing struggles surrounding health-care services and class, race, and gender (Thunhurst 1982). One major inadequacy in this work is the focus on abstract theorizing at the expense of empirical work on particular instances of state regulation and struggles against such regulation. State theories have also been constrained by a deep-seated reluctance to incorporate feminist perspectives on law.

The intrusion of the state into childbirth attendance is approached from historical and cross-cultural instances. In many countries childbirth was a community event that was later regulated by ecclesiastical authorities (Benedek 1977; Mason 1988, 99). With reference to birthing practices and state regulation in British Columbia, it is argued that the state's designation of birth as a medical matter has promoted a clientele for Canadian medical practitioners by eliminating competing practitioners such as lay midwives. Furthermore, the state's massive expenditures on medical training, hospitals, supplies, medical insurance plans, and so forth has enabled physicians to consolidate their practices and augment their income relative to other wage-earners. Doctors' incomes in Canada have been over three times greater than the average income of other workers since the 1950s (Naylor 1981). A clearer profile of physicians' incomes averaged over time is set out in figure 1.

Government sponsorship of medical services can be linked with a number of social and political interests. There is the importance of establishing a healthy workforce. As well, there are the largely reciprocal interests of the professions and the state in reinforcing patterns

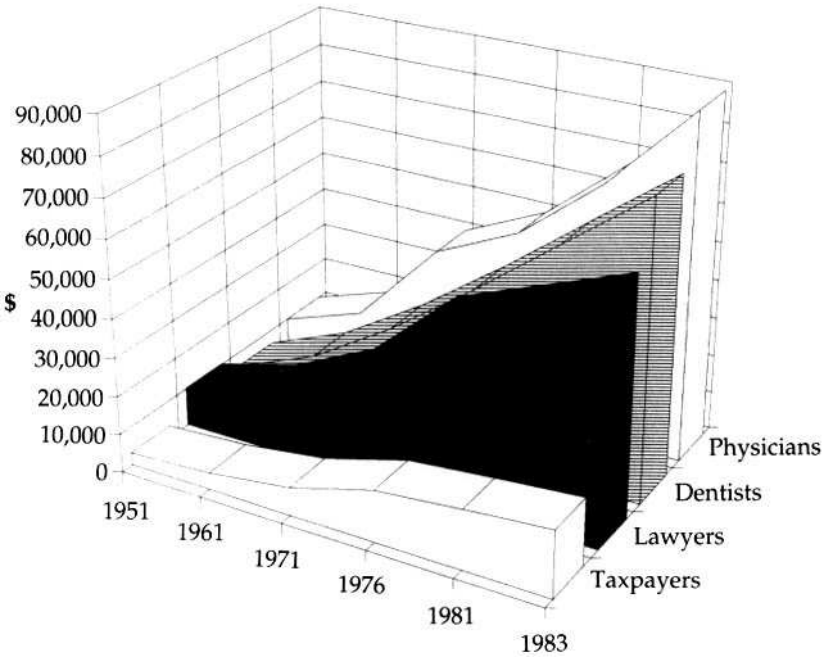

Figure 1
Average Income of Self-Employed Physicians, Dentists, Lawyers, and All Taxpayers in Canada

Source: Taxation Division, Department of National Revenue, Canada, *Taxation Statistics*, annual, various years.

of hierarchy and obedience (Jordan 1987). Some find that the redefinition of childbirth as a medical matter, dependent on technological interventions, bolsters demands for drugs and obstetrical equipment. Gough (1979, 55) refers to "Marx's own study of the British Factory Acts in the nineteenth century. He demonstrated how the Ten Hours Act and other factory legislation was the result of unremitting struggle by the working class against their exploitation, yet ultimately served the longer-term interests of capital by preventing the over-exploitation and exhaustion of the labour-force." Gough (1979, 62) also refers to the role of the 1906 Schools Act in improving the fitness of the working class (see also Larson 1977).

Social inequality and its near cousin, social injustice, are linked with the production and reproduction of class relations through struggle, including legal struggle (Sumner 1981; Smart 1989, 152–3). The instance of midwifery in Canada appears to reflect self-direction (in decision-making and recommendations) by legal officials (police,

judges, prosecutors). This self-direction by officials is less apparent in civil actions under the British Columbia Medical Practitioners Act, such as the charge of practising medicine without a licence. The protected monopoly status of the medical profession is not at issue in such cases, and the court generally has many precedents upholding findings against people practising medicine (or midwifery) without a licence. The self-direction of legal officials becomes more pronounced, however, when criminal law is invoked. This was evident in recent cases whereby the prosecution of lay birth attendants under the Canadian Criminal Code or under criminal statutes in the United States was often unsuccessful, despite representations against the defendants by physicians. The point remains that the Canadian courts have almost invariably upheld the legal monopoly of medical practitioners, including their prerogatives of restricting membership and disciplining members for conduct disapproved by the college.

The theoretical framework centres on the structuralist principle of the relative autonomy of state officials, including legal actors. It is suggested that the Canadian state, including provincial governments, has in modern history become allied with powerful interests, not only in the private sector, but also in the growth of the professions and social services. This alliance is dynamic, and allows for the exercise of discretionary powers by state officials. The midwifery controversy in Canada reflects a general reluctance by many state authorities to engage midwives in their own right; yet, paradoxically, pressure from within Canada and from international sources has led to the legalization of midwifery in Ontario (1991) and Alberta (1992), and to an intention to legalize midwifery in British Columbia (1993).

It is suggested that the medical monopoly over childbirth has been challenged through consumer action and the women's movement in recent decades. These challenges in British Columbia include home births practices of community midwives, the expanded role of nurse-midwives in hospitals, and the acquittal of some non-professional birth attendants on criminal charges; and yet birth attendance as a whole remains largely structured in the interest of medical practitioners.

The autonomy of the state thus appears to be indeed relative to dominant interests. Given the ambit of state control through prohibitions of alternative practice and through enabling actions on the part of the state (billing through the medical services plan, certification for midwifery instruction, and so forth), the role of the state in preserving patterns of occupational dominance is inseparable from the nature of midwifery practice and the legal forces that encumber

it. The relative autonomy of the state, as a plausible sequel to what may have been the instrumentalist character of the Canadian state in the nineteenth century, thus implies state recognition of counter-claims along with claims from dominant groupings, as well as state action that intervenes against specific interests of those dominant groupings. This framework may be more applicable to the issue of midwifery regulation than purely instrumentalist explanations of health care or the established literature on professional dominance in health care, which largely restricts analysis to interprofessional conflicts, with limited attention to historical antecedents or larger economic factors (Freidson 1970).

METHODOLOGY

When I first began studying midwifery in the early 1980s, midwifery was essentially illegal from coast to coast, there was little recent case law, and the available literature was very limited. Literature searches helped to establish the general parameters of discussion surrounding midwifery practice and regulation. In-depth interviews using a semi-structured interview frame were conducted with practising midwives in British Columbia. The semi-structured aspect of interviews allows for disagreements and elaborations of general or specific questions culled from the literature review. The interview format allowed probes of respondents' answers; the semi-structured format is suited to an exploratory study, especially since closed formats may artificially limit respondents' answers. Midwives' birth charts and related records (memoranda, correspondence) provided a reference point for interviews, and allowed a clearer profile of the 1,006 attempted home births in the empirical study. Thus, these research approaches provided original data on midwifery practices and a base of comparison for community midwifery practice with nurse-midwifery practice, as well as contrasts of midwifery practices with conventional obstetrical outcomes of hospital births.

Practising community midwives and nurse-midwives were drawn from a snowball sampling technique. Snowball sampling is especially advantageous for this research. On the one hand, the practice of community midwifery in British Columbia is essentially outlawed, with few midwives advertising their practice. On the other hand, the available roster of registered nurses is not sufficiently sensitive to current practice to isolate currently practising nurse-midwives. Reference to this registry, membership lists of such organizations as the Midwives Association of British Columbia, and adjunctive sources

of information served as a safeguard against overly skewed samples that might result from snowball sampling.

Once the two primary samples – community midwives and nurse-midwives – were established, the next step was to contact midwives to request an interview. This was managed through an initial letter that emphasized the importance of the research, assured confidentiality, and provided a brief outline of my interest in midwifery practice and its regulation.

Community midwives from British Columbia and Ontario provided the bulk of birth-related data. Documents from Saskatchewan and Manitoba were included in the analysis of birth records. The sample of practising nurse-midwives was composed of two of the four nurse-midwives active in the Low-Risk Clinic at the Grace Hospital (61 clients between 1981 and 1984), who served as a core group of informants. Reference was then made to other certified nurse-midwives known to those four informants, along with a province-wide register of nursing specialties. The objective was to record features of midwifery practice so as to allow comparisons between midwife groupings and province-wide and nationwide birth statistics. The available documents impose a clear limitation on inferences about midwifery care, or extrapolation to other jurisdictions.

With respect to historical documents, midwifery records are often unavailable, and many are no longer retrievable through oral histories or written accounts (but see Ward 1984). Accurate documentation of contemporary midwifery practices is essential. There are problems associated with the lack of standardized record-keeping among contemporary community midwives, although many variables are usually recorded as part of midwifery documentation. A major difficulty is securing access to records and allocating the time required to code information and to verify or supplement the documentary analysis. Nevertheless, a combination of statistical and non-statistical data was sought in this research. These studies are linked with in-depth interviews with midwives and others, together with reference to much of the world literature on midwifery regulation and practice.

There is considerable danger in going beyond the data in my exploratory study of Canadian midwives, or, for that matter, the available literature on midwifery practice. There have been no scientifically controlled studies on birth practices comparing midwives and other practitioners in North America. Dr. Bernd Wittmann, a medical practitioner and researcher, points to the shortfall in existing studies of home births in Canada: "Data about local home-births have been recently collected, and although to my knowledge the collection

has been as optimal as possible, we cannot call this a scientific, randomized prospective study which will stand up to scrutiny. This is one of the problems we face ... for that reason physicians continue to question the safety of home delivery. There are strong statements from all sides that home delivery is considered unsafe, as compared to hospital delivery as it is provided at the present time" (interview transcript, from *Midwifery and the Law* 1991).

Randomized studies are essentially out of the question: women seeking hospital-based attendance for birth will refuse allocation to out-of-hospital midwifery care, and women committed to attempting a home birth are unlikely to accept allocation to hospital settings. The very nature of the birth process would seem to militate against such a randomizing process. Nevertheless, despite the lack of such "pure" scientific studies, there is a considerable body of literature and professional experience that lends weight to the viability of midwifery practice.

The interview schedule also serves to obtain, where possible, documentary data regarding midwifery practice. Missing data were noted. The community midwives providing the records were asked to provide supplementary information where the documents were incomplete. Beyond noting to what degree the records are comparable (between hospital and home attendants, and within both groupings), a key task was to document levels of intervention for overall births. Since there were few births with only one midwife in attendance, the statistical analysis dealt with births rather than outcomes associated with particular attendants.

Additional sources of authority are derived from theoretical accounts of the state. A theoretical review of theories of the state with respect to the dominant ideology of liberal democratic pluralism and competing theories of the capitalist state – structuralism, instrumentalism, capital logic – is crucial to the (more restricted) analysis of nurse-midwifery and lay midwifery in this province. This review will take into account recent observations of a shift toward conservative ideology in Canadian politics, along with the continuing controversy over the functions and legitimacy of the state in advanced capitalist societies. The specific apparatus of legal authority is considered with respect to the regulation of health care and the professions in general.

Research with human subjects is subject to ethical review, with the protection of subjects a primary consideration. This protection was secured in this study through procedures to safeguard the identities of all research subjects. Names were replaced by codes, and the researcher concealed the identities of people contributing to the

doctoral research. As noted below, the precarious legal situation of community midwives interviewed by me had to be taken into consideration throughout the research.

Studies of midwifery in Canada are complicated by their legal status. While midwifery is not expressly prohibited in all provincial statutes – for instance, midwifery is not expressly prohibited by law in Nova Scotia – the practice of midwifery is clearly set within the bailiwick of medicine in British Columbia. Section 72 of the British Columbia Medical Practitioners Act stipulates that midwifery can be legally practised only by members in good standing of the College of Physicians and Surgeons. This places a serious responsibility on the researcher. Knowing that community midwives who were interviewed and who supplied birth records were in violation of the act, the researcher took a number of steps to avoid jeopardizing these midwives.

Community midwives interviewed by me were asked to speak in the third person rather than identifying themselves as birth attendants. This precaution was taken in the event that I would be called as a witness to some future legal proceeding. While this was improbable – experts consulted on this matter believed that researchers were not subpoenaed for childbirth-related litigation – the protection of research subjects was paramount. Under the Canada Evidence Act, the researcher-subject relationship is not privileged. Researchers could be ordered to release information for court proceedings. If a researcher refused, a contempt of court order might result in incarceration of the researcher (see Hagan 1984). If subpoenaed, the researcher could testify that no midwife directly identified her practice to him. Therefore, information supplied to the researcher via interviews could be interpreted as hearsay evidence and would likely be inadmissible under Canadian evidentiary rules.

A similar precaution was taken with birth records provided by midwives. The records invariably contained sensitive information concerning the woman seeking midwifery assistance. Details of each person's reproductive history, for example, were carefully safeguarded, and the data presented in this book are presented in the aggregate to protect these women. I asked that these records not be identified as the property of any particular midwife, and that discussion of missing data, clarification, and so forth not be tied to any midwife. The interview tapes, notes, and transcripts were kept in a locked area. Finally, upon completion of the study, the collected tapes were kept in a restricted area.

Some of these precautions, in hindsight, seem unnecessary if not entirely comical. Having people talk in the third person, as if they

brought an "imaginary friend" into their lives as children often do, seems to alienate the midwife-respondent. Although it is a technically correct strategy that might shelter the midwife's information or records from a subpoena, this process can demean the midwife and researcher alike. However, over a decade after the 1980 *Midwifery Is a Labour of Love* conference in Vancouver, there seems to be good reason to protect this alegal/illegal profession. Some midwives I spoke with in the mid-1980s have been subject to prosecution (or at least a distinct possibility of prosecution in criminal court for practising medicine/midwifery without a licence). Two community midwives in Vancouver, Gloria LeMay and Mary Sullivan, were convicted of criminal negligence in 1986; their conviction was overturned in 1991, following a successful appeal to the Supreme Court of Canada. Midwives have also been brought into the proceedings of the Office of the Chief Coroner in British Columbia, a costly and uncertain process. Thus, it appears that safeguarding midwives' identities and information was necessary, since a single complaint from a physician, nurse, or unhappy client could subject the midwife to formal proceedings. The 1991 trial and acquittal of an Alberta midwife, Noreen Walker, discussed in chapter five, was prompted by complaints from medical practitioners, not by parents or other midwives.

Another ethical consideration that surfaces during the study is the accuracy of research. Where possible, I recorded data as presented when compiling birth record variables; likewise, excerpts from interviews are presented verbatim or edited lightly to retain the speaker's meaning. Assertions by interview subjects were also critically examined and the comparison of home birth statistics with hospital birth statistics was conducted systematically. As noted above, this was not a randomized controlled study, but one that describes the course of birth and outcomes for attempted home births, and then compares those findings with published accounts of birth interventions and outcomes in Canada. In dealing with community midwives, nurse-midwives, lobbyists, and physicians, I adopted a helpful stance with respect to materials I had access to, sometimes alerting the interviewees about developments in other jurisdictions, pertinent research studies, and so forth.

This research addresses the safety of midwifery attendance, bringing together original data from several Canadian jurisdictions with published studies of birth outcomes in other regions. Proponents of midwifery certification, licensing, and training claim that midwifery attendance can augment conventional attendance by physicians in most births; moreover, in the minority of births that require specialized attendance because of complications, a transfer policy to

obstetricians and obstetrical nurses can ensure the safety of mothers and infants.

The evidence from the Canadian experience of midwifery practice, whether in institutions or at home, supports the generally favourable reputation midwives have established in many other countries (see Kitzinger 1988). Practices of nurse-midwives and community midwives have roughly comparable rates of infant mortality, and both groupings appear to have lower rates of obstetrical intervention (for example, caesarean section, forceps delivery, and induction), especially the community midwives. It is important to note, however, that many high-risk pregnancies are managed in hospital. Thus, the home-birth sample may be a healthier sample. This possibility is discussed in chapter four.

This book underscores the complexity of midwives' approaches to childbirth attendance. There are philosophical and policy differences within the midwifery movement (see Benoit 1991), perhaps most dramatically with respect to the viability of out-of-hospital birthing, and also surrounding the community midwife versus nurse-midwife distinction.

The theoretical implications of the study are connected with the longstanding debate over state regulation in general and the regulation of women specifically. Midwifery practice is a crucible in which the freedom of women to give birth as they wish, and of women to work freely as birth attendants, has been historically contained in North America, and continues to be challenged. This study thus explores the nature of the challenge to midwives and their clients – the threat of legal prosecution, barriers to hospital practice and to independent billing under the medical services plan, sanctions against physicians collaborating with community midwives, and possible co-option of nurse-midwives – and pairs this with the kinds of solutions forged by midwives in British Columbia. Two English researchers have identified a "wide variation" in midwives' care for women in labour and in the extent to which midwives contribute to policies affecting their profession (Garcia and Garforth 1991, 45). Concern has also been voiced about the structural limits of time for prenatal care of women in the United Kingdom, and this concern has sometimes been translated into programs, such as the "Know Your Midwife" initiative in London, England (Flint 1986, 1991). For community midwives in Canada and elsewhere, other constraints in services are evident. Midwifery stands as a social movement, one that has attained a higher profile in the 1990s as it has become associated with a challenge to the professions and the laws governing health care.

OVERVIEW: THE POLITICS OF MIDWIFERY PRACTICE

The following chapters serve to develop the themes identified in this introduction. Chapter 2 presents theoretical approaches in law and the state. The chapter raises the extent to which midwives are faced with rivalries from organized medicine, and to some extent, nursing associations in Canada. The somewhat implacable face of these more established professions is not the only source of opposition to independent midwifery practice. The midwifery debate is thus not simply an expresion of interprofessional conflicts over the management of births. Instead, the manner of state intervention in these conflicts, through legislation and subsidization, is critical in discussions of power in childbirth. State theories are reviewed in chapter two, including critical theories that highlight differentials in economic power, ideological outlooks, and the importance of maintaining social order. The Canadian state is not presented as an instrument of wealthy, privileged interests, but as a structure that has a degree of autonomy in responding to broader interests. This is not to claim that the material basis of the State is unimportant, especially in maintaining patterns of economic inequality between men and women in health care. It is suggested that the more mainstream liberal and conservative approaches to the state, as well as more critical theories following Marxist and socialist precepts, require a clearer appreciation of the politics of gender in health care, and social relations generally.

Chapter 3 brings together historical and cross-cultural documentation to trace the development of midwifery in global perspective. The redefinition of childbirth as the bailiwick of physicians, the relocation of birth in hospital settings, technological advances in monitoring and influencing pregnancy, and the creation of the professional nurse and nurse-midwife are major themes in this chapter. Claims that the incorporation of midwifery into the obstetrical team has been beneficial are questioned, including the assertion that obstetrical techniques (more than diet and hygiene) have dramatically reduced infant and maternal mortality. Another point is the great variation in birthing practices across (and within) cultures, as set against the often monistic premises of obstetrical training (for example, restrictions on delivery positions, length of the second stage of labour, and increases in the rate of caesarean sections). The politics of birth are placed in the context of how women's and infants' lives are jeopardized in some developing countries. Maternal mortality, a rarity in western societies, is far more common in poorer countries

where many women give birth without a trained midwife or other health-care worker. This is compounded by poverty and the perils of unsanitary conditions in the woman's immediate environment. The role of international associations, including the International Confederation of Midwives and the World Health Organization, is used to dramatize a worldwide effort to secure safe motherhood.

Historical and cross-cultural perspectives are indispensable to an understanding of the current dynamics of midwifery practice and legal encumbrances on contemporary midwifery initiatives in Canada. In particular, birth as a community concern was recast as a monopoly of doctors – except where their powers were delegated to (outpost) nurses, for instance – and midwifery was redefined as an offence under various medical acts in the provinces and territories. The requirements for proving an offence under such legislation were narrowed, thereby facilitating prosecution for quasi-criminal offences. Moreover, criminal prosecution of Canadian midwives has become more commonplace during the past decade. Just as the movement of the state into civil life is brought forward as a theme in chapter 2, so also has the state become involved in managing childbirth and related struggles.

Chapter 4 presents the major findings from my research on community midwives' practice. A statistical review of 1,006 attempted home births in Canada is contrasted with nurse-midwifery initiatives and earlier studies of home births in the United States and Canada. The findings of the home birth study mesh with earlier findings on the safety of attempted home deliveries relative to hospital deliveries. Rates of caesarean section, episiotomy, induction and augmentation of labour, and perineal tears are lower, sometimes dramatically lower, than hospital outcomes. There is also a substantial diversity in delivery positions adopted by women giving birth at home. The chapter provides an extended discussion of how midwives practise, and of the limitations facing midwives in community-based practices (primarily home births) as well as in hospitals. A common interest expressed by midwives was the importance of trust between the midwife and her client, a trust that was established by continuity of care well before the actual labour and delivery. A community midwife emphasized the psychology of birth as one factor in the delivery process: "The psychology is just not taken into account in the hospitals. A statement, or a change of nurses through a shift change or a coffee break can affect the birth process. A new relief nurse may come in whose energy is totally different. She may not agree with the way the woman is labouring, or may not like 'her' women squatting. In the hospital you are at the mercy of whoever is on that shift,

their philosophy and attitudes. In a home birth the midwives have been involved continuously and the birth approach has been worked out previously."

The context of midwifery care is developed through other excerpts from interviews with practising midwives in British Columbia. Birth records are also used to document patterns of practice, particularly the flexibility of midwife-assisted births in allowing different delivery positions for women in labour, while maintaining monitoring of the mother and infant. Tables are used to trace patterns of interventions in home births, contrasted where possible with larger data-sets from British Columbia and Canada. The available information on the clientele of community midwives is also discussed. It appears that this clientele is quite diverse in occupation and birth histories, and is committed to the importance of women's choices in caregivers and where birth ought to take place.

Trials of Labour is not a paean to midwives, however. The praising of contemporary community midwifery often overlooks problems with some practices. There are instances where a midwife misses the birth or is unable to attend simultaneous labours. There is sometimes an "oppositional" ideology that decries heroic, invasive obstetrics while attributing mystical properties to birth, possibly to the detriment of infants and mothers. The material basis for practice is also discussed in the context of an emergent profession (or calling) and the protectionism engendered by the struggle for midwifery. It is also important to note differences among midwives with respect to following guidelines, interactions with clients, and willingness to work toward legalization of midwifery (see Benoit 1991).

A discussion of nurse-midwifery initiatives is also presented in chapter four. Nurse-midwifery appears to be an Americanism, and is somewhat out of step with the traditional role of the midwife as a profession separate from nursing and medicine. In Canada, however, there have been few concerted efforts to establish a distinct role for obstetrical nurses who wish to practise as midwives, with a wider sphere of practice in their hospital-based work. The containment of nurse-midwifery within the hierarchy of doctor-nurse interactions is a central theme in this book. At the same time, the process is dynamic: some midwives with nursing training are aware of the power differences between midwives and doctors, including the reluctance of many professionals to grapple with feminist or other radical approaches to women and birth. A midwife who works in hospital outlined this dilemma in 1985 when she addressed midwifery in her professional role:

I never use the word "independence" in a talk. I always talk about a team, and consultation and collaboration. I don't talk about supervision [of midwives, by doctors] ever, which is how I think they perceive it ... I think that physicians are so far behind as a group of individuals [as far as feminism is concerned], perhaps even the women obstetricians. I was very careful not to use feminist terminology or women's issues terminology, because I thought I would turn them off, and that didn't seem to be the right approach. Then, when I heard them speaking, the power and control issues couldn't be separated from the professional, and male/female roles ... I use words like "women need to cultivate their strength." I think I left out the word "power," in fact, because I didn't think they could understand that word in a woman's context.

The evidence to date indicates that nurse-midwives are quite capable of managing pregnancy and labour and delivery. In Canada there has been a very limited sphere of practice for midwives or nurse-midwives employed in larger institutions such as hospitals. Most work as obstetrical nurses, providing valuable assistance to mothers, but seldom are permitted to practice independently or to assume responsibility at the time of delivery. Attempts to establish non-hospital settings have not yet succeeded in major centres, and the home has become the key site for independent (community) midwifery practice.

Chapter 5 provides a critical look at the recent history of legal actions concerning midwifery in Canada. One glimmer of hope in this history is the consistent failure to convict midwives for practising medicine without a licence, or for criminal negligence in cases where a baby or mother is harmed in a home birth. More to the point, many legal interventions have provided a stage on which the viability of midwifery has been documented, along with problems associated with medicalized births. It is likely that the weight of scientific evidence favouring midwifery was considered in the decision of provincial governments to legalize midwifery in Ontario (1991) and Alberta (1992). Nevertheless, chapter 5 also points to the costs borne by midwives as defendants in trials, or as key figures in coroners' inquiries and inquests. The general failure to establish a legal footing for midwives seems to be a pivotal factor in the decision of many midwives to discontinue practice. The rewards of midwifery are few, particularly in terms of income; the costs of a single trial or hearing are enormous. This cost is worsened by the tendency to prosecute midwives, an approach rarely applied to doctors or nurses, at least in a criminal context. Chapter 5 isolates examples wherein the

uncertain legal status of midwives has been re-examined, particularly in Ontario, where a task force has recommended the implementation of midwifery.

Chapter 6 explores paradoxes in legal regulation and midwifery practice and the future of midwifery. It places the nature of midwifery practice and its regulation and containment by the state in a more critical light. The chapter presents concerns voiced about modern nurse-midwifery and community midwifery practice. These themes include the possibility of co-option of nurses by the medical profession and hospital administration. For community midwives, serious concerns include variations in training and skill, willingness to transport mothers from home to hospital, and levels of prenatal and postnatal care, especially when the mother is transferred to hospital. The theoretical implications of state control over liberties are redeveloped in the context of the data analysis and the recent prosecutions of midwives under criminal and quasi-criminal statutes. Greater attention is given to future research possibilities regarding midwifery practice and to policy development regarding the training, licensing, and discipline of midwives in Canada.

The issue of control is central here: to what extent will midwives be self-determining? To what extent will state forces shape the nature of midwifery practice? The Pavlovian rejection of the midwife as an independent practitioner is still evident, but is increasingly challenged as women become aware of birthing options. Lobbying for autonomy and legal standing continue in the face of longstanding efforts to eliminate the midwife, or to reduce her power as a specialist in birth.

CHAPTER TWO

The State and Health Care

The state is indeed "pervasive in public and private life" and its nature is hard to grasp. But to understand fully the world we live in – much less to contest it – we must certainly grapple with the foundations and complexities of the circumscribing – if not overriding – issue of power.

Murray Knutilla, *State Theories*

INTRODUCTION

The virtual exclusion of independently practising midwives from the Canadian health care system is at the heart of the midwifery debate. In Canada and elsewhere, the considerable law-making and policy-making powers and financial resources of the state make it a pivotal force for midwives. This chapter examines various theories of the state, and offers some links between these theories and the status of Canadian midwives. As a starting-point, it is clear that the displacement of midwives was made possible with the passing of various medical acts and similar legislation in nineteenth- and twentieth-century Canada. The resurgence of midwifery as a modern social movement must again face the nature of the state: the interests it serves, the limits to reforms in state-sponsored services (such as health and welfare), and the treatment of women in health care systems and in law.

Displacement of the midwife in Canada has attracted a number of explanations. For example, those opposed to the reintroduction of midwifery services may argue that birthing women prefer the services of the orthodox professions – nursing and medicine. The provincial acts that govern health services may thus be seen as meeting a public interest in safe health care, with such professions as nursing, medicine, dentistry ensuring a high standard of practice. It has been

argued that midwifery, especially as practised out-of-hospital in clinics or at home births, is low-calibre and should not be countenanced by the state. Dr. Hedy Fry, a past president of the British Columbia Medical Assocation, argues in favour of further humanization of hospital births and against home births. Countries that support home birth would thus seem to be bedevilled by this practice, especially since hospital-based deliveries have become the norm in many countries:

> I find it sad and a little frightening that the issue of home birth is still a matter for debate in Canada. Surely there is much to learn from the experience of others. In Great Britain, home deliveries declined from 85 per cent in 1927 to less than one per cent in 1984. This drop was the result of the report of a House of Commons committee that was set up to investigate the high infant mortality rates, which recommended that "facilities should be provided to allow for 100-per-cent hospital confinement ... the greatest safety of the mother and child being the prime objective ..." International experience has shown that home births are more risky than hospital births. Women who expose their infants to such danger must be either ignorant, or irresponsible (Fry 1987).

In this approach, the work of community midwives seems to be fused with home births, which are presented as dangerous undertakings. The possibility of birthing clinics as part of a more pluralistic birthing policy is not raised. In any event, a clear message is sent to government representatives and state officials generally: reconsidering midwifery practices that provide a greater range of caregivers and more choices about where to give birth is indeed ignorant or irresponsible. Some argue that even if midwives are safe and desired by a number of expectant mothers, it would be too expensive to implement midwifery training, accreditation, and services. In this light, the midwife becomes a historical curiosity, a predecessor to the more evolved professions in modern maternity and infant care. In this chapter I will provide a critical account of ways in which the nature of laws governing the professions have essentially kept the midwifery movement in check in Canada. The limits to liberal ideology, including the rule of law, are assessed, along with feminist approaches to transforming legal structures so as to strengthen women's choices in birth.

In contrast, there are other explanations of how the Canadian midwife has been moved from the middle to the margin. These explanations concern not only Canadian midwives and their practices, but other jursidictions where the midwife's role has been eroded

or threatened and often superseded by medical supervision. This more critical literature points to the established interests of medicine and nursing in governing health care. It also builds on a growing number of evaluation studies that challenge the argument that midwifery per se, or domiciliary midwifery (home births), is riskier than hospital-based birthing. This general approach is not only forward-looking, but also takes into account historical epochs in which midwives and other healers were subject to witch-hunts in Europe between the fourteenth and seventeenth centuries. Some point to intolerance of ethnic minorities as a factor in the anti-midwife ideology in nineteenth-century Canada (Buckley 1979, 131–49). Distrust of women's reproductive capabilities and the gradual breakdown of communities of women are also mentioned as influential in the displacement of midwives. Unquestionably, advances in obstetrics worked to reinforce the claims of physicians and nurses that they were the future of maternity and infant care (see Mitchinson 1991).

In this chapter the nature of state policies is brought forward as a decisive factor. Through their powers of law-making and law enforcement, as well as general fiscal policies, the provinces and the federal government were instrumental in promoting birthing care that has been dominated by medical and nursing services. This domination is seen as legitimate, a progressive achievement that stands as the best of all possible worlds in state-sponsored health systems. In Canada, health care is the responsibility of provincial governments. These governments fund and administer many health-related services and create health policies and legislation. In Ontario, for example, medicine and nursing are among the professions governed by the Health Disciplines Act; a number of other health professions are governed by various statutes and regulations. In modern times, the willingness of state officials to enact legislation supportive of midwifery and to plan for the reintroduction of independent midwifery services can make the crucial difference between midwifery that is outlawed and midwifery that is recognized and respected. This chapter places the state as a central figure in the origin of the midwifery debate and in the mediating of contemporary conflicts between community midwives, nurse-midwives, and other health-care workers.

Critical theorists have pointed to the power of law in shaping consciousness and action. There is a growing body of critical literature that regards law as a paradoxical force, ensuring some measure of liberty in western democratic political systems, but also blunting various movements, including the women's movement. Carol Smart, in *Feminism and the Power of Law* (1989), argues forcefully that reliance

on legal reforms alone has not served and cannot serve to establish women's claims against male power. "The history of law reforms in the areas of rape, equal pay, [and] domestic violence must surely reveal the failure of law to legitimate women's claims. There are other ways of challenging popular consciousness other than through law, even though law may on occasions provide a catalyst. But it is also mistaken to imply that once legitimized by law, women's claims will not be delegitimated at a later stage" (Smart 1989, 81). Smart adds that the principle that women must govern their reproductive choices is a case in point illustrating how women's rights are weakened through various laws and social policies. The importance of examining results, not rhetoric, is crucial in understanding legal reforms.

The evolution of midwifery as a social movement is analytically inseparable from the manner of government intervention in Canada and other jurisdictions. In all Canadian jurisdictions the provincial and federal governments contribute to the development of maternity and infant care. Medical insurance programs, hospital construction, and medical education constitute major structural changes realized through the state. The monopoly practice accorded provincial colleges of physicians and surgeons is a significant form of power. Prosecutions under the federal Criminal Code underline the extensive state powers that can be brought against birth attendants in the event of damage to women or infants. Not only does the state wield these powers; it also is the site of lobbying efforts by midwives (and other health-care practitioners) to secure a legal status. In short, legitimacy through the state is a central goal for many alternative health-care practitioners, and their success or failure can reveal the manner of state regulation and the interests served by such regulation.

In this chapter, three main concepts will be defined and elaborated. The concept of the state will be drawn out with respect to various theoretical outlooks on state control. The concept of health is directly relevant to the issue of midwifery and childbirth, and is connected with debates over the purposes served by major expenditures in health care. Finally, the concept of justice is important in assessing state regulation of health care, including criminal and quasi-criminal prosecution of birth attendants.

THEORETICAL APPROACHES TO THE STATE

Theoretical work on the state is complex, usually grouped within core political perspectives of conservatism, liberalism, and radicalism, and increasingly with postmodernism (Rosenau 1992). The

conservative interpretation of the state will be outlined, followed by liberal and radical contributions to state theory. These theoretical approaches will then be assessed against the phenomenon of midwifery practice and initiatives to legalize midwifery in British Columbia.

Debate over the nature of the state, the manner of its growth, and the implications of state influence on social and economic life illustrates a vital epistemological issue in sociology and in the social sciences generally. This issue centres on the importance of *human agency* and *structural forces* in determining human relations. Social change may be interpreted with an emphasis on how social life is altered through "human agency" (thought, consciousness, will), or, conversely, with an emphasis on the overriding importance of structures – institutions and forces external to the individual – that more often than not shape our existence. This dichotomy – structuralism versus human agency – is clearly oversimplified, and some writers have emphasized the interplay between structural forces and human agency. This interplay is often remarked on with respect to lawmaking and the nature of state policies (Chambliss 1986, 30). Recent scholarly work on the state has tended to feature the interplay between large structural forces (the economy, dominant ideologies, social institutions such as education) and human agency as expressed by individuals, social classes, a variety of associations, and social movements.

For the midwifery movement in Canada, the contradictions of health care, law, and state policies have become very clear in recent years. In this respect, do contradictions in health care require that the state (provincially, federally, and to a lesser extent, municipally) act as a central force to ensure the dominance of particular classes or professions? In this book the state will be interpreted as a crucial force in attempts to preserve domination by privileged groups over other groups in ways that mediate the contradictory mix of forces and interests. State policies are not static, however, or always successful. They may be overtaken by events. For example, in defending the special powerful interests of medicine, hospitals, and nursing, there is a relative autonomy of the state from these interests in liberal democratic states. The fate of midwives hinges in large measure on this degree of autonomy and the pressures brought to bear on state officials.

Many scholars depict the essential character of western democratic states as liberal. The liberal perspective in law, for example, is frequently hailed (and more frequently debunked by critical theorists). Nevertheless, the power of conservative philosophy is also evident in

western democracies – for example, the electoral successes of conservative politicians in a number of western countries, including Canada, England, and the United States (Taylor 1980). Some point to the increasing secrecy and centralization of federal powers in the Canadian state. It has been argued that rather than "developing their own political capacities," Canadians are increasingly faced with deference to what Woodcock (1990) refers to as "the cult of leadership." This shift away from a more active, responsive democracy is linked with autocratic decision-making.

Conservative approaches to the state highlight social order and the authority vested in the legal order. Order is paramount, for without social, economic, and political stability, civil life becomes more warlike, industrial and cultural development is impaired, and life is jeopardized through domestic and international conflicts. Hobbes articulated this sense of a common interest in social order that is met through a strong central authority. Commerce, the arts, the very fibre of civilization were dependent on a social covenant between individual citizens and the state (Hobbes 1974). In 1652, in *De Cive*, Hobbes interpreted the state as a public power, a supreme political authority that was separate from the ruler (the Monarch) and the public (see Held 1983, 2).

A key issue with respect to state policy is the intolerance of minorities that has often been associated with conservatism. Discrimination in immigration policy, law enforcement, and work is more likely to appear under a conservative approach than a liberal state policy (Gordon 1983). The conservative approach is open to criticism for its emphasis on tradition and order, even in the absence of convincing evidence that far-reaching measures and powers are needed. The abstract value of the "general good" is likewise overemphasized, appearing often in generalizations about the public or the general will. Another criticism is the reliance on penalties and force as standard reactions to deviancy.

Contemporary discussion about the capitalist state has been dominated by liberal pluralist principles (Mankoff 1970). Liberal perspectives on the state often involve the concept of pluralism and tolerance. As societies modernize, some suggest that government policy has gravitated toward a more positive approach to multiculturalism through increased immigration and various government enactments (see Elliott and Fleras 1992, 290–1). It is significant that while liberal ideology emphasizes multiculturalism and diversity, it does not necessarily follow that racial or ethnic stratification is in fact reduced under a liberal state regime (Bagnell 1980; Bolaria and Li 1988). For some liberals this requires a reconciliation between substantive social

inequality and formal guaranteed freedoms. This can take the path of abolishing aristocratic privileges, unchecked bureaucratic discretion, and racial and gender supremacy (patriarchy). Programs to reduce inequality in access to education and legal representation for people charged with crimes are emblematic of the liberal response to inequality.

Liberal-pluralists emphasize the central role of law in making social policies and in the distribution of punishments, rewards, and protections. Part of this legalistic ideology is the importance of the rule of law: that is, equality before the law, procedural fairness, due process procedures, and of course the belief that law is fundamentally legitimate (see Caputo et al. 1989, 3).

There is also an appreciation of spheres not directly controlled by the distributive powers of the state: kinship relations and love are two examples (Walzer 1983). The conservative emphasis on social order and traditional morality is thus leavened through liberalism. Social order is balanced against fundamental freedoms, and the state is entrusted with protecting constitutional freedoms as well as meting out sanctions.

There have been innumerable criticisms of liberal approaches to law and the state. A key criticism is that liberalism rests too heavily on principles and ideals, and misses the *realpolitik* of economics and antagonisms that fuel capitalist democratic societies. A related criticism is that the larger issue of gender, class, and racial oppression is compromised as liberals focus on invididual liberties and rights. In defence of liberalism, some argue that liberals are aware of economics and its influence on democratic politics. Wider struggles for justice and decency are seen as indelibly connected with individual integrity. Michael Walzer argues that each citizen is potentially an active member in the distribution of rewards, penalties, and opportunities: "The citizen respects himself as someone who is able, when his principles demand it, to join in the political struggle, to cooperate and compete in the exercise and pursuit of power. And he also respects himself as someone who is able to resist the violation of his rights, not only in the political sphere but in ... other spheres" (Walzer 1983, 310). Walzer's vision of liberalism is thus not wholly detatched from economics or, for that matter, political corruption. He refers to the "dominance of money" in politics as the most typical expression of power and powerlessness in U.S. society. He adds that primary political campaigns in that country are akin to "commando raids," with citizens largely reduced to spectators (Walzer 1983, 301, 310). The conservative emphasis on public order and discipline is replaced with a clear delineation of private spheres by liberals. The

value of these private spheres is consistent with the liberal emphasis on toleration and pluralism. The liberal tradition thus favours limits to sovereignty while protecting various rights of citizens (Held 1983, 2–3).

Marxist theories of the state present a very different portrait of law and social control. For classical Marxists and more contemporary neo-Marxists, the state is the pre-eminent political institution that sustains patterns of class oppression (Miliband 1973, 464). Unlike the conservative theory of the legitimacy of the state or the liberal watchdog function with respect to excessive state powers, Marxist theories invariably recast the necessary powers of the state as forms of domination. The democratic maxim of "the greatest good for the greatest number" in capitalist economic systems disguises how the state serves the interests of the few while claiming to represent the commonwealth. Marxist theories are important with respect to health care, including midwifery attendance, since they incorporate differentials in illness and longevity, along with occupational stratification, in analysing race, gender, and class. Major branches of Marxist and neo-Marxist theory include instrumentalism, structuralism, class conflict, and capital-logic.

Instrumentalist Marxists claim that there is a direct correspondence of economic power and political rule such that the state is linked with a dominant class or set of classes. In a famous passage by Marx and Engels, the executive of the modern state is portrayed as "a committee for managing the common affairs of the whole bourgeoisie" (Marx and Engels 1979, 82). The state may be defined as a system that comprises the government (at federal, provincial, and municipal levels in Canada), the civil service, the military and the police, the judiciary, subcentral governments, and parliamentary assemblies. This formulation by Ralph Miliband (1973, 50–1) builds on the importance of state élites in shaping state policies, and distinguishes the state from the political system as a whole. Empirical studies of instrumentalism thus focus on the class composition of those in state command positions, and also on class-based sanctions by the state.

Instrumentalism has been widely criticized for oversimplifying economic and political developments in capitalist societies. A common criticism is that instrumentalism reduces the relation of state to civil society to actors' intentions, backgrounds, and affinities, thereby limiting the appreciation of structural influences (McMullan and Ratner 1983). This interpretation also fails to account for state interests in controlling the budget and in maintaining legitimacy (for electoral reasons), and the ability of state officials to initiate reforms

in the interest of equity and justice. Nevertheless, instrumentalism places an important emphasis on class struggles and the central role of the state apparatus in disguising and managing struggles (Grau 1982; Jessop 1982; Mandel 1987).

Structuralist approaches to the state emphasize the total integration of power and domination in social and political life. Structuralists have also emphasized the play of structures external to the will of individuals. The power secured by physicians through scientific research and clinical practice *and through monopolistic powers of practice under state auspices* poses serious obstacles to others seeking official recognition as health-care workers.

This sense of a social totality that largely determines human action is clearly set out in the work of Nicos Poulantzas. He reconceptualized the state to include schools, trade unions, media, and other (ideological) apparatuses along with formal state (repressive) apparatuses. An abstract, complex structuralist approach was developed in which political struggles are properly to be directed against the state. The state serves as the "factor of cohesion" between various levels in constituting a given social formation. Thus, it is not sufficient to seek to transform civil society or to alter the mode of production without engaging in political struggles against the juridico-political superstructure of the state. The distinction between the private sphere of the family and the public sphere of the state is artificial, according to Poulantzas. His position is that the state assigns the site of the family, and that the family is largely unable to resist or evade this power of the state (Poulantzas 1972; 1978, 66). His approach is opposed to strict economic determinism or historicism, and yet the precise contours of structural determinism are not identified in his writing.

Structuralist-Marxists have been criticized on several grounds. For example, Poulantzas has been faulted for overemphasizing the power of political institutions, and Miliband has commented on the lack of data to develop and ultimately verify structuralist theory (Jessop 1982, 181–91; Miliband 1972, 29). The need to bolster theorizing with careful empirical work has also been recognized by Marxists and their critics. Retrospective "explanations" of economic and political developments and abstract theorizing without reference to a data base are not uncommon. Indeed, some writers point to the frequent clash between "essentialist" Marxist assumptions and the lack of empirical substantiation of those assumptions (Mouzelis 1984; Jankovic 1980, 104). Vincent (1987) credits Marxist theorizing with developing an appreciation of the effects of political economy on human activities, and for its central interest in class dynamics and their

relation to the state. He notes, however, that structuralism suffers from several difficulties, among them needless abstractions, and its rather ironic effect of highlighting human agency "while covertly bringing in a new form of super-determinism." For Vincent (1987, 175), structuralism lacks a theory of the state, substituting merely "a negative appraisal of its nature."

Michel Foucault's work, somewhat akin to structuralists' sense of the social totality and the force of objective structure over human agents, differs in important ways from structuralism (Harris and Webb 1987, 58). Foucault writes of the takeover of human consciousness by technologies of control in various sites – the factory, the schools, the military, and prisons. Bodies become "docile," and human action is increasingly monitored, measured, and controlled (Foucault 1977). Foucault's work is especially important in reconceptualizing the joining of power as disciplinary knowledge. These forms of knowledge are convertible into power relations, although the nature of the power/knowledge relationship is complex and not reducible to class relations or economics as such. The "clinical gaze" of medicine (Foucault 1973) is especially pertinent to the midwifery debate. Foucault describes the clinical gaze as an epistemological and perceptual system that builds on categorization and classification of the subject. With the growth of obstetrics as a scientific and clinical operation, powers of observation and treatment became the raison d'être of assessing pregnancy and birth. For Foucault, clinical observation required the joining of the hospital domain and the teaching domain. The family (or community) became secondary to the powers of these unified spheres: "Not long ago the family still formed the natural locus in which truth resided unaltered ... As soon as medical knowledge is defined in terms of frequency, one no longer needs a natural environment; what one now needs is a neutral domain, one that is homogeneous in all its parts and in which comparison is possible." (Foucault 1973, 108).

Such critical theories break important ground in that they recognize how individuals are frequently treated as cases, and how individual choices and perceptions are often submerged within a regimented, disciplinary structure where (professional) knowledge is converted into professional power. Foucault's work has been profoundly important in showing how permeable power can be, and how it is not attached in a predetermined way to a particular class or grouping. Yet at the same time there are concerns about the *sources* of the new disciplinary powers, and thorny questions that are not addressed with respect to law and social policies. Ignatieff expresses some misgivings about accepting Foucault's perspective as is; specifically, care must be

taken to consider how state powers, in their myriad forms, can be checked by a democratic tradition. And even the most dramatic forms of state control, such as the prison, continue to attract suspicion and new suggestions about the proper exercise of officialdom (Ignatieff 1985, 94–5). Others have argued that suspicion of state powers is deeply embedded in some political cultures, including Britain and the United States (Vincent 1987, 2).

The English social historian E.P. Thompson concluded that cultural forces can limit the deployment of state powers. Attempts to use the legal apparatus are subject to reversals (for example, jury acquittals) and due process safeguards. Accordingly, while the state may often have the upper hand in dispensing justice and ordering social relations, it is sometimes checked by public pressure and its own doctrine of the rule of law; that is, fairness, natural justice, due process, voting rights, and equality before the law (Caputo et al. 1989, 3). In a classic passage from *Whigs and Hunters,* Thompson warns against dispensing with some safeguards associated with the rule of law: "[T]here is a difference between arbitrary power and the rule of law. We ought to expose the shams and inequities which may be concealed beneath this law. But the rule of law itself, the imposing of effective inhibitions upon power and the defence of the citizen from power's all-inclusive claims, seems to be to be an unqualified human good. To deny or belittle this good is, in this dangerous century when the resources and pretentions of power continue to enlarge, a desperate error of intellectual abstraction ... It is to throw away a whole inheritance of struggle *about* law, and within the forms of law, whose continuity can never be fractured without bringing men and women into immediate danger" (Thompson 1977, 266).

Thompson's writing has been directed against the reduction of human action to mere "vectors of ulterior structural determinations." Thompson has affirmed the viability of historical understanding against the dismissive approaches of Hindness and Hirst, Althusser, and others (Thompson 1977, 1978). His work combines an appreciation of resistance and human agency with a sober assessment of the increasing movement of the state into spheres that were either unregulated or weakly regulated by state authorities. The growth of technological surveillance and intrusive policing policies in Britain, for instance, illustrate this statist movement (Thompson 1983, 479). Another theoretical approach closely allied with the cultural paradigm is the Gramscian outline of human agency. "Human agency" refers to the will and initiative of people, and stands in contrast to the more deterministic theories of the state described above. Gramsci (1971) emphasized human agency in the development of the state

and civil society. Ideological and political practices enable a dominant class (or class fraction) to maintain its hegemonic status so that dominated classes and groupings consent to oppression and exploitation (Jessop 1982, 18). Gramsci emphasized the complexities of ideology, class, and law and the potential for countermovements within the state superstructure. Gramsci also encouraged the role of "organic intellectuals" of the political left, skilled workers who would develop social and political policies; they would bridge the gap between intellectuals and manual workers. A synthesis of intellectualism and populism was favoured: "The intellectual's error consists in believing that one can know without understanding and even more without feeling and being impassioned (not only for knowledge in itself but also for the object of knowledge): in other words that the intellectual can be an intellectual (and not a pure pedant) if distinct and separate from the people-nation, that is, without feeling the elementary passions of the people, understanding them and therefore explaining and justifying them in the particular historical situations and connecting them dialectically to the laws of history" (Gramsci 1971, 418).

For Gramsci, then, the potential of social movements was central in an understanding of state domination and strategies for realizing a socialist state. State domination appears as a form of hegemony, the dominance of a "fundamental social group" over other subordinated groups. This dominance is not achieved simply through threat and force: consent is secured ideologically by posing issues on a universal level rather than with reference to powerful groups. As Gramsci indicates, the state is an instrument that serves to shape civil society to the economic structure.

There is also an appreciation of civil society as a source of political change. Even though there has been a statist tendency, the power of the state is limited by the resistance shown by various groupings (Gramsci 1971, 120–5). These forms of resistance bring Gramsci's work directly into the debate between determinism (structure) and free will (human agency), since Gramsci, himself incarcerated as an enemy of the people in Italy, was well aware of the structural forces that limit human action.

Claus Offe has attempted to synthesize instrumentalism, relative autonomy, and structuralism. For Offe, the capitalist state is caught in the contradictions of a capitalist economy. Offe presents the contradiction between the state's interest in preserving accumulation and favouring private appropriation of resources on the one hand, and the requirement that the state present itself as a neutral force operating in the general interest on the other. Just as the state depends

on a vital private sector for its revenues, so also does the capitalist state depend on legitimacy of the public. It is important to note that Offe does not agree with the instrumentalist tenet that the state is directly interlocked with capitalist interests. Limits are set on the state by law and by pressures from "strategic groups" such as organized labour (see Held and Kreiger 1983, 487–97).

Difficulties are evident with Marxist and neo-Marxist theories of the state. There is a tendency (perhaps most evident in the Poulantzas-Miliband debate: see Poulantzas 1972) for some writers to resist useful criticisms in developing their particular paradigms. A second difficulty involves the validity of claims. Many of the theoretical works do not include empirical evidence, remaining instead at the level of theorizing. Accordingly, there is no clear methodology for assessing how accurate these claims are, nor is there a clear sense of refining hypotheses or statements (Hagan 1984; Turk 1980).

Marxist-based approaches nonetheless are valuable, bringing forward material considerations as a way of challenging utopian or idealistic discussions of law and liberties. It is important to note that Marxist theory is far from monolithic, with some theorists arguing for a more humanistic or more empirically based appreciation of Marxist theories of law and society. Some see an overlap between the dominant liberal approach to law and Marxist approaches. For example, Bob Fine (1984, 1) recognizes such liberal accomplishments as establishment of civil liberties and the rule of law, yet also draws attention to the "limited democratic character" of law and politics within capitalist societies.

Notwithstanding the parallel discourses within critical theoretical approaches to the state, the articulation of economism (whereby the mode of production shapes specific social and political activities), instrumentalism, structuralism, and culturalism has been useful in developing critical theory about the state. These issues are brought forward in the following section with respect to the nature of state regulation of health and health care.

THE STATE, THE LAW, AND HEALTH CARE

The instrumentalist approach to health care emphasizes the benefits of state intrusion (statism) into civil society for dominant economic groupings. This benefit is evident in the early legislation in Upper Canada. The Parker Act of 1865 gave physicians a licensing monopoly, including the power to regulate the supply of physicians and qualifications for the practice of medicine. In the twentieth century, with

the advent of medical insurance, physicians were guaranteed payment for their services, usually about 90 per cent of the profession's fee schedule (Swartz 1979, 328). Physicians' incomes in the United States are highest (on average) among the professions. Waitzkin (1983, 36–7) associates this financial dominance with a monopoly control that is bolstered through state legislation. Ehrenreich and Ehrenreich (1978, 57) found that the average income of doctors in the United States rose proportionately from about twice the average family income (in the 1920s and 1930s) to approximately four times the average family income.

The economic underpinnings of the relationships between the health-care sector and the state have been developed through Marxian structural analyses. For example, Navarro (1976, 1976a) has developed a theoretical framework in which health services are governed, for the most part, by considerations of political economy at regional, national, and international levels. This means that in capitalist societies such as the United States and Canada, economic factors become critical in shaping the nature of medicine and health. Navarro contends that social relations between physicians and patients reflect a "material basis" that underpins varying degrees of power between patients and physicians (Navarro 1986, 238–9).

The contradiction between patients' needs and profit-orientation in health services is also developed by Waitzkin. He criticizes coronary care units (CCUS) in the United States for their expense and inefficiency. The units ostensibly serve the public interest through improved emergency care for people suffering coronary illnesses. Waitzkin contends that CCUS generate considerable profits for corporate interests, partly through state subsidies, without demonstrating their value in alleviating the suffering associated with coronary attacks (Waitzkin 1979). A difficulty with this approach, however, is that it dismisses or minimizes authentic contributions to health and other benefits of health-care services (Hart 1982).

Waitzkin (1983) is critical of the misuse of the medical model and the interests served by some aspects of medical technology. He indicates that the development of expensive medical technology and pharmaceutical commodities becomes profitable through state auspices. As health care in the United States has become increasingly commercialized, profits for corporations have been secured. Waitzkin points to a public–private contradiction whereby the state is encouraged to subsidize the growth of private sector health care; for example, by diverting public funds to construction costs of private hospitals.

Waitzkin does not see the state and civil society as a unitary set of apparatuses. He extends Miliband's definition of the state beyond

officialdom: "The state comprises the interconnected public institutions that act to preserve the capitalist economic system and the interests of the capitalist class. This definition includes the executive, legislative, and judicial branches of government; the military; and the criminal justice system – all of which hold varying degrees of coercive power. It also encompasses relatively noncoercive institutions within the educational, public welfare, and health-care systems. Through such noncoercive institutions, the state offers services or conveys ideologic messages that legitimate the capitalist system" (Waitzkin 1983, 52).

Others have developed structuralist interpretations of state involvement in health care. Renaud (1978) argues that the capitalist mode of production constrains state solutions to such health-related issues as treatment, occupational health and safety, and environmental concerns. These constraints largely supersede the "volition" of individual health-care workers, public officials, and the population at large. The dominant approach of expertise and health engineering draws together healing and consumption – in other words, promotes a commodity approach to health care. This approach mistakenly treats diseases created by industrial development as natural phenomena. Ischemic heart diseases, various cancers, and mental and nervous disorders are examples of these diseases. This point is raised in Doyal (1981) and developed by Epstein (1979) with respect to carcinogens and co-carcinogens.

Renaud believes that medical knowledge operates within a paradigm of the "specific etiology" of diseases, with analysis centred on the cellular and biochemical diseases of the body. This approach promotes an overemphasis on individual responsibility for health and illness and obscures the structural limitations on health care that are inherent in capitalist societies (Labonte 1983). This alienation of environmental influences, political economy, and health is promoted through the state, the legitimate problem-solver in advanced capitalist societies. The state is cast in Marxian terms as the manager of crises, serving the general interests of capital accumulation and maintaining social harmony while presenting itself as a neutral agent. Thus, government officials are reluctant to address work satisfaction and safety, a reluctance rooted in the commodified relationships of workers to work. Renaud (1978, 115) adds: "[The state] cannot question the basic factor that makes work unhealthy: the fact that workers largely are only commodities utilized for maximum output, efficiency, and profit. It can only act on very limited, discrete, and easily identifiable working conditions." While promoting the interest of professionals with respect to more secure income and increments in

earnings, state intervention in the form of hospital and medical insurance programs also serves as a concession to working-class struggles for improved health care (See Swartz, 1979, 335; Morton 1980).

For the midwifery movement and other social movements (see Melucci 1988; Young 1990), the political economy of health care requires a historical perspective on work, law, and health. Doyal (1981) documents the worsened health of the populace in Britain during the transition from feudalism to early capitalism: long hours of work, restrictions on food production due to enclosure, poor sanitation and overcrowded habitats, accidents in factories, and the ubiquitous use of women, children, and men as labourers contributed to a general drop in the standard of health. She concludes that the allopathic perspective on medicine is largely empiricist, disease-oriented, and professionalized. This in turn acts against critical social theory, holistic treatment of illnesses, and the work of "non-professionals." The focus of medical research and practice is on individual pathology and curative medical treatment, dubbed time and again as the doctor-patient relationship. Midwives counter that this relationship is frequently limited in time (short prenatal visits), familiarity, and the freedom of expectant women and their partners to design birth plans. Indeed, women who provide detailed birth plans in some conventional-care settings may become objects of ridicule. A midwife working in a hospital in the 1990s recalled how she spoke up for a couple who had submitted a birth plan for consideration by hospital staff: "They had expectations of no episiotomy, no medications, sufficient time to labour, a chance to walk about. Some staff treated this as a joke. I thought it was a responsible effort by the couple."

Heroic medicine and high-technology approaches to illness coexist, reinforcing the medical sphere. High-technology medicine and the dramatization of medical breakthroughs serve as "window-dressing" and support the existing system (Doyal 1981). Doyal's analysis also emphasizes two imperatives: the production of commodities in the health sector, and the securing of authority relations. Authority relations are divided along lines of race, class, and gender. The importance of gender in health care is central in terms of occupational stratification. The Women's Work Project examined 1970 data gathered from New York City hospitals. They determined that between 75 and 85 per cent of lab technicians, licensed practical nurses, and manual services aides were women; 80 to 90 per cent of workers in the last two categories were non-white (Women's Work Project 1976, 19). The structuring of occupations along gender lines is clear in other reports. In the professional and technical spheres in the United Kingdom,

only 12 per cent of medical consultants in the 1970s were women. In 1982–83, 99.8 per cent of nurses in the United Kingdom and 13.7 per cent of physicians were women (Archer and Lloyd 1985, 225). In more recent years, a pattern of more women entering medical school and other professional schools is evident; yet medicine, law, and other professions remain predominantly male (see Brockman 1992).

In their recent analysis of sexual stratification in the Canadian workforce, Phillips and Phillips (1983) reported that two features of the workforce at the turn of the century are still evident: differentials in income (whereby women earn approximately 60 per cent of men's wages, averaged for full-time work) and the concentration of women's paid employment in specific groupings. A recent assessment of women's occupational status in Canada also indicated that women remain concentrated in relatively low-paid jobs (service sector, non-unionized positions). Full-time, female faculty members constitute only 17 per cent of full-time university faculty across Canada (de Wolff 1990, 32).

The segregation of women into occupational groupings in the health and other sectors is linked with market forces. These forces can act in contradictory ways. Fuentes and Ehrenreich (1991) trace numerous examples of exploitation of women in the "global factory" of multinational work. They note, however, that women can organize with respect to pay levels and their work conditions (ibid. 44–6). Another researcher sees waged work in the developing world as providing some opportunities for women, even though such work might reinforce patriarchial elements in the economy: "The expansion of employment opportunities for women in these industries does improve conditions for women in the labor market. In however limited a way, the availability of jobs in multinational and local export factories does allow women to leave the confines of the home, delay marriage and childbearing, increase their incomes and consumption levels, improve mobility, expand individual choice, and exercise personal independence" (Lim 1983, 83). The key to health-care policies, then, is the dialectical relationship between domination and exploitation on the one hand, and changing patterns of health and health services on the other.

LAW AND THE REGULATION OF HEALTH CARE

The specific appartatus of law is a critical factor in promoting and discouraging initiatives in health care. Subsidization of research and formal education are forms of promotion, while restricted access to medical insurance billing numbers and the prosecution of practi-

tioners serve to deter some workers or to limit their practices. Legal mechanisms are a pervasive and decisive force in the restructuring of health care, including maternity and infant care.

As with state theory, theoretical work on the sociology of law is complex and often contradictory. Spitzer (1983) reviews the emerging theories of law that move beyond simple instrumentalism and economism. Structuralism (exemplified by Althusser) and Culturalism (exemplified by E.P. Thompson) are the major competing theories. Both attempt to redefine the nature of relationships between human actors, external structures, and law. A structuralist tenet is that although law is in some sense relatively automous, along with other superstructural features of society, the vectors of legal action are ultimately traced back to the economic system. The reformulation of this structuralist approach by Poulantzas involved a recognition of the role of law as an apparatus that preserves "real rights" of dominated classes (see Spitzer 1983). These rights are embedded within a dominant ideology; consequently, there is an overlap between justice and domination.

E.P. Thompson's emphasis on cultural factors involves an appreciation of the interplay of superstructure and economic infrastructure, as well as a more fundamental critique of the formulation of infrastructure and superstructure. Law is conceived as more than an influence on the material base of society. It is an integral part of the material base (Spitzer 1983, 109).

The relationship between law and the state has thus undergone a contemporary reevaluation among Marxists and neo-Marxists. As Spitzer (1983) indicates, the shortcomings of legal economism and of structuralism have generated a more vital paradigm of law in which law is portrayed as having been created out of an "ideological pool" comprising beliefs and assumptions from all social classes. In turn, the relatively autonomous role of the state – whereby the state is not governed by the will of a dominant class but preserves autonomous powers against direct interests of this class – reflects the contradictory nature of legal ideology and the law as practice: "Legal ideology not only reinforces, enshrines, and legitimates the victories of the capitalist order, it also registers and presages its defeats ... the contradictory nature of law threatens to destroy the symmetry and closure of a Marxism that refuses to acknowledge its mediative and transitory character" (Spitzer 1983, 117).

Other radicals have also been concerned with the hidebound quality of Marxist orthodoxy. Some suggest that modern families can be a site in which progressive interactions can replace patriarchial ones, in which intimacy, cooperation, and child-rearing can exist

within a feminist and socialist context (Gordon and Hunter 1977–78, 19).

Eisenstein (1981) portrays the state as an agency that constrains radical alternatives, including radical feminism (see also Navarro 1986, 232). The state is structured such that it cannot allow women's equality with men. The "sexual ghetto" of lower-paid occupations is one instance of sexual stratification that the state, as employer and arbiter of social conflicts, perpetuates. Through law, the state mystifies what women are and what they do. It serves to constrain people's actual options. Yet it can establish "positive rights." Eisenstein recognizes the political power of the state over women while endorsing struggles to secure the recognition of the state. Other writers appreciate the role of "ginger groups" – pressure groups that maintain a critical focus on public policies (Lessing 1986, 15).

In summary, liberalism and conservatism have largely shaped the development of health care practice in Canada. The current interest in cost-containment reflects the waning of liberal programmatic expansion. The state has become a gatekeeper, monitoring expenditures and in recent times implementing cutbacks in services and employment in Canada.

The economic underpinnings of this have been addressed through radical perspectives on the state and economy. Significant disagreements on state theory and political practice emerge between those who view the state critically. The extent to which alternative health care systems can exist alongside traditional ones is a cardinal issue (Mills and Larsen 1986).

In this context, the midwifery movement can be interpreted in the light of critical theory. Midwifery begins with a critique of professional powers, and extends into a critique of media depictions of midwifery, patriarchial elements of law enforcement, and critiques of state allocation of health resources. At its core, midwifery is a celebration of diversity and new possibilities. It not only restores ancient elements of community and female familiarity, but argues for an honouring of these elements. In recent history, the Canadian state seems to have opted more for prosecution than protection of these customs, however. Two examples from England are useful in this context. Dr. Wendy Savage, an obstetrician in London, was suspended from practice in large part because of "her decision not to perform a caesarean in situations where her colleagues would have done so" (Francome 1986). As we shall see with North American midwives, the decision to suspend Dr. Savage provided an opportunity for critics of medicalized birthing procedures to argue for Dr. Savage's reinstatement. It also dramatized variations in caesarean

section rates, and raised questions about unnecessary recourse to caesareans and other interventions. The second example involves a researcher and teacher, Marjorie Tew. Tew's research has argued against the equation of hospitalized birth with reductions in maternal and infant mortality. Campbell (1992, 364) notes: "Marjorie Tew's work has continued against a background of great hostility, the non-renewal of her contract by the Department of Community Medicine in the University of Nottingham after the publication of her first paper on the subject being just one example of this. There is probably another book to be written about the response to her work." The point here is that professionals openly supportive of midwifery may pay a price for challenging established practices. At the same time, the movement away from medicalized care and toward continuity of care by midwives is not abating.

Theoretical and empirical studies of midwifery illustrate the nature of state intervention in restructuring health care occupations and suppressing the controversy over alternative maternity care. It will be argued that the state is not a neutral party in the controversy, but that it retains a level of relative autonomy from the contesting parties. A point to be developed in the following section and in subsequent chapters is the importance of appreciating diversity among midwives. They are far from a monolithic bloc: there are some substantial disagreements over the directions their practice ought to take, and the price that may be paid in return for the state's imprimatur of legalization. A related point is the diversity within the state: some jurisdictions have been more receptive to midwives' calls for greater autonomy, while other jurisdictions are so far not concerned with the midwifery movement.

THE MIDWIFERY MOVEMENT AND THE CANADIAN STATE

Midwifery practice is a complex phenomenon in Canada and other industrialized societies. Legal regulation of birth attendance influences all forms of midwifery, but most dramatically community midwifery. Recent criminal trials have been launched against community midwives, and prosecutions for violations of provincial medical acts have also been undertaken.

Midwives have often received respect from their communities. Whether we look back to the oral histories of twentieth-century midwives in Newfoundland as reported by Benoit (1991), or to texts from eighteenth-century France (Gelis 1991, 109–11), it is clear that midwives were generally treated with respect by those who used

their services. Interestingly, midwives not only served as birth attendants, but were active in other rites of passage: "She brought to birth and nursed a number of the inhabitants; she also attended to the laying out of the dead ... By presiding at births and preparing people for their last journey, the midwife held both ends of the thread of life" (Gelis 1991, 110). With the advent of medicine and science, midwives have often been caricatured as witches, harridans, or simply as meddlesome practitioners (Donnison 1988; Biggar 1972; Mitchinson 1991). A closer look at contemporary midwives in North America indicates that they are not so easily stereotyped. Midwives vary in their experience, professional training, and philosophies of birthing and politics. A common ground for many midwives, however, is that the practice of midwifery is in many jurisdictions foreign, and at first glance out of step with what is expected by way of obstetrical care.

There is considerable common ground for midwives. First, there seems to be a general agreement among midwives that pregnancy is not synonymous with illness. Morbid situations will develop, but birth can generally be managed skilfully and safely without current levels of obstetrical intervention (often recast as obstetrical interference). Second, it is recognized that the midwife can operate more autonomously than is currently provided for under provincial law (which requires the direction of a physician, or his or her delegation of responsibility where applicable). The dependent status of midwives is thus generally seen as artificial. This perception is often linked with the economic interest of physicians in attending births and the sense of control that some physicians (especially male physicians) prefer to employ over parturient patients and the nursing staff who assist doctors in birth management (Buckley 1979).

A third point is that women's right to be informed and to make decisions about maternity care is vital to the midwifery debate. Midwives place considerable trust in the ability of clients to inform themselves about some aspects of pregnancy and birth. Midwives also appear to be less suspicious about women's abilities to give birth in their own time and way. Fourth, a sense of iatrogenic (physician-related damage) practice is often expressed. Reliance on such procedures as the lithotomy delivery position, drugs to induce labour or to relieve pain, lack of continuity of care (throughout the prenatal period, labour, delivery, and post-partum), and the overarching ideology that birth is a medical event, is seen as contributing to substandard maternity care.

Differences within the movement occur at various points. First, there is an ongoing debate over the importance of nursing training

as prerequisite to midwifery training. Others favour direct entry into midwifery, or multiple routes of entry, such that nurses and non-nurses could undertake midwifery education. This issue will be discussed in more detail later, but it is one point of disagreement among North American midwives. Some argue that direct or multiple-route entry could incorporate some useful aspects of orthodox nursing curricula, while others maintain that formal criteria are not a necessary condition for midwifery practice.

Second, there has been a movement toward establishing guidelines (or standards) for practice. Most midwives' associations have developed guidelines for practice. These guidelines may require that members do not manage breech presentations or the delivery of twins at home, that women are to be transferred to hospital if their amniotic fluid is discoloured (this may be a sign of fetal distress) or if the fetal heart rate falls or rises sharply, and so forth. A few midwives believe that such contraindications to midwifery management are unnecessary controls on the midwife's judgment. There seems to be some evidence from the American literature that legalization and establishment of guidelines for various aspects of midwifery care may result in more punitive actions against midwives (such as suspensions, fines, or loss of a licence to practise). This is a central paradox of the midwifery movement: in establishing a legal status, which entails the scrutiny and the direct influence of state and professional bodies, are midwives complicit in building their own prison? Some have argued that recent American experiences in states with legal midwifery reveal more frequent and more punitive disciplinary action against midwives than in earlier times when midwifery was either illegal or of undetermined legal status (see DeVries 1985).

Another point of disagreement involves the necessity of midwives working with physicians and the delegation of ultimate responsibility for maternal and infant welfare to physicians. The traditional division of responsibility between nurses and physicians involves the delegation of primary responsibility to the physician (College of Nurses 1983). A counterposition is that midwives can work independently of physicians, at least in cases of uncomplicated deliveries (Van Wagner 1984).

Still another dispute goes to the core of home birth practice. For some midwives, home births attended by community midwives represent an ideal (or near-ideal) method of practising midwifery while respecting the client's needs. It is, in the current lexicon, empowering and respectful of women. Others have expressed concern over the limits of home birth practice. Not only does it dramatically limit the number of women who have access to full midwifery services (even

if home birth were fully supported and legalized, it is unlikely that anything near a majority of expectant women in Canada would choose home birth over hospital or clinic birth), but there is evidence that past generations of midwives suffered from some aspects of domiciliary birthing. Cecilia Benoit's (1991) research on Newfoundland and Labrador midwives draws our attention to the bounds of such traditional practice. Midwives' decisions and discretion were limited. The work was often lonely, involving around-the-clock readiness to leave for a birth. Outport midwifery was invariably low-paid, and offered little opportunity for career progress. Benoit suggests that the cottage hospital system was a better organizational structure for midwives than traditional lay midwifery at home. Hospital midwives provided a valuable service, but without necessarily being overworked and isolated and to some extent at the mercy of individual clients. In the modern day, most midwives active in the 1980s have chosen midwifery education and other forms of post-secondary education as a means of acquiring more knowledge and connecting with a wider midwifery community.

My field work on midwifery in British Columbia allows a few observations on the sources of support for community midwives. First, community midwives are able to avail themselves of a variety of resources in conducting their work. There are legal resources available to them, sometimes connected with litigation and sometimes not. A number of lawyers and lobbyists supportive of midwifery remain active today, more than a decade after they first became involved with midwifery and the law. There are legal defences available to midwife-defendants. As demonstrated by attempted criminal prosecutions of Canadian midwives in the 1980s and the unsuccessful charge of practising medicine without a licence (laid against Noreen Walker in Alberta in 1991), these defences have been successfully employed against criminal charges. The various court-situated contests over midwifery and birth-related issues have been accompanied by some political support from opposition parties. In Ontario and British Columbia, for example, the provincial New Democratic parties, through caucus or private member's bills, have supported the legalization of midwifery (Cooke 1984; Stephens 1984). The National Action Committee on the Status of Women also passed a resolution in 1984 in support of the legalization of midwifery in Canada (Sweet 1985). Moreover, the former Liberal government in Ontario was undertaking the legalization of midwifery during its tenure in the late 1980s and early 1990.

A second point is that many practising midwives are aided by the material and emotional support of people close to them – spouses,

other midwives, neighbours, family members. Third, resources can be mobilized if a midwife is threatened with legal action. In one instance recounted to me by a Lower Mainland midwife, the threat of prosecution for the unlawful practice of midwifery under the Medical Practitioners Act was not followed through, possibly because as a politicized midwife she was prepared to muster considerable support in defence of community midwifery (Burtch 1987). Fourth, midwives often work in conjunction with sympathetic physicians and other personnel with respect to back-up and transfers of women into hospital. Fifth, midwives utilize various forms of medical technology (oxygen for rescuscitation, sutures for tears) and a variety of communications devices (telephones, answering machines, pagers) in their practices.

Community midwives have also developed the resource of media exposure through letter-writing campaigns to newspapers and contributions to such periodicals as *The Maternal Health News*. Increased income is another resource. Fee increases for birth attendance are especially important in the light of the relatively low incomes generated by community midwifery and the economic strain on family earnings. Midwives' fees for prenatal care, labour and delivery, and postnatal care were approximately $1,200 in 1993. Finally, international support from other midwives' associations and agencies has bolstered the midwifery movement in Canada. The 1993 International Congress of Midwifery, convened in Vancouver, reflects considerable support by ICM representatives for Canadian midwives.

These resources must be placed in a larger context of midwifery containment. Community midwives are liable to quasi-criminal prosecution for the unlawful practice of midwifery, and are occasionally faced with the real possibility of criminal prosecution or proceedings through the office of the chief coroner. Such legal proceedings, along with the considerable media publicity attendant on these proceedings, can have dire consequences for midwives. Ideally, such proceedings might lend strength to midwives' claims that they ought to be respected and recognized as health care specialists. Practically, however, such proceedings can spell the end of independent practice, even if the findings are favourable to the midwife in question. Peter Leask, a Vancouver lawyer who has represented and advised midwives for many years, observes a "chilling effect" created by such proceedings: "[T]he circle of people using that attendant [midwife] or those attendants will spread. Mothers tell potential mothers about their good experience, and you start to get more people – in a small way – taking advantage of this option. Then, we have some sort of either a tragedy, or a tragedy combined with a legal case, and that

undoubtedly has a chilling effect. It has a chilling effect on both sides of the relationship. The prospective parents wonder whether it's safe to have babies at home ... Birth attendants who do not make much money from doing [home births], and mostly do it out of a sense of service and obligation, start counting the cost of being caught up in such a tragedy ... some of them say, 'No, the price is too high'" (Peter Leask, transcript from *Midwifery and the Law*).

The personal incomes of midwives are far below those of physicians and those of obstetrical nurses working full-time. Nurse-midwives face constraints in existing law and the policy position of their college and the College of Physicians and Surgeons. Recent initiatives to permit the practice of midwifery on a more autonomous footing required the unpaid involvement of nursing professionals from the Low-Risk Clinic in Vancouver. There has also been a reluctance to acknowledge midwives *as* midwives (since midwifery is seen as a physician's monopoly under current legislation); there has been a recent unsuccessful attempt to define hospital-based, trained midwives as "primary care perinatal nurses." In British Columbia, as of August 1993 there were approximately fifteen community midwives attending home births in the lower mainland area of Vancouver. This is in sharp contrast to a thriving community midwifery practice less than a decade earlier.

CONCLUSION

The practice of midwifery is, for the most part, both constrained by and facilitated through its legal status. A key element in the involvement of the state through its legal powers in what was previously a localized neighbourhood event in North America has been the assumption that midwifery practice is intrinsically more hazardous than physicians' attendance. A related assumption is that midwives require supervision by physicians, although legislation such as the 1902 Midwives' Act in England has established a basis for self-regulation by midwives. A second assumption is that legal constraints on midwives emerge from a public consensus on the appropriateness of restricted birth practices (Howitz and Ussing 1978; Greater Vancouver Regional District 1993).

The constraints on midwifery practice should not, however, overshadow the role of the midwifery and nursing professions in various countries in lobbying for recognition and resources. As set out in the discussion of nurse-midwifery and community midwifery, support has emerged from within the state and within the professions for the implementation of midwifery services. Reconceptualizing midwifery

as being governed by the state also requires greater attention to the resources provided through the state. One of the difficulties with the oppositional ideology that appears among some community midwives is the bold line drawn between natural childbirth and obstetrical intervention, between spiritualism and science, and between home and hospital. The machinery of the state can be seen as emerging from popular concerns over safety and welfare, not simply from the logic of capital or the interests of specific professions.

Feminist theorizing on the capitalist state is especially important in considering reproductive issues, including birth. Ursel reviews legislation concerning the role of the state in women's reproduction. She argues that state intervention in Canada "demonstrates both the continuing existence of patriarchy as a regulator of reproduction in industrial capitalism and its change from a familial to a social form" (Ursel 1988, 109). Ursel (1988, 143) also reviews various commissions and legislative enactments, and concludes that the state has not only gained greater control over the supposedly private sphere of family life, but has also restructured patriarchy rather than ending it. This appreciation of patriarchy challenges not only the more complacent liberal and conservative approaches to the state, but also Marxist and other critical theories that do not adequately deal with women's positions in the workforce and their reproductive powers.

The instrumentalist portrait of the state is further qualified by the requirements of due process and procedural rules. A variety of enactments, including the Charter of Rights and Freedoms, can be and have been used to offset the potentially absolute powers of the state. The law of evidence and judicial rulings have generally not been helpful in prosecuting community midwives for criminal negligence causing death. Also, despite the hegemonic powers exercised by the state and the professions, the midwifery movement continues a tradition of collective self-help and opposition to professional control in health care. The state may attempt to "colonize all forms of existence" (Ewan 1972), but this attempt in law is not wholly successful.

Chapter three provides additional information on the diversity of childbirth practices, including the status of midwives from a global perspective. An important dimension that connects state theory with cross-cultural and historical materials is the need for specificity. Some liberal democracies, such as Canada, have promoted an outlaw status for midwives; other democracies have supported direct entry training of midwives and a broader sphere of practice for trained midwives active in hospitals. The theme of the relative autonomy of the state, evident in clashes within the Canadian courts and legislatures and also evident in this global perspective, captures the structuralists'

premise that the state is used to contain initiatives from relatively powerless groups. This containment is nonetheless subject to change, and the sources of change emerge not only in civil society but within the very framework of the state. This is an apt theme in the Canadian context: whereas the monopoly status of medicine in childbirth reflects an instrumentalist perspective, there is evidence that the medical thrall is diminishing in North America as other health professions demand legal status (Starr 1978, 1983; Coburn et al. 1983). Groups that currently enjoy legal status may also mobilize against unwarranted interference in their work. A case in point is recounted by the Association of Radical Midwives (ARM) in England. Although midwives in England have had legal status under the Midwives Act since 1902, there are concerns over limitations imposed on their work. In 1986 ARM published several proposals to restructure maternity services in England. The authors indicate that many midwives are dissatisfied with the fragmented care offered to pregnant women, and that midwives are hardly considered "practitioners in their own right" (Association of Radical Midwives 1986). The agency of midwives is also apparent in the way the argument against the greater empowerment of midwives can be turned on its head. Rather than seeing midwives as duplicating doctors' services in maternity care, the ARM paper places midwives at the centre of such care. This woman-centred approach offsets the possible trap of women moving to alternative birth centres (ABCs) that are not consumer-oriented and -managed, but largely controlled by professional interests: "Much of the obstetric care given by GPs at the moment results in either duplication of or failure to make full use of midwives' skills. We recognize that the GP has a long term commitment to the family and could be the source of much valuable background information in such cases" (Association of Radical Midwives 1986). In the United States, the opposition to home births, and to midwives' taking a more central role in assisting with deliveries and pregnancies generally, has been fierce. And even though the arguments may become less inflammatory and more subtle as midwives and doctors vie for access to birthing women, there is still a depiction of superior caregivers versus their enemies (Treichler 1990, 126–8).

The vast literature on the state serves the useful purpose of speaking to the issue of power and its translation into control over thought and practices. The very hegemony of the medical profession in western countries rests not only in its claims to powers but in its special status as a prestigious profession. Obviously, there are contradictions evident here, not least in the paradox of a self-governing, self-directing profession that is, in some countries such as Canada,

dependent on the public education (of doctors) and publicly supported resources such as health insurance plans and the running of hospitals and clinics. Nonetheless, the translation of power into action seems far easier for the medical profession than for ejected groups such as midwives. The strength of occupational monopolies such as medicine includes its ability to manage allied groups in such a way that medical prestige and income are not substantially threatened (Larkin 1983, 4).

These modern conflicts surrounding monopolistic professional powers, safety of infants and mothers, and women's right to choose the place of birth and birth attendants become understandable when two dimensions are considered: the historical dimension of control over childbirth, and the cross-cultural variations in birthing practices, particularly in the role played by midwives. Chapter three elaborates on these points and on the pivotal role of the state in shaping the historical directions and, to some extent, the cross-cultural expressions of midwifery and birth practices. The point to be developed in this book is that the mistrust of midwives in Canada has a long if not very distinguished pedigree. Arguments against midwives have tended to emerge from those professions that have become responsible for assessing and treating diseases: medicine and nursing.

Theories of the state are useful in assessing the politics of resistance to midwifery, including of course groups within nursing and medicine who favour the implementation of midwifery. The role of the state in safeguarding the material interests of the professions has been strong, yet a growing criticism of the limitations of the intervention-oriented medical model has challenged the equation of professional management of birth equalling better outcomes, including women's satisfaction with birthcare. Feminist critiques of the nature of reproductive rituals and technology pose an important challenge to medicalization, and serve to highlight women's choices in reproduction (Cox 1991). Patriarchial control measures in routine obstetrics are thus the subject not of passive acceptance, but oftentimes of questioning. Thus, the hegemonic power of the medical profession in "presiding" over births, as well as the restrictive legislation that provinces have traditionally enacted, face growing criticisms, especially in their outlawing what might be termed more holistic professions, such as midwifery and chiropractic (see Biggs 1988). A combination of structuralist theory, feminist theorizing, and especially the role of human agency in protesting restrictive controls (and presenting innovative approaches in maternity and infant care) highlights the obstacles midwives and their supporters face in overcoming legislative restrictions and the material interests of the more established players in health care.

CHAPTER THREE

Historical and Crosscultural Aspects of Midwifery

Then the king of Egypt said to the Hebrew midwives, one of whom was named Shiph'rah and the other Pu'ah, "When you serve as midwife to the Hebrew women, and see them upon the birthstool, if it is a son you shall kill him; but if it is a daughter, she shall live." But the midwives feared God, and did not do as the king of Egypt commanded them, but let the male children live.

Exodus 1: 15–16

And if there is a single piece of wisdom that has more humanity in it than any other it is this: befriend the womb.

Hugh Hood, *Reservoir Ravine*

INTRODUCTION

Thousands of years separate the biblical account of the midwives' defiance of Herod and the current conflicts over state policies concerning midwifery. This chapter provides an overview of major developments in the evolution of midwifery worldwide. Two broad areas are considered. The first is historical developments in formalized midwifery practice, with special attention to England, continental Europe, the United States, and Canada. This discussion goes beyond Canada's anomalous situation in not recognizing midwifery practice. In Europe, ecclesiastical and state regulation and advances in science and obstetrics profoundly affected traditional birthing cultures. Birth was claimed as part of the medical terrain. In North America, midwives were often subjected to antagonistic campaigns by medical and nursing associations. Historically, deep conflicts and competition emerged between midwives, who had attended births since ancient times, and aspiring male medical practitioners. These conflicts have

not spelled the eradication of the midwife, but have foreshadowed ongoing conflicts surrounding the proper practice of midwifery as a health profession.

The diversity of midwife practices in various cultures is explored in the second part of this chapter. In virtually all cultures women have been customarily been responsible for assisting at births. Birth attendance and assistance after birth often involved kin and neighbours. Birth was a local event, unadorned with technological aids or monitoring devices as we know now them. The advent of professionalized midwifery, or the displacement of midwifery by medical and nursing personnel, is set in the wider framework of technological advances, centralization of maternity services, and formal bureaucratic structures. These crosscultural materials are used to argue for the viability of community-based approaches to birthing (Askew et al., 1989; Rifkin 1990), and to document the seriousness of infant and maternal mortality rates in many developing countries (Maine n.d.; Kwast 1991, 1993). The transformation of birth is a complex process, riddled with contradictions and opportunities. Wider structures of medical ideology, opposition to medicalization, and structural limits imposed by customs and by disparities in wealth are also reviewed across several cultures.

HISTORICAL PERSPECTIVES ON MIDWIFERY

The evolution of midwifery in Europe reflects technological advances in the medical sciences and the changing patterns of control through the professions and the influence of the state. These structural changes have contributed to the eclipsing of the traditional midwife by physicians and her near-replacement by the nursing and nurse-midwife professions in North America. This intrusion into what was historically women's sphere transformed the role of women in maternity care. This intrusion means that reproduction is usually mediated and controlled by an élite of primarily male physicians (Oakley 1980, 8–10). This intrusion was contested and limited to an extent by custom and by concerns about the improper takeover of midwifery practice. Nonetheless, the traditional role of the midwife was changed with the growth in number of rival practitioners, and new knowledge concerning anatomy, physiology, and obstetrics.

Bohme (1984) traces four phases in the social history of European midwives. The first phase, solidary aid, is traced to the early days of civilization. Knowledge of childbirth was gained by witnessing births and through personal experience. Giving birth was a necessary

aspect of becoming a midwife. Solidary aid was based on the communal involvement of women assisting other women during labour, delivery, and the post-partum period.

The second phase is that of office. The ecclesiastical overseeing of life in the Middle Ages was extended to childbirth. Midwives were appointed and licensed by the church to ensure that the moral character of birth attendants befitted the office. The midwife was not only to provide care to women, but also to thwart abortions, to watch for substitutions (changelings), and to prevent infanticide. Paternity was established by midwives, and newborns were baptized by midwives. Midwives could not profit by their work. The office of midwife sought "poor but honest" practitioners (Bohme 1984, 375).

The third phase, traditional profession, marked the transition from an assigned office to a more secular conflict between midwives and male physicians at the beginning of the eighteenth century. Surgeons and barber-surgeons, once restricted to performing caesarean sections or extracting stillborn babies (or babies who could be removed otherwise), asserted their superiority via innovations such as the forceps and anaesthesia. The exclusion of women from the universities and the development of gynecology and surgery further reduced the province of the appointed midwife (Bohme 1984, 375). The current status of midwifery as a modern profession is the fourth phase discussed by Bohme, in which midwives become self-regulating and licensed, a system that predominates in modern Europe. Specialized training of midwives, the establishment of local and international associations, and the combination of theoretical knowledge and practical midwifery skills exemplify this phase.

The growth of new structures of knowledge surrounding obstetrics and midwifery was influential in shaping the role of midwives. In contrast to its neighbourly quality in earlier times, the phenomena of pregnancy, birth, and post-partum care fell under the mantle of scientific management. This scientific basis revolutionized the management of birth. In some important respects this revolution benefited mothers and infants; in other ways, birthing lore and respect for women's ability to give birth were eroded (Lang 1972). The "miracles" associated with heroic medicine and the less dramatic aspects of the work of medical and nursing disciplines, were not always extended to lay midwives or aspiring midwives.

Descriptions of the historical development of English midwifery are rich, and provide a useful account of a nation that has entrenched midwifery care, but not without criticism of the limits facing many midwives. Jean Donnison (1977, revised 1988) has provided a comprehensive history of English midwives, and documents the rivalries

that emerged over maternity and infant care. In *Midwives and Medical Men* (1977) she traces these rivalries, accompanied by the growth of professionalized medicine and nursing. English midwives in the Middle Ages were likely to be middle-aged married women who had given birth. Donnison adds that women were active not only as midwives but in the healing arts more generally. Medicine and surgery were offered by women active in charitable work among the poor, and some women practised medicine for pay. In England, "until the thirteenth century practice in the whole field of medicine appears to have been open to all, men and women, whether possessed of education or training, or not" (Donnison 1977, 2–3).

The customary practice of lay midwifery was altered dramatically with the advent of barber-surgeons' guilds in the thirteenth century. Surgeons were granted an exclusive status in towns and surrounding areas. They were often designated as the appropriate birth attendants for abnormal deliveries. Surgeons were thus permitted to perform instrumental deliveries and deliveries by Caesarean section. Donnison (1977, 2) concludes that guild membership seems to have been open to women, "but their number does not appear to have been large."

Donnison outlines the wide compass of human affairs subject to church control. Episcopal licensing was a form of midwifery regulation that influenced birth attendance. As noted earlier, midwives were to be of good moral character. They could be required to take an oath and to produce witnesses to vouch for their good character. They were obliged to see that babies were christened in accordance with church doctrine. Midwives served also to inquire into fathers' identities in cases of bastardy. Along with these obligations, midwives were forbidden to practise abortions or to be involved in witchcraft (Donnison 1977, 4). The licensing of physicians was vested in church authorities in England in 1511, while the informal regulation of midwives by the church was legalized in 1512. Power over birth attendants, particularly midwives, was thus transferred from the community and the parish and centralized at the bishops' level in the church hierarchy.

Midwives were hindered by church proscriptions on their conduct and by the lack of an internationally recognized knowledge base. The absence of a knowledge base contributed to the limited powers of community midwives in resisting the growth of scientific obstetrics developed in France and adapted in Britain (see Arney 1982, 21–9). Fifteenth-century English midwives were sometimes denounced as agents of the devil, but were not subjected to the inquisitorial

punishments to the same degree as midwives in continental Europe (Donnison 1988, 17; Ben-Yehuda 1980).

Midwives in Europe were denounced as witches, and thousands of midwives and female healers were executed. Donnison sees this campaign against heresy as rooted in misogyny. One book, *Malleus Maleficarum* (*The Hammer of Witches*) is described as "a classic in misognynist writing" (Donnison 1988, 17, 40–1). A document written in 1484 by two men active in the Inquisition, the *Malleus Maleficarum* justified the prosecution of midwives and other healers. Donnison (1988) believes that this book and witch-hunting were premised on the belief that women's essence was irrational and "passive," and inferior to men's essence and talents. She notes that the thesis of the *Malleus Maleficarum* "is that women, because of their greater 'carnality,' are easily tempted to serve the Devil, who in this 'twilight' of the world was using them in his attempt to overthrow Christendom" (Donnison 1988, 17).

The witch-hunts endured for centuries, shored up by the power of formal legal procedures. In America, the infamous Salem witch trials of 1692 led to the execution of fourteen women and six men (Williams and Adelman 1992, 200). Ehrenreich and English (1973, 9) criticize interpretations that attribute the witch-hunts to a kind of hysteria; rather, the hunts "were well-organized campaigns, initiated, financed and executed by Church and State." These vilification campaigns were not without their critics. Some opposed the encroachment of male midwives in birth on grounds of modesty as well as the unnatural methodologies and inferior skills of male attendants. In *A Treatise on the Art of Midwifery* (1760), Elizabeth Nihell criticized the lower pay available to women attendants relative to men (Arney 1982, 30–1).

Beginning in 1890, many midwives' bills were proposed in England. The first act governing midwives was passed in 1902. The Midwives Act of 1902 followed the efforts of the Midwives' Institute and its supporters to gain legal recognition and a protected status in law. Midwifery was not given an autonomous status, however. This result followed a longstanding pattern of medical opposition to the registration of midwives. Medical authorities were generally agreeable to registering midwives only if medical control was secured over registration. It appears that general practitioners were especially wary of midwives, who were seen as competitors for family practice. Opposition to midwives also fed on the notion that midwifery would, almost by natural selection, give way to medical care in future. The science of obstetrics, aided by such instruments as the forceps (Nagy

1983–4), heralded the eclipse of the ancient art of midwifery by the medical model: "In the more affluent and educated world of the future, every woman would be delivered by a doctor, and the midwife, a relic of a less civilized past, would vanish from the scene" (Donnison 1977, 158).

The Midwives Act of 1936 subjected the midwives to local authorities. It also provided broader grounds for deregistration on grounds of professional misconduct. The private lives of midwives were open to scrutiny. The Midwives Act enacted in 1936 reflected concerns over the falling birth rate in England and the likelihood of war. Local authorities were to secure salaried, full-time midwifery services adequate to the citizenry. The act also promoted the development of professional midwifery: unqualified midwives were banned from attending birth in any capacity (Donnison 1977, 191). The amended Midwives Act of 1951 stipulated that the board could strike off midwives whose conduct unrelated to their work brought the profession into disrepute (Donnison 1988, 181). Some have suggested that the greater degree of institutionalization of midwifery in Britain (relative to the United States) hinges in part on the lack of regulation of midwifery in colonial America, and the failure to establish midwifery as a centrally controlled institution in the face of opposition by organized medicine (Anisef and Basson 1979).

Clearly, the 1902 Midwives Act was an important achievement for midwifery in the United Kingdom. The act helped to secure midwifery practice in the face of ongoing efforts to eliminate midwifery altogether. It maintained female attendance in childbirth as a feature of English society. Moreover, the scope of "improper practice" was more broadly defined. It was especially important that the medical profession secure "a dominant voice" in midwifery governance (Donnison 1988, 74).

European municipalities gradually devised systems providing for midwifery care and licensing. Donnison believes that while the midwives' character was important for municipal authorities, greater emphasis came to be placed on the midwives' "technical competence." Midwives were examined by other midwives or physicians, and sometimes by a combination of more experienced midwives and physicians, constituting an examining board. These municipal systems helped to establish midwifery practice, but by the same token served to limit its operations. Donnison cites the requirement that midwives seek medical assistance for difficult births, and the prohibition against midwives' using various obstetrical devices to extract infants. In Strasbourg, for example, midwives who used sharp

objects (hooks) to extract infants could be subject to the death penalty (Donnison 1977, 174–5).

A key point is that these early regulations were directed toward the exclusive practice of some forms of midwifery, an approach that carried penalties for those violating regulations. This produced "a system of licensing skilled and approved practitioners, and for the punishment and suppression of the rest" (Donnison 1977). There were of course exceptions in the enforcement of regulations. Midwives who could not afford the licensing fee might continue to practice, with authorities turning a blind eye if they practised among the needy (Donnison 1977).

The declining prestige of midwives throughout Europe is traced to several factors. Scientific advances beginning in the sixteenth century were undertaken by men. As labour and delivery became the focus of science and medicine, "operative midwifery" became more commonplace, spreading from France throughout Europe (Donnison 1977, 10–11). Donnison concedes that some midwifery practices at this time posed dangers to mothers and infants. She adds two important points: first, that midwives were not alone in engaging in unjustifiable practices, and, second, that there was no provision at this time "to help midwives improve their professional competence" (Donnison 1977, 11).

For Donnison (1988, 34) from 1720 onwards, midwives were "losing ground" to men. The ancient art was depicted as an anachronism, in contrast to science and medicine. Male practitioners not only established their power in managing abnormal births; they also began to attend ordinary births in greater numbers. Donnison notes men's advantages in gaining formal instruction in obstetrics, as well as the critical power of using forceps to assist in deliveries. The forceps could be life-saving for mothers and infants, and midwives had customarily done without such devices (Donnison 1988, 12). Men's involvement in births intensified, despite opposition from midwives and dissent from some doctors. Opponents voiced concerns about female modesty, as well as principled objections to the exclusion of midwives from new knowledge. John Douglas, a London surgeon, argued in his *Short Account of the State of Midwifery in London, Westminster &c* (1736) that it would be better to provide instruction for midwives rather than admonishing them for their lack of skills (see Donnison 1977, 23–24).

Donnison's work is remarkable for its detailed account of the allies and critics of midwives. Some innovations, such as the creation of lying-in hospitals in Dublin, London, and other cities beginning in

the late eighteenth century, offered instruction opportunities to female students. Overall, however, the creation of a class of trained midwives was frequently blocked by limited opportunities and catcalls from their medical competitors: "[Male practitioners] exaggerated the dangers of childbirth and frightened women into believing that extraordinary measures, and therefore male attendance, were more generally necessary than they actually were. At the same time they made the most of every occasion to denigrate the understanding and competence of midwives, and to blame them, however unjustly, for anything that went wrong" (Donnison 1977, 29).

Donnison notes that for 250 years midwives had been subject to encroachments on their practice, with very little improved training and few opportunities for practice. Midwives lacked their own scholarly journals, midwifery textbooks, professional societies, and, above all, political organization and alliances. Midwives were not completely without support from outside the ranks of midwifery. Florence Nightingale, for example, not only promoted nursing as a vocation, but also favoured the establishment of government-sponsored schools of midwifery. The women's movement in England was also active in support of midwives and women who were barred from entering medical schools. Even as midwifery and improvements to women's legal, social, and occupational status were promoted, Donnison (1988, 92–3) concludes that midwives continued to lose ground to other caregivers.

The Female Medical Society (1862–1872) was an important force in the midwifery movement in England. Although it lasted only a decade, and did not produce a large number of qualified midwives, Donnison credits this society and its supporters with strengthening the argument for midwifery. The society, led by Dr. James Edmunds, joined with wider movements of the day in seeking improvements in public health (including temperance and the prevention of contagious diseases), and argued publicly in favour of midwifery practice. The lack of adequate midwifery attendance for mothers and infants and the artificial obstructions to talented women seeking to practice midwifery were decried by the society (see Donnison 1977, 73–4).

In Germany, concerns were expressed about unregulated midwifery practices. These concerns included illiteracy and superstition among midwives, along with injuries to women (caused by the practice of manually removing the placenta) and to infants resulting from incorrect cutting of the infant's frenum (the small ligament controlling the movement of the tongue: see Shorter 1982). These concerns led to formal regulations specifying the responsibilities of midwives and physicians in Germany. One requirement of late fifteenth-century

and early sixteenth-century urban ordinances in Germany was that midwives were required to summon physicians for advice or direct assistance in complicated deliveries (Benedek 1977). More brutal measures were also taken against midwives. Witch-hunting resulted in the executions of thousands of midwives, and it appears that those not affiliated with a man were especially vulnerable to witch hunts (Midelfort 1972; Daly 1978, 184–5). In spite of this inquisitional legacy, midwifery found its foothold in Europe as midwifery schools became established in the eighteenth century (Donnison 1977, 40).

The opposition to lay midwives was evident in France. As Theophile Roussel indicated in 1874, many birth practices of the day were seen as unenlightened. In eighteenth century France, child care given by "wet" and "dry" nurses not uncommonly resulted in infant deaths through neglect (Badinter 1979; Colette 1979, 128). The menace of untrained midwives was denounced: "Notwithstanding the disinterested counsel of physicians and enlightened persons, the force of habit, the brutish stubborness of the peasants, and the foolish advice of the midwives maintain practices that are fatal to children whose health needs are poorly attended to" (cited in Donzelot 1979, 30–1).

The French government also established midwifery instruction at the Hôtel Dieu Hospital in Paris. Midwives received instruction in midwifery, textbooks on midwifery were made available, and lying-in hospitals were established (Donnison 1977, 40). Donnison concludes that government intervention was to the benefit of French and German midwives. That said, by the late nineteenth century midwives in France "were gradually being brought under the authority of the medical profession," while in Germany midwives were increasingly relegated to attending "routine" births, and men became more prominent in attending wealthier women (Donnison 1977, 85).

The situation was worsening in England. Government-subsidized instruction was lacking in the eighteenth century, and charitable institutions were not greatly involved in furthering midwifery practice. By the 1720s male midwives were becoming more prominent in attending normal and abnormal deliveries (see Donnison 1977, 21). Without adequate financial rewards for the practice of midwifery, it seemed inevitable that midwives in England were destined to disappear altogether as men became more and more involved in managing births. Donnison notes that the practices of male midwives became more pervasive in England than in any other European country.

The growth of state authority served to mediate the growing rivalry between traditional female midwives and the male midwives who aspired to attend a greater proportion of births. Midwives and

medical practitioners were vilified and satirized, and appeals were made to government for recognition of the superior skills of either profession. Competition between midwives and medical practitioners is still very much in evidence in western obstetrics: midwifery, as a profession independent of nursing and medicine, continues to face opposition on many fronts (Picard 1991).

Midwifery in Canada

> There is an underside to every age about which history does not often speak, because history is written from the records left by the privileged. We learn about politics from the political leaders, about economics from the entrepreneurs, about slavery from the plantation owners, about the thinking of an age from its intellectual élite.
>
> Howard Zinn, *The Politics of History*

The historical study of midwifery in Canada has until recently suffered from the elitist view outlined by Zinn. Historical approaches have favoured a version of history written "from above," not from a working-class perspective (Shortt 1981). Biographical accounts of eminent physicians and chronicles of dramatic medical advances are featured in this antiquarian approach, while accounts by working-class people are absent or minimal. Nellie McClung (1935) stated that those who did "the work of the world" were not written about by historians. There is, however, a renewed interest in social history, and in the use of oral histories (Thompson 1978) to explore events and experiences ignored in existing accounts. Women's experiences have often been "hidden from history" (Rowbotham 1973). Several Canadian historians have recovered some of these histories (see, for example, Strong-Boag 1988; Backhouse 1991; Creese and Strong-Boag 1992), including accounts of the ways in which women's reproduction was regulated (McLaren and McLaren 1986; Mitchinson 1991).

The absence of historical documentation by and about Canadian midwives is most evident in the lack of records and documents of lay midwives in frontier and post-frontier eras. Lay midwives in Canada rarely kept systematic records. For example, documentation on births attended by a Regina-based midwife between 1916 and 1918 noted only the date, the name of the mother, whether a doctor was present, and the street address ("Mrs. F.A. Wayling"; see also the records of Jane Hamilton Sorley, 1851–1893, "Five Islands, N.S., Midwife"). Mrs. Sorley's records contained only the date of the child's birth and the mother's name. Records from Ukrainian, Scandinavian, Acadian, and Quebecoise midwives do not appear to have been

translated into English (but see Ward 1984). The absence of written records has also been observed in historical accounts of lay midwifery in the United States (Donegan 1978, 3–4). In keeping with other scholars who have studied hospital practices in nineteenth-century Canada, Shortt (1981) reports that historical records of lay midwives are often incomplete or unavailable. Historical writing on Canadian midwives has thus been limited, although there is a renewed interest in excavating documentary materials related to lay midwives and trained midwives and nurses who succeeded them (see Benoit 1991).

The nature of birth attendance in early Canada varied considerably. As the report of the task force on the implementation of midwifery in Ontario indicates, midwifery was established in Nova Scotia and Quebec. Midwives were an integral part of Mennonite communities in Manitoba, and in first-generation Japanese-Canadian communities in the lower mainland of British Columbia. Nevertheless, throughout Ontario and the western region, "women whose primary function was midwifery were rare." Instead, a "neighbour network" developed in North America, with neighbours assisting one another in childbirth (Mason 1987, 201–3; Edwards and Waldorf 1984). Lay midwives in pre-Confederation Canada were often affiliated with specific immigrant groups (Canadian Broadcasting Corporation 1981). Cameron (1982, 243–9) provides a fictional account of native Indians attending a white woman in labour. Historical accounts indicate that native midwives assisted settlers and one another in the colony of British Columbia: "In the earliest days there were no trained nurses such as we know in 1945, and there were no hospitals. It was not considered necessary for a mother to go to a hospital for the birth of a child, and, further, it was not considered a matter for hospital attention. Children, in those days, were born in their homes – not in hospitals ... In Moodyville, a neighbour acted, assisted by an Indian woman, and at the Hastings Sawmill, and in Granville it was much the same ... Indian women never had mid-wives other than another Indian woman" (Matthews 1945).

A history of Pemberton, British Columbia, reports that native midwives assisted settlers in childbirth: "Babies were delivered by Indian mid-wives trained in their own traditional herb medicines, or by neighbours such as Mrs. Neill. The more prosperous or more nervous [women] preferred to travel to Vancouver several weeks ahead of time" (Decker et al. 1978, 241). The authors add that trained nurse-midwives were desired by women in the Pemberton area, and eventually trained nurse-midwives affiliated with the Squamish Public Health Service practised there. By the beginning of the twentieth century, maternity cases in British Columbia were increasingly

directed to two general hospitals and four or five maternity homes, although "dozens" of midwives attended women in labour at home (Matthews 1947). There are oral histories on frontier midwives and nurses in Western Canada, including Icelandic and other ethnically affiliated midwives. In some places women trained in nursing and midwifery worked with country doctors; sometimes neighbourhood women were the sole birth attendants (Rasmussen, Savage, and Wheeler 1976; Gahagan 1979, 1). Coburn (1974) concludes that community midwifery was essential, since few doctors practised in the colony.

Mason (1988) has studied traditional birth cultures in Canada. She notes that outside the more densely settled areas, women relied on one another for labour support. Women were discouraged from labouring alone. Female kin and neighbours often assisted in birth, providing what midwives today refer to as "continuity of care." A cardinal rule for midwives in this traditional birth culture "seems to have been to stay with the mother throughout the whole of her labour, to comfort her, and never to leave her by herself" (Mason 1988, 101). Parallels to modern community midwifery practice are evident: for example, women were encouraged to adopt various positions for delivery, and to move around during labour rather than being confined to the lithotomy position, or bedridden (Mason 1988, 102). She summarizes the traditional birth culture as offering several benefits: familiarity, companionship, various kinds of assistance to women and their families, provision for bedrest for women following birth, remedies, and birth attendance based more on reciprocity than on fee payments (see Mason 1987, 206). Strong-Boag (1988, 154), acknowledging that some concerns over unsafe midwifery practices might be justified, argues that these neighbourly midwives were valuable assets for many women: "Whatever their lack of professional qualifications, such women were cheap, potentially extremely helpful with domestic duties, and often reassuringly familiar when compared with their more scientific rivals ... as long as the pregnancy was normal and hospitals remained centres of infection and intervention, domestic surroundings and experienced, if unlicensed, care might be a very sensible solution."

The traditional birth culture stood for more than community customs in less settled areas. Mason (1988) found that where this culture was established, lower rates of maternal mortality were documented in midwife-attended home births than in physician-managed births. But even in the face of evidence favourable to some aspects of traditional birthing arrangements, "the proponents of more extensive medical involvement in birth had no interest in documenting the

positive attributes of the traditional birth culture" (Mason 1988, 106). Possibilities for preserving the community-based culture gave way to an ethos of physician control of deliveries. Mason (1988, 111–12) uses the example of the Dionne quintuplets to highlight how physicians had positioned themselves as the most important caregivers. Although three of the Dionne quintuplets, born in 1934 in northern Ontario, were delivered by midwives, Dr. Dafoe delivered two of the babies and was given sole credit for his work. This credit was bolstered by his nomination for the Nobel Prize in medicine and his involvement in raising the quintuplets in an institution (see also Berton 1977).

The public health movement, showcasing medical attendance in tandem with nurses' involvement in maternity and infant care, began to accelerate after the First World War. Mason indicates that public health nurses helped to "propagandize" this system of birthing, a system that undermined women's confidence in birthing (Mason 1988, 212–15). This cultural emphasis on doctor-nurse management of birth was accompanied by technological experimentation, as well as a greater reliance upon caesarean section, the use of chloroform, and routine episiotomies. This experimentation did not lead to radical improvements in maternal mortality rates, and published findings suggested that many maternal and infant deaths were preventable (Mason 1988, 218–20). In North America, calls to reintroduce midwifery as part of an optimal health system fell from fashion and carried little weight in the early part of the twentieth century.

Midwifery care was not replaced so quickly in some areas of Canada. Midwives continued to practise in some outposts and in outport areas of Newfoundland. Benoit (1983, 1991) collected oral histories of empirical midwives in twentieth-century outports in Newfoundland. She explores the tradition of community self-help and folkways, along with the transformation of midwifery into obstetrical nursing. The Newfoundland midwives were typically forty years of age or older. Local midwives were generally well respected. Their practice was diversified, and ranged from birth attendance to bone-setting and veterinary care. In contrast to the fee-for-service practices of the professions, payment to community midwives was often made through bartering. The world of the outport midwife in Newfoundland was not entirely self-contained. Health threats to mothers and infants remained, and it was not uncommon for local midwives to accompany women to hospitals or nursing stations staffed by doctors or nurses. Some midwives also took formal training in Boston or other urban centres. Wendy Mitchinson points out that the movement toward hospital births in Canada

was a feature of the twentieth century: "As late as 1939 more births occurred at home than in hospitals in the province of Ontario. For most of the nineteenth century few women would give birth in a hospital unless they absolutely had to. Hospitals were not particularly attractive places, and many refused to accept midwifery cases except in cases of emergency" (Mitchinson 1991, 183).

Coburn (1974) suggests that patriarchial ideology aided in the relegation of women to the domestic sphere, while professional ideology attracted trained nurses as allies with physicians against folk-healing and birth attendants. Historical accounts confirm the displacement of lay midwives by pioneer doctors and nurses. Increasingly, doctors were involved in home and hospital deliveries, occasionally assisting by telephone when travel proved impossible (see Burris 1967, 223–4). The exclusion of female birth attendants in the eighteenth and nineteenth centuries was accompanied by the refusal of medical schools in the United States and Canada to admit women (Donegan 1978, Strong-Boag 1979) to admit women. A female student who graduated from Queen's Medical School in Kingston, Ontario, faced hostility from male classmates (Smith 1980). Likewise, a woman applying for admission to the Royal College of Surgeons in Edinburgh in 1869 was ridiculed by her fellow students. There are more recent examples of dismissiveness and hostility directed toward female students in physics, psychology, and other disciplines (Ashley 1980, 16–17; Tuna 1989).

The exclusion of women from medical education can be linked with broader restrictions on women in nineteenth-century Canada. There was concern among some physicians that anatomy and physiology should not be taught to girls for fear of triggering hypochondria. The belief that women were by their nature ill-suited for competition and higher education was also reflected in this patriarchial differentiation of women and men (Mitchinson 1979, 16–17; 1991).

The professionalization of childbirth attendance in Canada has thus been placed in a critical framework of patriarchy and gender. Coburn sees the general ideology of women's inferiority as promoting work structures in which women's labour was auxiliary to men's work, voluntary (charitable), or poorly paid, and in which the material concerns of doctors and legislators were joined. The displacement of the lay midwife in Canada was not connected with the intrinsically superior power of medical and nursing attendants. Coburn (1974) adds that the intertwining of professionalism, sexism, and exclusion of women healers from lay practice and the barring of women from medical schools facilitated capital accumulation and industrialism.

The movement from the home to the hospital promoted structural disciplinary environments more conducive to industrialism.

Suzann Buckley maintains that the liaison between nurses and doctors in Canada, far from reflecting public preferences for professional attendance, stemmed from the professionals' interest in securing a monopoly over health-related services and from middle-class preferences for higher-ranking attendants. The securing of childbirth attendance also served to establish family medical practices for general practitioners. David Cayley (Canadian Broadcasting Corporation 1981) found that doctors obstructed attempts to establish midwifery certification and practice in Canada, and launched a "campaign of vilification" characterizing lay midwives as ignorant, dirty, and dangerous. As outlined earlier in this chapter, such campaigns were standard fare among European opponents of independent midwifery practice and training, and gained currency in North America as births became more medicalized. The strength of the opposition to midwifery stemmed in part from state prohibitions on improper practice, prohibitions that became entrenched in various statutes across Canada.

Law and the Containment of Midwifery

The ideology of professional attendance at birth and a growing number of surgical interventions were powerful forces in the movement to medically supervised hospital-based births. Legal prohibitions on midwifery practice also offered a deterrent to midwives practising without the protection of law. As Ward indicates, the movement of the state in regulating birth has varied considerably. In New France in the 1720s and 1730s, the Crown subsidized midwives trained in France. By 1788 the British required midwives practising in Montreal and Quebec City (and adjacent areas) to have a certificate. In 1879 the Quebec College of Physicians and Surgeons extended its control: in fact, approximately 95 per cent of midwifery licences were issued to male physicians and surgeons. In 1872, midwives in the City of Halifax were certified through a medical board while country midwives remained unregulated. In 1881, licensed physicians were legally empowered to practise midwifery. Peter Ward (1984, 7) reported that "even educated, well-qualified licensed midwives found themselves largely superseded, while those without training were confined to the countryside."

Biggs (1983, 22) saw legislation governing midwives in Upper Canada and eighteenth-century Ontario as a device enabling the exclusion of lay midwives: the 1795 Medical Act prohibited the

practice of physic and surgery. This prohibition was reversed, however, by new legislation enacted in 1806; that legislation expressly protected midwifery practice: "nothing in this Act contained shall extend or be construed to extend to prevent any female from practising midwifery in any part of the Province, or to require such female to take out such license as aforesaid" (see Biggs 1983, 22).

Three bills to regulate or exclude domestic midwifery practice were defeated between 1845 and 1851. Nevertheless, medical influence was extended through the establishment of licensing powers, a system of registration, and medical education. With the increasing objections to midwifery – for undercutting doctors' fees, and for allegedly dangerous practices – midwifery attendance declined as doctors established practices in urban areas and as new legislation removed the protective status of female birth attendants set out in the 1806 legislation (Biggs 1983).

There was thus substantial opposition to suggestions that lay midwives could be trained and used in (remote) district nursing in nineteenth-century Canada. Attempts to import trained midwives were also resisted by some nineteenth- and twentieth-century Canadian physicians. Charlotte Hanington, the chief superintendent of the VON, hoped to assist prairie women by hiring approximately one hundred nurses from Britain. Buckley (1979, 145) notes that "the Canadian nurses were unreceptive ... sisterhood was narrowly defined in terms of the economic bonding of Canadian nurses. With the anticipated return of approximately 1,800 nurses from war work ... [the Canadian nurses] did not want to risk possible competition from group immigration of British nurses." Hanington's proposal and the objections to it followed much earlier attempts to restrict the practice of medicine in Upper Canada in 1795 to graduates of universities in the British Empire (Coburn 1974, 133–4).

In the United States there is no nationwide legislation to provide for midwifery services. Legislation regulating midwifery varies considerably: ten states prohibit the practice of lay midwifery, and in twenty-one states the status of lay midwives is unclear. In states that allow lay midwives to practise legally, a host of regulations can limit their practices: "attributes of state regulation which define the boundaries of practice, prohibit use of drugs, and require collaboration and backup by physicians are potentially inhibitory or hostile to lay midwifery. Having to depend on physicians to define which clients are low risk and experiencing normal pregnancies can be used as a device to restrict clientele, and having to rely on physician willingness to cooperate, consult, and provide support when complications arise or emergencies occur limits autonomy and can stifle the practice of lay midwives" (Butter and Kay 1988, 1168).

Opposition to lay midwives was generally tempered by the geographical distribution of the Canadian population. Until the early part of the twentieth century the population was primarily rural. The substantial distances that often separated inhabitants, compounded by inclement weather and rudimentary transportation, meant that birth attendance was often left to neighbouring women. Even where a clear preference for physican-attended births was stated, such limitations were recognized: one commissioner reporting to the Saskatchewan Services Survey Commission allowed that "while it is desirable to have women delivered by physicans, if possible in a maternity home, there are still numerous sections of the province that have no physician at all, and that, during the winter, are completely cut off from hospitals. In such regions, a nurse-midwife, that is a nurse trained in midwifery, could render invaluable services, *without encroaching upon the field of the physician.* A course would have to be devised for which the system practised in Alberta, England and other countries, would have to be consulted" (Sigerist 1944, emphasis added). Opposition to midwives was not characteristic of all doctors in pioneer Canada: there is evidence that relations between some doctors and midwives were amicable (Ward 1984, 13).

A controversial point is whether the monopoly status of Canadian doctors and nurses contributed to direct improvements in maternal and infant well-being. Buckley (1979, 132) established that maternal and infant mortality increased during this period of urbanization and replacement of the midwife. Shortt (1983–84) acknowledged that hospitals were often regarded as "gateways to death," and, where possible, were avoided by those who could afford home attendance and the general practice of physicians. It is farfetched to attribute declines in the rates of infant and maternal mortality to medicine per se when larger factors influence these rates. Besides improvements in sanitation, diet, and so forth, child-rearing customs affected the neonatal mortality rate.

The lack of resources for expectant mothers has been amply documented. Strong-Boag (1979, 154) notes that maternal deaths did not decrease between 1921 and 1938 in Canada, and concerns over preventable deaths led to many campaigns for better public health. Even these documented disparities in health between Canada and other countries did not lead to acceptance of midwifery among the medical profession: the "great majority" of doctors were unwilling to share birth attendance with midwives, and licensing was not made available to many practising midwives.

The transition from home births to hospital births involved an interstitial period in which domiciliary midwifery was practised extensively by public health nurses. In 1925, Coburn notes, 38,634

births occurred in VON hospitals or Red Cross outpost hospitals, whereas the VON attended 14,700 obstetrical cases at home (Coburn 1974, 150). Thus, approximately 27 per cent of births managed by the VON at this time were home births.

Domiciliary midwifery in Vancouver was praised for its safety. Nationwide, approximately 24,000 maternity cases were assisted by members of the VON, of which 5,000 were home births. Apparently, however, only a small minority at this time were managed by the nurse without the doctor present (Whitton 1945, 5, 27). Notwithstanding the work of public health nurses in attending home deliveries, the shift to hospital delivery was dramatic. It has been estimated that only 40 per cent of Canadian mothers delivered in hospital in 1939, and that 93 per cent delivered in hospital by 1959 (Cosbie 1969). The reasons underlying this shift from home to hospital deliveries include greater accessibility to hospitals and professional attendance, improved availability of services through provincial and federal funding of hospital construction, the development of medicare plans, and a cultural shift that promoted the skills of physicians and surgeons over those of midwives.

Midwifery in the United States

The hegemonic status of doctors in the management of childbirth also characterized developments in the United States (Starr 1982). The shift from lay practitioners, many of whom were women, in colonial America was gradual. Midwifery in eighteenth-century America was not subject to substantial formal regulation. Midwives were not regulated until the middle of the sixteenth century, when episcopal licensure ensured, among other things, that babies were baptized at birth (Donegan 1978). After 1776, many legislatures extended licensing powers to medical societies. These licensing powers usually exempted apothecaries, botanists, and midwives. In the Jacksonian period, however, women were no longer so dominant in healing.

Doctors mobilized against lay midwives. An ideology of protection of women from "unfeminine" work gained currency, and urban middle-class women began to choose physician attendance in childbirth between the mid-1700s and the Civil War (Starr 1982, 49; Donegan 1978, 4–5). In the nineteenth century, the campaign against "granny midwives" continued in the southern United States. In W. Eugene Smith's photographs of Maude Callen, a black nurse-midwife, the accompanying essay clearly favours nurse-midwives over traditional birth attendants. The nurse-midwife maintained

aseptic conditions and had proper supplies – a blood-pressure gauge, cord ties, a stethoscope, and sterilized gloves. The distrust of lay midwives is unmistakable: "The new midwife had succeeded where the fast-disappearing 'granny' midwife of the South, armed with superstition and a pair of rusty scissors, might have killed both mother and child" (Smith 1951, 135). Implicit in the pictorial essay is a sense that with their training, versatility, and commitment these nurse-midwives met many unmet needs, not least of all among the poor.

In the early nineteenth century, fatalities attributed to unlicensed midwives attracted newspaper coverage. Concerns over high rates of childbirth-related deaths culminated in 1933 in a major report on maternal mortality in New York City. The recommendation that proper training of midwives should be encouraged was largely disregarded (New York Academy of Medicine 1933). The lay midwife was seen as competing with physicians. Nurse-midwives were valued by obstetricians for their assistance in childbirth (Starr 1982, 223). Even if midwives could circumvent licensing restrictions, they could not collect from Blue Shield plans, and their patients could not collect under indemnity insurance plans (Starr 1982, 333). Like their European counterparts, American physicians were successful in establishing clinical instruction programs in which medical students viewed the birth of babies. This was not a wholesale movement away from midwifery. Litoff (1978, 20) points to the proliferation of dispensaries and hospitals in which demonstrative midwifery was acceptable. Demonstrative midwifery required that the birth attendant abandon the norm of modesty and view the woman's genitals during labour, birth, and the post-partum period. Manual examinations of women by male physicians were permitted in the mid-nineteenth century but visual examination of a woman's genitals was forbidden (Ward 1984, 14). The innovation of "demonstrative midwifery" by Dr. James White in Buffalo in 1850 was widely debated but eventually became established (Litoff 1978, 20; Drachman 1979).

As in England and Canada, medical opinion in the United States was divided over midwifery. Some American physicians spoke for midwives in the late nineteenth and early twentieth centuries. For example, in 1884 Dr. T.H. Manley argued for the utilization of trained midwives. Seeing midwifery and medicine as complementary, Manley suggested that midwives could utilize physicians in difficult cases, while physicians could respect the skill of "the properly qualified midwife" (Litoff 1978, 21–2). Concerns were expressed over the supposed dangerousness of midwives, the folly of investing money in training midwives (when medicine and nursing could be fostered),

and the need to incorporate midwifery practice by law as a branch of medicine practised exclusively by the medical profession (Litoff 1978, 22). The controversy over midwifery led to proposals for nurse-midwifery, a term coined in 1914 by Dr. Fred Taussig, a Missouri physician. Taussig believed that midwifery training should be restricted to nursing graduates. The nurse-midwife would receive specialized training in obstetrics, and in Taussig's view would be the best possible complement to medical attendance at births (see Litoff 1978, 22–3).

The midwifery debate in the United States brings forward many themes discussed earlier in this chapter. First, there were few avenues leading to training and certification for midwives, even in late nineteenth-century America. Some programs that did exist were clearly substandard, although a number of midwifery colleges and schools were established. Litoff (1978, 136) concludes that at the turn of the twentieth century, programs for midwives "were highly inadequate." A second feature of the American debate was the debate within the medical profession and public health agencies. The anti-midwife campaign reached its zenith between 1910 and 1920. Some physicians believed that midwifery interfered with the proper development of obstetrics and posed a hazard to the public. Conversely, some public health officials believed that midwives, properly trained and supported, could lower maternal and infant mortality rates. These proponents of midwifery drew on European data in support of midwifery as well as American studies of midwifery programs (Litoff 1978, 136–9).

The hegemonic status of physicians in birth in many parts of America was not a boon for all Americans. Sullivan and Weitz indicate that recorded rates of mortality and morbidity increased as physicians displaced midwives and instrumental deliveries became commonplace. They add that with formal development of medicine, certain groupings were disadvantaged. Medical training was accompanied by higher standards of admission, longer programs, and greater tuition costs, and few schools were accessible to "blacks, women, or working-class students." Consequently, birth attendance shifted away from midwives and toward control by wealthier white males (Sullivan and Weitz 1988, 17). The fusion of medicine and birth continued, despite published accounts of unwanted and potentially dangerous interventions during birth. These interventions – artificially delaying birth so as to allow physicians to attend; strapping women to delivery tables (sometimes without medical or nursing attendance); routine shaving of the pubic area; and injuries attributed to forceps deliveries – were often countered by those enthralled with

the importance of keeping the "obstetrical field" sterile and protected, and by the belief that these complaints were "in the mothers' heads" (Sullivan and Weitz 1988, 24–5).

Nowhere has the midwife been displaced without controversy. That controversy is very much alive today in many parts of the world (see Kitzinger 1988). The great campaigns to dislodge midwives – in the United States, between 1850 and 1930 and in the early to mid-twentieth century in Canada, for example – have attracted opponents as well as advocates of midwifery. It appears that today a renewed appreciation of the politics underlying midwifery is gaining strength. Arguments that medical supervision and routine technological intervention are in the public interest seem facile and lacking in empirical proof. That said, midwifery is not gaining strength worldwide; some commentators suggest that midwives as a group are declining in influence in Europe, for instance. The following section provides a selective look at midwifery and birthing practices in different cultures.

CROSSCULTURAL PERSPECTIVES ON MIDWIFERY

Midwifery is not only a local practice in many countries, but has lodged as a worldwide organization or set of organizations. The International Confederation of Midwives (ICM) is based in London, England. The ICM represents sixty-one countries worldwide, including Canada. The ICM holds a triennial congress. The 1993 Congress was held in Vancouver, Canada. The ICM and many other world bodies, including the United Nations and the World Health Organization, have been largely favourable to midwifery practice. As set out below, there are many differences in the ways midwifery is practised across cultures, and there is a growing sense of urgency with respect to persistent patterns of preventable maternal and infant deaths and injuries, especially in the developing world. As we will see, there is also concern that the principles of continuity of care for expectant mothers and a varied sphere of practice for qualified midwives might be compromised.

Cross-cultural variations in midwifery practice and birth practices in general have long been recorded. Midwives are variously called *sage-femme* (France and Quebec), *dukun bagi* (Java), *nana* (Jamaica), and *partera* (Hispanic countries). Other names include *comadrona, bidan,* and *dai* (Cosminsky 1976). Traditional midwives are almost always women, although there are cultures in which male midwives have practised. Laderman (1983) describes a male *bidan* in a Malaysian

hamlet as "a great rarity." His practice ceased when a female village midwife moved to his hamlet. Hart (1965, 22–3) reported that males began practising midwifery in the rural Philippines after 1963. Male midwives were referred to as *sibulan*.

Several themes become evident when one examines cross-cultural materials on midwifery and childbirth. First, anthropological studies have captured the diversity of childbirth practices in various cultures. In many non-industrialized cultures a variety of beliefs and customs have been recorded. These include dietary restrictions and proscriptions concerning those who may attend births. In some cultures, husbands are expected to be absent during the birth; in others the absence of the father is seen as a portent of misfortune for the newborn child. Birthing positions likewise vary from the standard lithotomy position (on one's back) in western medical practice to a variety of birthing positions, including squatting, on all fours, on birthing stools, and using ropes or poles for support. The complexity of this subject is evident not only between cultures but also within some cultures. Research on the Rogai of South Vietnam, for instance, showed that women deliver their babies using a variety of gravitational aids: birthing stools, ropes, vines, and poles for support (Lee 1972, 40).

One issue in the modern debate over obstetrics and midwifery is the use of technology for control purposes. Critics of the unnecessary use of obstetrical technology claim that a variety of surgical measures such as episiotomy and caesarean section do more serve than medical purposes; they also help to consolidate and reinforce medical power during childbirth. There have been shifts in this debate, however. Women's associations lobbied for the use of scopolamine (a narcotic and analgesic, also known as "twilight sleep") in 1914 and 1915, whereas some modern feminists lobby for the option of unmedicated births:

> The twilight sleep movement helped change the definition of birthing from a natural home event, as it was in the nineteenth century, to an illness requiring hospitalization and physician attendance. Parturient feminists today, seeking fully to experience childbirth, paradoxically must fight a tradition of drugged, hospital-controlled births, itself the partial result of a struggle to increase women's control over their bodies (Leavitt 1980, 164).

A number of writers have linked the growth of technological approaches to childbirth with the alienation of mothers. Recourse to routine induction of labour (in the absence of a sound medical reason) has been associated to some extent with professional convenience (Cartwright 1979). For some, the act of accepting pain relief in labour

alters the essential quality of birth, reducing the woman receiving medication to "a passive thing" (McMillan 1982, 133).

Variations in Infant Mortality Rates

The cycle of birth and death has changed dramatically in modern times. In developed countries, the average lifespan has lengthened dramatically compared with earlier times: "'It is not uncommon, I have frequently been told,' Adam Smith soberly noted, 'in the Highlands of Scotland for a mother who has borne twenty children not to have two alive.' The poor died freely, in unrecorded numbers, but even men of means thought long life a stroke of unexpected luck" (cited in Gay 1970, 21). High rates of infant mortality were a feature of early life in colonial Canada, and maternal mortality was also a threat (Backhouse 1991). Mitchinson (1991, 224–5) notes that puerperal fever – "infection originating in the birth canal, which can spread throughout the body, causing septicaemia and eventual death" – was especially common in the nineteenth century.

If the ideal of a "best birth" and long life have become cultural expectations in western countries, the same cannot be said of many other countries. It is estimated that every year half a million women die of childbirth-related problems (including complications from abortion, infection, and other aspects of birth). In many countries, women are likely to suffer from too many closely spaced pregnancies, compounded by giving birth at too early an age. These dangers are often exacerbated by inadequate sanitation and hygiene, and a weak health-care infrastructure. In the World Health Organization's film *Why Did Mrs. X Die?*, the viewer is shown several points at which a mother's life could have been saved if adequate resources had been made available to her. A report issued in 1986 confirmed the extent to which women's and infants' health is compromised in many countries: "Some progress has already been made in reducing infant mortality, but the differential in maternal mortality between rich and poor countries is among the highest observed in public health, reports WHO (World Health Organization). Eighty-five per cent of the world's births take place in developing countries but these same countries suffer 95 per cent of the world's *infant deaths*, and a terrible 99 per cent of all *maternal deaths*. WHO figures also show that more women die in India in 1 month than die in all of North America, Europe and Australia in 1 year" (Anonymous 1986, 53; emphasis in original).

Beyond the problem of direct assistance in childbirth, international attention is increasingly focused on the status of women, especially in the developing world. Illiteracy and discrimination contribute to