eclipse of community bonds as medical and legal experts occupy the terrain of birth – has also been challenged. But the state use of legal force has clearly not been successful in establishing social policies *against* midwives. Time and again in trials and inquests authorities in Canada and elsewhere have been advised of the viability of midwifery, and the unfortunate illegal or alegal status of midwives.

It is also significant that the midwifery movement incorporates traditional values of collective life, along with what Melucci (1978, 205) calls "fresh hypotheses." Dramatized by the peace and environmental movements, and also applicable to the midwifery movement, is the link between private and public spheres. In these contemporary social movements there is "a complementarity between private life, in which new meanings are directly produced and experienced, and publicly expressed commitments. Living differently and changing society are seen as complementary ... One does not live to be a militant. Instead, one lives, and that is why from time to time one can be a public militant" (Melucci 1988, 206).

The reappearance of a community-based, independent midwifery practice in British Columbia in 1975 was followed by a series of events that have transformed the nature of the original movement. Begun as a collective initiative with a primary emphasis on the safety of mothers and neonates, great importance was placed on supporting women seeking birth outside hospital and without recourse to unnecessary medical interventions, including caesarean section, forceps delivery, induction of labour, episiotomy, and analgesia and anaesthesia. The politics of midwifery as a countercultural movement were articulated in Raven Lang's *Birth Book* and Ina May Gaskin's *Spiritual Midwifery*, and in a wider set of practices and writings surrounding women's health care. The appropriation of childbirth by the predominantly male medical profession and the cultural definition of women as incapable of managing birth were strongly contested by midwives.

The human agency – action and consciousness – of British Columbia midwives has been altered in contradictory ways. Other midwifery organizations, most notably in Ontario, have persisted in working toward independent practice, legally recognized and supported through such government auspices as post-secondary education. For Canadian midwives, playing host to the 1993 Congress of the International Confederation of Midwives in Vancouver was a major coup. Another accomplishment was the development of the Vancouver-based Midwifery School. Accredited by the Washington State Department of Health, the school graduated twenty-eight students and has established several preceptorships (clinical placements) internationally. The school ceased operation because of limited enrolment, which was in

turn linked with the lack of a legal status for trained midwives in the province. Finally, coroners' inquests and inquiries have in general regarded midwifery care favourably, and have recommended the legal recognition of qualified midwives.

Another phenomenon is the growing effort to establish coalitions among midwives. The *realpolitik* of professional resistance and limited resources among pro-midwifery groups has led to the formation of broader alliances. In British Columbia, for example, the Midwives Association has established working relationships with the Western Midwives Association, the Midwifery Task Force, the Midwives Association of North America, and the International Confederation of Midwives, and has maintained contact with provincial government representatives (such as officials of the Ministry of Health), the Registered Nurses' Association of British Columbia, and the British Columbia Medical Association, among others. Gaskin notes a growing interest in midwifery among U.S. women, adding that the most effective strategy for associations favourable to midwifery is to enter into coalitions. The Midwives Alliance of North America (MANA) is one example of solidarity among different kinds of midwives. Such solidarity holds the promise of extending beyond practising midwives and numerous associations that promote midwifery care, to society at large (Gaskin 1988, 59–60). Ehrenreich and English (cited in Edwards and Waldorf 1984, 195) envision a wider consciousness of birthing and childcare, such that those activities are not left to the responsibility of individual women, but recast as a "transcendent public priority."

A more cooperative model of midwifery seeks the support of government officials and medical and nursing associations, and aims for the legalization of midwifery as a semi-autonomous profession. This cooperative model, as it stands, undermines certain principles of the midwifery movement, especially the desirability of independent midwifery. Nonetheless, it would allow midwives to assess their practices, to assist one another, to respect women's wishes for intimacy and safety, and to work without routine medical supervision or subordination within the hierarchy of hospital care.

One concern is that midwifery will be absorbed within a nurse-midwifery model. A professional model would very likely include mandatory liability insurance, adherence to guidelines of practice, statutory recording and reporting policies (to be reviewed by government), and no clear commitment to respecting out-of-hospital births. This rather sinister picture of state surveillance and discipline is not the final word, however. Midwives have generally favoured legal status, but only if midwifery is seen as standing apart from medical

and nursing colleges. The illegal or alegal status of midwives in Canada is clearly not tenable for most midwives, given the attrition rate in recent years and the difficulties experienced by midwives working without colleagial support or other resources (Benoit 1988, 1991). An auxiliary status for midwives is equally untenable. Professionalized midwifery would link Canadian midwives more directly with midwives worldwide, through such organizations as the International Confederation of Midwives.

CONCLUSION

In British Columbia, midwifery policy has been formulated, or deferred, by contrasting midwife-based initiatives against policy declarations of more dominant groupings, notably state officials, and spokespersons for the medical association and the registered nurses' association. It is suggested that while there is some autonomy on the part of these groupings with respect to positions on midwifery practice, the midwifery initiative has retained a sense of integrity (in its demands and practices) without substantially altering the power structure of obstetrics and state control over women's health care. Its achievements to date have involved changes in birthing practices in hospital and a legacy of re-establishing, albeit for a very short time, a range of birthing options, including midwife-attended home birth.

While there is resistance to full implementation of midwifery care in many Canadian jurisdictions, the recommendations of international associations lend considerable support to the movement for qualified midwifery services. The International Confederation of Midwives, for example, has supported the implementation of midwifery in Canada. The World Health Organization (1987) said that "the training of professional midwives or birth attendants should be promoted. Care during normal pregnancy and birth, and following birth should be the duty of this profession."

These developments in midwifery advocacy and practice underline the importance of human agency in shaping culture. As the conflicting evidence is weighed, it is clear that there are no telling arguments against the implementation of midwifery services as part of Canadian social policy. Opponents of midwifery seem to keep midwives in the backcourt (through expensive litigation and a litany of what are, in my view, fallacious arguments concerning skills, women's preferences in childbirth, and costs of establishing midwifery training). Midwives are moving to the forecourt, however, and have access to international support via the ICM and a growing research base made up of professional journals such as *Midwifery* and the

Journal of Nurse-Midwifery, the Midwives Information and Resource Services (MIDIRS), and ongoing work by Page, Tew, Flint, Kitzinger, Rothman, Benoit, and others.

In many other jurisdictions, midwives' efforts for recognition indeed reflect "inter-professional rivalries" (Donnison, 1977). Nevertheless, there is a sense that the dominant approach in law and social policy in Canada is very much out of touch. The examples of Ontario and Quebec, the two most populous provinces in Canada, as they move toward the implementation of midwifery very likely signals a greater integration of midwives in all aspects of birth care. The political will of government officials, court officials, legislators, and the medical and nursing professions is likely to be decisive in positioning midwives. Legal struggles to re-establish parental rights and restore a sense of community of women in childbirth are necessary to achieve innovations in birthcare. As Carol Smart (1989) has cautioned, however, it is crucial that we recognize that new forms of legal control may create substantial gaps between what women seek by way of freedoms and what is offered to them in policies.

CHAPTER SIX

Moving into Midwifery: Paradoxes of Legalization

INTRODUCTION

A generation ago, the twin issues of medicalization of birth and professional control of women's reproductive capacity brought into focus the ways in which childbirth was managed. For critics of obstetrical procedures, medicalized births reflected the (mis)management of birth. Recourse to medicated birth and rising rates of caesarean sections, episiotomies, perineal shaves, forceps deliveries, and induction of labour no longer were characterized as "progressive" birthing practices. As part of an effort to humanize obstetrics and allow for birthing situations tailored to women's needs, the movement has lobbied for the legal recognition of midwifery as a self-governing profession. Legalization would herald an end to the criminal trials used to examine midwifery practice, and would establish midwives as expert practitioners in the management of uncomplicated births. Specifically, many supporters of midwifery wish to obtain not only legal status for the midwife, but a degree of autonomy in practice. Midwifery controlled by other professionals – notably physicians or nurses – would, for these advocates, be midwifery in name only. The gap between fully fledged midwifery services and compromised services is evident for midwives in various countries (see Kitzinger 1988).

Midwifery in North America has met with a mixture of support and resistance. This has led to the current "state of uncertainty" surrounding midwifery observed by the former chief coroner of British Columbia, Robert Galbraith. The prosecution of midwives for criminal negligence and the calling of coroners' inquiries and inquests do little to alleviate this state of uncertainty. Midwives seek to assert their own hegemonic status as experts in the management

of normal obstetrics. This role would stand apart from obstetrical nursing, general medical practice, and specialty obstetrics. Self-regulation through a college of midwives would be sought. Midwifery, as envisioned by many midwives, would require a greater recognition of parental rights, and continuity of care for expectant mothers through pregnancy, labour, and delivery and into the postpartum period. While the midwifery movement has secured international recognition in recent years, there has been a pattern of midwives leaving independent practice. In British Columbia this usually takes the form of discontinuing birth attendance altogether, or obtaining employment in prenatal instruction or shift-nursing on labour and delivery wards of hospitals.

The status of midwives in Canada is unique. In 1993 only two provinces have legalized midwifery, and even in those provinces few women have ready access to qualified midwives. Largely replaced by physicians and nurses, midwives in Canada and the United States were discouraged from attending births. Childbirth was increasingly defined as a medical event to be properly supervised by medical practitioners in hospital settings. This ideology of medical control is reinforced by legislation restricting or prohibiting other forms of birth attendance and ceding monopoly powers to physicians. Many American states outlawed midwifery, and midwifery became isolated from theoretical and clinical training: "In Europe, scientific advances became incorporated into the repertoire of midwives' techniques. In the United States, on the other hand, no systematic attempts were made to upgrade the profession through training. Midwives were increasingly seen as ignorant and dirty. Childbirth passed into the medical realm, and midwifery suffered a decline that is only beginning to be reversed" (Jordan 1980, 96–7).

The development of community midwifery in Canada stems from a much wider challenge to obstetrics and gynecology. Women's reproductive health, including the ways in which birth was managed in the middle part of the twentieth century in North America, was seen as subject to medical definitions of health and excessive surgical and medical intervention. Historical accounts of midwifery in Canada show that midwives were eclipsed and nearly eradicated across Canada. Restrictive laws and ideologies surrounding birth spiralled together, establishing medicalized birth as a desirable norm, an advance that was in the interests of birthing women and in the general interest. As midwives became less prominent, the work of obstetrical and maternity-care nurses was truncated. The sphere of practice for nurses was circumscribed, with male physicians "presiding" over birth. Thus, in North America, birth attendance was

increasingly defined in medical terms. Medicalization carried some benefits, such as pain relief, for patients; however, even those benefits occur within the context of a "masculinist biomedical view" (Riessman 1989, 215) ill suited to the empowerment of women. Gaskin (1988, 42) highlights the artificiality of American obstetrics: "By the 1920s, the United States had founded a truly novel custom: that of sanctioning men to make the rules and supply the knowledge for an intimately physical process that they never experienced. Lost totally to the general public was the idea that a woman could be trained to safely attend another woman in labour."

Significantly, as midwifery was being eclipsed in twentieth-century Canada, primary birth attendance was not undertaken by female physicians. Despite the role of the Ontario Medical College for Women (closed in 1906) and the subsequent establishment of Women's College Hospital, female physicians were a rarity. By 1911 only 2.7 per cent of physicians in Canada were women. This percentage fell to 1.8 per cent in 1921 (Buckley 1979, 128–9).

Medical control of birth led to a cultural transformation of birth. Attempts to connect the tradition of birth as a neighbourly and comunity-oriented event saw the formation in 1897 of the Victorian Order of Nurses (VON). Mason (1988, 107–8) depicts the VON as a movement that "threatened the doctors' prospects for hegemony over birth" more directly than other efforts to preserve traditional birth culture. The VON initiative to provide training to lay midwives generated "virtually unanimous" opposition in the medical profession. The end result was a lessening of the nursing role envisioned by VON proponents, such that members of the VON were primarily seen as fulfilling an assistant's role alongside physicians. In the traditional birth culture, women were able to assume delivery positions that were comfortable for them, in contrast to the obligatory use of the lithotomy position (in stirrups, with legs spread) used in modern obstetrical practice. "Most women tried to walk around and keep to their activities as long as possible during the first part of their labour, and squatting seems to have been common during the pushing stage" (Mason 1988, 102).

The medicalization of birth thus involved the transformation of women into receptive clients and assistants to male physicians, unable to understand or influence their own wellbeing. In her novel *Surfacing*, Margaret Atwood vividly described the feeling of being treated like a thing: "They shut you in a hospital, they shave the hair off you and tie your hands down, and they don't let you see, they don't want you to understand, they want you to believe it's their power, not yours. They stick needles in you so you won't hear

anything, you might as well be a dead pig, your legs are up in a metal frame, they bend over you, technicians, mechanics, butchers, students clumsy or sniggering, practising on your body, they take the baby out like a pickle out of a pickle jar. After that, they fill your veins up with red plastic, I saw it running down the tube. I won't let them do that to me ever again" (cited in Treichler 1990, 118).

One woman described her experiences of childbirth in Canada in the 1950s: "I had my first baby in the mid-50s and it was impersonal and very terrifying. You went to the hospital and your husband just dropped you off. He wasn't allowed to come into the case room or the delivery room. You went into the delivery room and you were with strangers. You didn't know anybody. I think the most terrifying part for me was delivering when you were laying on your back. Your legs were strapped in stirrups, and then he strapped your hands down, so you were completely strapped down and that's how you delivered. Just before the baby was born, they put you under again and when you woke up this is when you were told if it was a boy or a girl ... It was lonely, very lonely ... I found all three births a terrifying experience for me" (Gerrie White, in *Midwifery and the Law* 1991).

Gerrie White compared her delivery with her first experience of seeing a live birth in 1976, when her granddaughter was born at home in Vancouver. That birth was "a very loving experience." Yet her daughter, Lee Saxell, reported that being part of the circle of friends and family at a midwife-attended birth evoked a sense of loss when she thought of how women gave birth a generation before. Lee Saxell spoke of the bridging of the two worlds of women's birth: "My mother and my aunt, her best friend, were both at the birth. When my daughter was born, they were ecstatic with the birth of the baby, but afterwards they went downstairs and they both cried their eyes out at the table. And later they told me that they realized between them, they'd delivered five babies and had never seen one born ... they felt such a loss that they didn't get to experience that ... the midwives were down in the kitchen with them, because they were crying ... it was the joy of the birth of a grandchild, but also the loss (Lee Saxell, in *Midwifery and the Law* 1991). These experiences lend weight to the argument that births need not be controlled in ways that alienate women or their families. Today women establish birth plans that set out their expectations, such as allowing greater access for partners, husbands, or relatives, rooming-in of mothers and newborns, and a general humanization of obstetrics, including support for midwifery services (Van Wagner 1984).

THE RE-EMERGENCE of midwifery in Canada and the United States has generated considerable resistance. In Canada, most midwives seeking legal recognition and acceptance within the health-care system have not succeeded in establishing the requirements of a distinct profession: control over their work, a self-regulating body to establish standards of care and disciplinary measures, legal protection, and specialized research and education forums. In the United States there has been some acceptance of nurse-midwifery to the extent that midwifery is established as a subspecialty of nursing. Nurse-midwifery is defined as "the independent management of care of essentially normal newborns and women, antepartally, intrapartally, postpartally, and/or gynecologically" within a system that permits collaboration and referral among other health practitioners. Moreover, nurse-midwives must meet the standards of the American College of Nurse-Midwives. In Canada, there have been attempts to place midwives within the compass of provincial nursing bodies. Nevertheless, midwives generally seek to establish midwifery as a distinct profession, with multiple routes of entry to practice. These multiple routes would include nursing training, yet would also allow for direct entry to midwifery training and certification without the requirement of nursing experience.

The midwifery movement is a valuable initiative in terms of women's health and the law. It challenges the extraordinary powers of monopoly vested in the professions, and shifts the focus in pregnancy from pathology to women's power in giving and attending birth. It also undercuts the expanded powers of the state in regulating women's health by restoring childbirth to the status of a private matter and one that is conducted, where possible, in the sphere of civil society. Midwifery advocates point to women's satisfaction with the intimate, skilled aspects of qualified midwifery care, and to several studies that testify to midwives' skill in reducing morbidity rates for mothers and infants.

There is little value, however, in asserting the benefits of contemporary community midwifery without seriously considering valid criticisms. The following sections set out the difficulties of oppositional ideologies, the emphasis on meeting the mother's wishes for delivery, the material basis of practice, the lack of formal guidelines for safe practice, and the safety of midwife-attended home births. Consideration is given to the value of legal regulation of midwifery services, and how the practice of midwifery might be altered under the auspices of the state and the professions. Recognizing midwives by allowing them a central place in maternity and infant care has been associated with reduced levels of morbidity and mortality for

mothers and infants. And while these advances in safety may be most evident in developing countries (Begum, Kabir, and Mollah 1990; Nasah 1991), Canadian midwives could enhance health care here. In 1983 there were 8.5 deaths per 1,000 live births. This rate compared favourably with many other countries; for example, the Federal Republic of Germany (10.9), England and Wales (10.8), Czechoslovakia (16.9), France (9.7), Poland (20.2), Mexico (38.5), and the United States (12.6). Japan and the Netherlands had lower rates of infant mortality (6.6 and 8.3 respectively) (Statistics Canada 1986, 56).

"WE AND THEY": OPPOSITIONAL IDEOLOGIES

Many have noted the danger of oversimplifying the platforms of one's rivals. Apparent oppositions between groups or ideologies may sometimes overlap, and there is a possibility that one group claiming superiority over others may take on elements that mirror those of the discredited group.

Some midwives take an oppositional approach to medicine, hospitals, and technology, such that their resistance to institutionalized birthing may jeopardize the health of newborns and mothers. This is an ironic twist. While midwives have complained that they have been unfairly characterized as menaces to mothers and infants, it seems that some midwives are so opposed to the institution of the hospital and the staff therein that the life-saving uses of professional resources are cut off. One case in point involves the birth of an infant with respiratory difficulties after birth. The community midwife consulted with a family physician before suggesting that the child would do well at home. Unfortunately, the infant died shortly thereafter. While there is no assurance that the infant would have survived had it had hospital care, this case highlights a resistance to the use of orthodox resources and an ideology that may well overemphasize maternal-infant bonding and the superiority of home environments over hospitals. Marsden Wagner (1985, 55) alludes to a possible tendency on the part of midwives to be inflexible and dogmatic. Recently, a mother of two children editorialized against the essentialism of some advocates of natural childbirth. Barbara Wade Rose (1992) resented the ways in which some birth attendants or advocates might try to "compensate for their own disappointment" in childbirth. She added: "In such a creed, everything about home births and midwifery is 'right' and everything about hospitals and doctors is 'wrong.'" Long demonized in some western societies, some birth attendants now may be demonizing more established practitioners.

In her 1980 trial, Margaret Marsh, a spiritual healer and ex-physician, was alleged to have asked the couple, "Don't you believe in angels?" when they said they wished to transfer to hospital (*R. v. Marsh* 1980). A number of midwives I interviewed stated that midwives should transfer if the mother wishes to transfer, even if there are no tangible signs of distress.

The home birth records I studied clearly indicated that midwives are accustomed to transferring women or infants to hospital when complications arise. Beyond this, most midwives urge their clients to see a general practitioner and an obstetrical specialist if required. However, many midwives agree that a collegial spirit of working with other health professionals ought not to be translated into a subordinate position.

SERVING MOTHERS

The principle that a woman's wishes should be respected in childbirth may become problematic if the woman refuses to transfer to hospital despite the recommendations of her midwife. There are incidents where the back-up physician and the community midwife recommend hospital delivery. When the woman refuses, the midwife may support the woman's choice. The clash between respect for the client and the obligation to protect the infant (and possibly the mother) is sometimes evident in instances where a breech presentation occurs; in British Columbia two legal actions (a trial and the issuance of a warrant for the arrest of a midwife who fled the country) followed infant deaths after breech presentations in 1979 and 1980. A community midwife offered the following thoughts in 1985, just prior to two major inquests and related events in British Columbia: "If you look around, the only two deaths that have been significant [with respect to prosecution] have been breech presentations at home, and that tells quite a story in itself. I know a midwife who attempted to manage a breech at home. It was a disaster, and ended up in a transfer and a caesarean delivery. To the midwife, it wasn't a disaster; to me it was ... There are women who say that they will [deliver] anyone at home because it is a woman's right to choose where she gives birth. This is true, but on the other hand, the midwife's responsibility goes beyond the mother to the child. It is the midwife's responsibility to take both of them safely through the delivery. If someone came to the Midwives' Association adamantly wanting a breech delivery managed at home, we would refer her to a hospital."

In one instance documented by a senior midwife in Ontario, the police and paramedics were called by the midwife. The mother

refused to accept the midwife's suggestion that a transfer was advisable. By calling the authorities, the midwife followed professional protocol, and her interests would have been protected if legal action was considered. Although these conflicts are rare, they underscore the dilemmas that can arise when guidelines are unavailable, or unenforceable.

There is a tendency for critics of medical intervention to interpret professional power in medicine as structured primarily to maintain "conspiracies of silence" aimed at protecting the profession's members. This instrumentalist outlook has been challenged by studies such as Bosk's (1979, 190) observations of surgical practice in the United States: "Postgraduate training of surgeons is above all things an ethical training. Subordinates are harshly disciplined when they violate the ethical standards of the discipline. They are promoted and adopted into the ranks as colleagues on the basis of their ethical fitness. It is true that the moral standards demanded and the superordinates' self-interest converge here to a high degree. Nevertheless, the point remains that normative standards of dedication, interest, and thoroughness are applied in evaluating subordinates rather than narrow technical standards."

The line drawn between "spiritual" midwifery and medical attendance obscures the hard-fought attempts of women to gain access to medical knowledge and to practise medicine. There is clearly a substantial overlap between midwifery practice and more conventional resources (laboratory work, general practice, obstetrics, and hospital resources). It would be misleading to suggest that most community midwives adhere to a strict oppositional ideology or to one that blindly follows clients' wishes. Most community midwives active in British Columbia in the 1980s have become licensed midwives and/or registered nurses. Some are contemplating graduate studies in midwifery in England starting in 1993. The following excerpt from a letter to the *Times-Colonist* in Victoria conveys this general spirit of concern for the safety of mothers and babies and the need to combine choice in childbirth with greater interaction between midwives and other birth attendants: "As a Vancouver Island representative of the Midwives' Association of B.C., I am responding to a letter ... headed 'Home births risky' [written by the president of the provincial medical association]. The MABC is also looking forward to the establishment of a committee to investigate obstetrical care in B.C. It is indeed a tragedy whenever an unexpected death occurs during childbirth, no matter where it happens. It remains a concern for all midwives, parents and physicians that this occurs and I am sure that when it happens in the hospital, it's no less a tragedy ... The task force struck

by the Ontario government in 1986 took nearly two years to complete an in-depth study and recommend the legalization of midwifery in that province. Some of the issues addressed were safety, education, qualifications and back-up. One hopes that the proposed committee for B.C. does as thorough an investigation and joins the many voices for responsible, safe and legalized midwives in this province" (Ray 1988).

SOCIAL CLASS AND MIDWIVES' CLIENTELE

Historical sources suggest that midwives have often assisted the poorer classes in many societies; the Frontier Nursing Service in rural Kentucky and the Maternity Centre Association in New York City are two examples. In recent times, however, the re-emergence of community midwifery and of nurse-midwifery in North America has been tied to the presence of a more advantaged, middle-class clientele.

Research on the class composition of midwifery clients is complicated by the different foci taken by researchers. Some concentrate on natural childbirth, others on people choosing home births or nurse-midwifery services. A study of childbirth records from thirteen hospitals in Erie County in New York state indicated that parents inclined toward natural childbirth tended to be older (on average, by two years), college-educated, white, with higher income and higher socio-economic status. These findings were reported to be consistent with earlier studies in New York City, Boston, and New Haven (Cave 1978). Citing a 1989 article on childbirth in the United States, Mitford (1992, 209) notes that women giving birth in alternative birth centres "are typically white, middle-class, over eighteen, married, college-educated, well-nourished." Other researchers noted that women with a high school or some post-secondary education had a greater need to establish personal control during labour than women with less education (Butani and Hadnett 1980, 77). Two reports on out-of-hospital births noted that women who elected home births tended to have a higher level of education than women who elected hospital births (Divorky 1981; Devitt 1979). The issue of social class has been raised with respect to birthing in England. A Community Health Council representative noted: "Criticisms are often made that organisations such as the National Childbirth Trust are very elitist and middle class in their attitudes, making it very difficult for working class women to penetrate the networks of coffee morning and afternoon teas. These criticisms are valid in that the NCT is a very powerful pressure-

group pushing for natural childbirth methods which meet the needs of its predominantly healthy, well-nourished, white, middle class members. There is a danger that if the NHS is pushed into meeting their demands for non-medicalised childbirth, there may be a failure to pick up the minority of working class women at risk who do require medical intervention during labour" (Langridge, cited in CSP editors 1982, 64; but see J. Kitzinger 1990).

As set out in the previous chapter, while few mothers in the Canadian home birth sample are on social assistance, the sample is hardly uniformly advantaged. Few families enjoy above-average incomes, and to label them as "middle-class" is misleading. A second difficulty is that, given the structure of health services for parturient women in Canada, it is not possible for community midwives to remain self-employed unless they generate a sufficient income through self-employment (prenatal care, birthing attendance, postnatal visits). This is not to suggest that the equation "midwifery = middle class" is fixed. There are possibilities for extending midwifery services if midwives achieve a legitimate standing among other health care practitioners. Finally, the available literature on birth management suggests that midwives (and other birth attendants) need to tailor their care to all social classes. Some studies suggest that working-class women may have more positive attitudes toward medical intervention than middle-class women (McIntosh 1989; Nelson 1983). Clearly, for some midwives, this raises the issue of women's socialization and expectations of birth.

Another criticism involves the limitations of de facto community midwifery practice. Alan Schwartz, vice-chairman of a four-member task force studying midwifery in Ontario, has noted this concern: "[Schwartz] said [the task force] must find a way to make midwifery acceptable to a wide population that is not 'culturally attuned' to it. 'We have to ensure that it comes into the system gradually so it's not only accepted by the very small number of people today who are looking for midwives, but by the population as a whole as a real and viable alternative. It would be a great pity if you ended up with a system that ultimately serves only a very tiny percentage of the population" (Kershaw 1986, 21).

One problem with this approach is that it raises two questions: first, whether only a small number of people prefer midwifery attendance; and second, whether midwifery practice out of hospital is indeed not a "real and viable alternative." It is critically important in the discourse over midwifery to suspend any such assumptions, for there is evidence to indicate that midwifery services are desired by a good proportion of expectant mothers. Furthermore, as this study

demonstrates, contemporary domiciliary practice in Canada and elsewhere need not be more dangerous than hospital-situated births managed by conventional obstetrical teams. The successful domiciliary approach would require adequate training of midwives, appropriate emergency response services, careful screening, and guidelines for practice. There is also a serious question concerning the structuring of exclusion. There is little evidence that most community midwives in British Columbia object to the possibility of working in hospital on a more independent footing. Likewise, there has been no shortage of nurse-midwives willing to participate in the demonstration projects devised in Vancouver and other parts of Canada.

MATERIAL BASIS OF PRACTICE

One aspect of midwifery practice is the material basis of practice. Community midwives are largely self-employed. While some supplement their incomes with labour coaching in hospital or other work, most are dependent on client payments. This issue is a common ground for midwives and other birth attendants. The self-interest of the medical and nursing professions in managing births is more frequently discussed than the material interests of community midwives. Subsequent research should explore the possible overlap between the ideal of midwifery and the material reality. The ideal that midwives should attend even high-risk births may dovetail with some midwives' interest in generating a sufficient income. Dr. Sidney Sharzer, the chief of the obstetrics and gynecology department in a Los Angeles hospital, has been quoted on the issue of monetary self-interest and what in his view appears to be a hypercritical approach by some midwives toward hospital-based maternity care. "Sharzer thinks midwives are out to make a buck like anyone else. And, he says, they have overestimated the demand for 'natural' births. Since the public demand for alternative birthing is low, 'they've got to emphasize negative things that go on in a hospital to draw business.' Hospitals, too, he says, 'are concerned with personalizing the birth experience'" (Mittelbach 1986, 10).

Once again, the possibility of midwives' making a living from the community appears to have run its course for most community midwives of a decade ago in British Columbia. Community midwifery, with its long hours, legal uncertainties, and low pay, seems to be best suited to more formal integration in the health-care system, notwithstanding concerns about "watered-down" midwifery care because of needless regulation by the other health professions.

FORMAL STRUCTURE, IDIOSYNCRATIC PRACTICE?

Another important issue is the need to establish standards of practice while granting discretion to practising midwives. Unlike nurse-midwives, obstetrical nurses, and physicians, the community midwife movement in British Columbia has not yet generated a clear and enforceable set of guidelines for practice. To carry on in the absence of formal standards of practice, provision for peer review, and a range of penalties creates a risk that practice will become idiosyncratic and unsafe. The 1984 coroner's inquest in Toronto followed the delivery of an infant on an island. The distance from hospital and the speed of transportation may be factors to be considered in deciding whether or not to attend a home delivery; so may be the need to have more than one midwife present at a birth in the event that complications arise for the mother and infant.

In 1986 a community midwife with experience in only a few primary care deliveries attended a mother in labour on an island in British Columbia. In retrospect, there might have been concerns about a relatively junior midwife's managing a birth in a locale where emergency assistance was limited. Nevertheless, the birth proceeded without complications, and no formal complaint was made to the Midwives Association of British Columbia. It is arguable that the midwife could have refused to attend, citing the delay in transporting from an island to hospital, the need for a more experienced midwife, and the limited number of prenatal visits by the attending midwife. As it happened, the birth was uneventful; however, this case dramatized the tension between private agreements between midwives and clients and the public concern over safe practice. Midwives may answer that they are cautious in agreeing to attend clients who do not live near them. One community midwife spoke about her practice in the mid-1980s:

> I have been on Vancouver Island, a few Gulf Islands, and up to the northern interior of B.C. It is relatively common for the midwives practising in Vancouver, because quite often they will get a call from people out of town where there are no facilities, no practising midwives in their area, and the hospital routine is so awful. These people want alternative birthing, and it just isn't available to them in their community hospitals ... Things are improving, but there is still a long way to go. In the little, outlying hospital so much depends on who the physician is ... Sometimes clients come down to see me. What I did with my people was to get a copy of their prenatal records from their doctors who knew they were going to have a home birth ... I would go about

a week early, depending on their history. All the clients I have had from out of town were having their second or third baby, and quite often I had already been involved with the delivery of the first, so I know the people. They have had a really straightforward history, without any complicating factors.

Certainly the gap between the formal structure of midwives' associations and the specific practices of members has not been satisfactorily addressed. Doctors and nurses have been critical of midwives' delays in transferring women from home to hospital if, for example, bradycardia (a drop in the fetal heart rate) is manifested during labour. Concerns have also been voiced about misjudgments by midwives managing home births. A Vancouver physician who is openly supportive of midwifery expressed some misgivings about certain midwifery practices during his testimony in the 1986 Sullivan-LeMay trial in Vancouver. The doctor "said he can understand the reasons people choose for home births, such as feeling more comfortable in a familiar setting to a distrust of hospitals, but he 'would have some scruples' about attending home deliveries himself. 'There are some children who have not survived which I feel might have if they'd been delivered in hospital'" (Banks 1986, B6).

Another aspect of midwifery practice that has attracted some criticism is variation in record-keeping. Community midwives in Canada have not produced a systematic study of their practices and birth outcomes. This reflects in large measure the time devoted to prenatal assessments and consultations, labour and delivery, and postnatal care and visits. The situation is not helped, however, by uneven patterns of documentation in the 1970s in British Columbia. Some births receive only cursory documentation; many others are accompanied by precise, detailed notations of prenatal and postnatal care and labour and delivery processes. A related problem is that midwives have not established a collation of attempted home births through a central agency, and it is very difficult to discern patterns of practice, let alone analyse the central issue of maternal and infant health.

These difficulties have been compounded by the apparent reluctance of some midwives to establish a standardized set of charts for practice. Standardization would allow comparisons of such variables as time of the stages of labour and the social class and occupation of the mother (and partner, where applicable). The latter would be a useful addition to birth records, given the association between socio-economic status and infant mortality, as mentioned earlier. On a broader scale, the absence of standardized collection procedures hinders research and development possibilities for community midwives. It is virtually impossible to monitor transfer rates to hospitals, birth

weights of newborns, types of deliveries, and a host of other variables unless there is a comprehensive data base. The absence of standardization reduces the possibility of midwives' learning from each other's practices, and lessens the kinds of statistical contributions they could make to other midwifery associations and publications. Flint (1986, 134–40) offers a thoughtful discussion on the merits of keeping a thorough "booking history" for clients. Paine (1991) favours more accurate information on midwives' work. She believes that without such information midwives' contributions may be ignored. Midwifery practice and research are thus integral parts of promoting midwives' status: "This knowledge about practice is the beginning of the midwife's power base of information. She will have regained the essential information needed to elevate her professional status" (Paine 1991, 202).

Clearly, there is a contradiction between the need for comprehensive documentation of birth attendance and outcomes, and the very limited infrastructure of research resources available to the community midwives and to nurse-midwives. We can hardly expect midwives to produce reliable statistics when they are limited by their illegal or alegal status, and do not have direct access to hospital, regional, or provincial data bases. If structure serves to discourage scientific analyses of midwifery practice, however, it is not completely prohibitive. Some Canadian midwives have produced statistics on their practices. Moreover, there is considerable interest on the part of midwives in contributing to research on midwifery practice, as evidenced by the strong support provided for this present study and other studies of Canadian midwives. It is important to note that research attributed to midwives tends to be regarded (by midwives) as less important than research attributed to physicians (Hicks 1992). It is encouraging to learn, however, that as part of the continuing education of graduates of the British Columbia School of Midwifery a session was convened to discuss the principles of research and writing, including the development of standardized birth records that would facilitate computer analysis. Research and writing skills have also been emphasized by the architects of a master's degree in midwifery practice at Queen Charlotte's hospital and Thames Valley University in London.

HOSPITALS AND THE EXPANDED ROLE OF NURSE-MIDWIVES

Another possibility is that the role of obstetrical nurses might be expanded. The nurses could help to meet the public demand for

hospital-based midwifery. The counter-argument is that the nurses might be co-opted into a dependent role, even if their sphere of practice was expanded. This argument may be too dismissive. Midwifery attendance could be brought within the ambit of provincial nursing legislation such that nurses would be more self-directing in managing births. In fact, the legislation now being developed in Ontario relies heavily on input from nurse-midwives for its implementation. It is also noteworthy that the Midwives' Program in place in the Grace Hospital in Vancouver has been designated as a "functional program" in the hospital budget. This means that the hospital board has endorsed the program as an integral part of labour and delivery services, and the program will be evaluated or reviewed by the board. Moreover, Doctors' Hospital in Toronto has presented a brief to a legislative task force in Ontario proposing the development of clinical training for midwives in conjunction with the medical and nursing faculties at the University of Toronto (*Whig-Standard* 1986).

It is also possible that hospital services could be altered to become more client-oriented, more humanizing, and less oriented toward interventions. The hospital or an adjacent birthing centre could meet some of the demands for reformed childbirth practices, and it offers rapid access to emergency measures in the event of cord prolapses, hemorrhage, fetal decelerations, and other complications of childbirth. As some have suggested, however, it is questionable whether hospital staff are making drastic reductions in interventions. Further, birthing rooms are not as yet proliferating in hospitals. Nevertheless, if midwives are given hospital privileges or are allowed to work on a salaried basis, then the home birth option may become less frequent.

A related point is that legalized midwifery, whether practised by nurse-midwives or direct-entry midwives (who would not require a separate degree or diploma in nursing), might become as bureaucratic and restrictive as other components of Canadian health care. This possibility rekindles earlier commentary in this chapter: what is lost when human services become more formal and health practices become increasingly controlled by the professions? A danger is that as community midwifery becomes subject to peer review (or outside review), midwives are more likely to be suspended or otherwise disciplined than if they practised independently. It is likely that midwives' current autonomy will be reduced if midwifery is legally recognized. Some will suggest that legalization of midwifery will correct for idiosyncratic and risky practices, but others fear that the special relationship of community midwife and client will be compromised as midwives become state-controlled. Clients may likewise be precluded from obtaining midwifery services if they are deemed to be

at high risk. Once again the state or the professions will emerge as mediators of community decisions, particularly if health services become more centralized and bureaucratic.

Criticisms of midwifery practice need to be kept in context. First, it is misleading to speak of midwives as a totality, for practices and philosophies vary markedly among midwives. For example, some will accept high-risk clients, while others will not. Second, some of these criticisms highlight isolated concerns that may arise but are not indicative of the usual processes of midwife-client interaction. Nevertheless, for the reasons outlined above, there is a danger in merely advocating community midwifery as a good. Risks may be taken on the grounds of spiritual idealism; record-keeping may be unsystematic and difficult to assess in the aggregate; and the emphasis on empowering the woman in labour may obscure wider concerns such as the class or ethnic composition of clients served by community midwives in British Columbia and elsewhere. Midwives counter that they would prefer to serve a broader socio-economic range of clients, but since midwifery is outlawed and must generate private income (outside the provincial medical billing plans) it will attract clients who can afford to pay for private midwifery services. A key point here is that midwives have become more self-critical of their work, and have stepped up research activities and clinical skills on many fronts.

Self-regulation contributes to the freedom of practising midwives and their distance from controlling bureaucracies. Self-regulation can become problematic when one considers the established regulation of other professions involved in childbirth, along with the general trend toward rational bureaucratic systems in law and health care. The classic formulation of legal-rational domination was set out by Max Weber. In *Economy and Society,* bureaucratic rationality is cast as an impartial system of rules. Ideally, this system of rules and formal procedures is not controlled by bureaucrats for their own interests. The contemporary critique of technologically based childbirth management indicates, however, that the client and the community can be engulfed as their power is replaced by professional control over childbirth.

MAKING A DIFFERENCE: WOMEN'S PREFERENCES IN BIRTH

Just a note to thank you for your support, caring and direction during the birth of our baby. Without you I don't know if we would have been able to

stick to our birth plan of almost no medications, and no episiotomy. You made the team work.

I just want to write to you to once again say "thank you" so much for all your help during my labour on Sunday. I honestly cannot thank you enough. I have never ever been in more pain in my life. My first two deliveries were easy compared to the intensity of Sunday's experience. Without your knowledge and guidance and total devotion to me during that time, I think I would have lost my mind. I can't imagine a more supportive person than you. You go so far beyond the call of duty. I just thank God that you were on shift when I was in labour (Notes to midwife Carol Hird; see Burtch 1992).

Much of the medical discourse on childbirth centres on the importance of safety in childbirth. Culturally speaking, the death of an infant at term or a serious injury to a newborn child can be viewed as a major loss – an emotional loss for the parents and, given the possibility of litigation, a loss of legitimacy for the hospital and attendants. In over a thousand home birth records from Ontario, British Columbia, and Saskatchewan, most clients placed less emphasis on morbidity or death in birth, concentrating on preparation for childbirth. Preparations for birth – diet, exercise, prenatal examination, physician back-up, and hospital access – were often emphasized (Burtch 1988). Thus, while midwives and their clients are likely to discuss the prospect of infant loss, this is not the overriding feature of interactions with their midwives. The nature of modern obstetrics and legal practice has nevertheless been recast, transforming loss in childbirth as a problematic event that may well result in civil litigation against caregivers. In the United States, midwives are increasingly being required to carry malpractice insurance. In Canada, the Task Force on the Implementation of Midwifery in Ontario (1987) recommended that midwives carry such insurance.

Midwives tend to be flexible in their practices. Most have experience in assisting women in hospital by acting as labour coaches. In addition, for community midwives in Canada, home birth is a source of income and more autonomous experience in labour and birth attendance. What is striking about their work and their records is the willingness of midwives to respect their clients' wishes. In many cases, there is a quality of reassurance for women who, having delivered a baby in hospital, are now seeking to give birth at home. Similarly, midwives can reassure clients who wish to give birth at hospital, having already had a home birth. The following extract is taken from a letter written in 1989 to a community midwife: "Since our conversation last week I've felt so much better. I still feel that

this time we should birth in hospital. It was real interesting to know that I could have chosen a homebirth too & that you would have been available, willing etc, & yet deep down I felt better about hospital! ... I want to say 'thank you' for taking the time to listen, for understanding & for your thoughtful words of advice. We have such wonderful memories of you from past births, I'm sure I'll think of you in labour!"

Women's preferences in childbirth have not been a central focus of scholarly work on maternity and infant care. However, there has been a growing critical literature that documents women's dissatisfaction with many features of modern obstetrics. This work includes interviews with women following birth, and general critiques of the medicalization of childbirth (Oakley 1984; Rothman 1984; Ginzberg, 1989; Hird and Burtch 1991; Mitford 1992). The socialization of physicians has also been criticized for its emphasis on unnecessary intervention and fragmented care for women.

The literature has often linked historical practices with modern obstetrical structures and practices. Martin refers to the power of the metaphor of the body as machine in seventeenth- and eighteenth-century French medical research and practice. LaMettrie's influential treatise, "Man, the Machine," made an analogy between human bodies (as functioning or malfunctioning machines) and the appeal of medical intervention, using such "mechanical devices" as the forceps. Reliance on these medical devices "played a great part in the replacement of female midwives' hands by male hands using tools" (Martin 1987, 140–3). Concerns have been raised about the costs of using high technology in health care. This technology absorbs millions of dollars but serves only a small fraction of the population (see Jordan 1987). Some favour greater autonomy for midwives in reducing unnecessary interventions such as caesarean sections and routine epidurals (Wagner 1990).

Significantly, even as the medical and nursing disciplines established medical control over various stages of pregnancy and childbirth, there have been objections to the treatment of women in maternity wards. Kitzinger, reviewing letters and other sources concerning women giving birth in England, likens some of their feelings to those associated with women who have been raped or otherwise violated (Kitzinger 1990). Stanko (1990: 97) uses the concept of "little rapes" to denote the everyday indignities, humiliations, and threats that affect many women. We can draw a parallel between women's feeling restricted in their movements and their sense of security, and the discomfort of some women in current birth settings and practices. This feeling of being discounted or devalued is clearly tied to other

reports of how "femaleness" may be disregarded or insulted in many cultures (Renzetti and Curran 1989). The midwifery movement, recognizing an obstetrical field that may operate at the expense of women, seeks to empower women in birthing choices.

Empowerment can take many forms. These range from collective action, such as lobbying for legal recognition of autonomous midwifery, to individual acts against medicalization. Martin recognizes patterns of resistance by expectant women to medicalized childbirth. She notes the establishment of childbirth activist groups that offer guides to "self-defence in the hospital." Mothers may also deliberately delay their trip to hospital as a strategy of reducing the likelihood of intervention by hospital staff (if the labour does not progress according to their expectations). Martin indicates that once in the hospital, some women unstrap fetal monitors or take extended walks or showers – activities that give them greater privacy and freedom of movement during labour. For Martin, such tactics stand as methods of resistance by women to an interfering, interventionistic approach to managing births. She concludes that the decision to give birth at home – a decision that is generally denounced by medical and nursing associations in Canada and elsewhere – may be "the most effective tactic" in women's reclaiming birth (Martin 1987, 140–3).

Against the power of the machine-metaphor of birth, women's agency in leaving, delaying, concealing, and opting out of conventional birth care is celebrated. This is not to reduce these and other actions to mere resistance: much of the critical literature recognizes women's power in childbirth as well as the importance of ritual celebrations of women's integrity. One example of this is midwifery practice that allows women greater freedom of choice in delivery positions. The lithotomy position has become conventional in obstetrics; but many women in Canada use other positions in home births. This finding matches evidence that delivery positions other than a supine position have been used in many cultures (Hedstrom and Newton 1986, 182–3). A growing body of scientific literature supports a less interventionistic approach. For example, Klein and his associates (1983, 1993) have explored the use of episiotomy by North American physicians. They recommend that the liberal or routine practice of episiotomy be discontinued. Episiotomy

> should only be utilized for specific fetal indications such as evidence that birth must be expedited for reasons of fetal distress or of clear maternal indications, such as the woman's inability to give birth without an instrumental intervention. It should be kept in mind that this recommendation can only be implemented in a context in which the birth attendant is trained for,

and is skilled in, the protection of the perineum from severe trauma. In fact, even the use of forceps and vacuum extractions are not absolute indications for utilizing episiotomy. The acquisition of skills in the use of vacuum extraction and forceps is also recommended (Klein et al., 1993).

Reviewing the work of Sheila Kitzinger, two researchers contrast the "splendid ritual" of technocratic births with modern attempts to restore a new sense of "identity and respect" for birthing women. The "splendid ritual" in many hospitals "affects all women no matter what their economic status ... Through its procedures, women are removed not only from their personal identities but from the actual birth and are drawn into medical rites as zealously guarded as any ceremony in the old cultures. Step by step, the woman is divested of all that is familiar in a bionic environment where she is totally dependent on strangers who themselves rely on machines for information. Inherent to this new ritual is the belief that the machines are faultless, truthful, and indispensable in the delivery of a healthy baby" (see Edwards and Waldorf 1984, 140).

PROFESSIONAL SUPPORT AND RESISTANCE

It is commonplace to pit an emerging group against more established health professions. One of the difficulties with this tactic is that there are differences of opinion *within* these health professions. Midwives differ over some aspects of practice, qualifications, and legal status (Benoit 1991). For years, community midwives have shared information about physicians who are supportive of midwifery practices. Beyond this, official position statements on the midwifery question have been formulated by medical and nursing associations. In some cases there is fairly strong support for implementing midwifery services. Even so, most medical and nursing associations express concern over the home birth option. A statement on midwifery approved by the Society of Obstetricians and Gynecologists of Canada (1986) noted that there was "a large amount of work to do" before midwifery could be established in Canada. Nevertheless, the SOGC recognized that "certified, licensed midwives play a major role in provision of services to pregnant women in most western countries." The statement referred to "a widely recognized exodus" of physicians – both general practitioners and specialists in obstetrics and gynecology – from obstetrical care in Canada. The society expressed concern over proper standards of training and practice for midwives in Canda. The SOGC is also on record as disapproving of home births. Birth

attendance, other than that in accredited institutions such as hospitals or birthing centres, should be discouraged: "The issue of home births is often confused with the introduction of midwifery. The Society of Obstetricians and Gynecologists of Canada believes that these are two (2) entirely different issues. Our Society wishes to re-emphasize its policy that *"Ideally all deliveries should occur in an accredited hospital maternal unit. We strongly disapprove of home births as not being in the best interest of either mothers or infants. Any free standing childbirth centre should have a physical and organizational attachment to an existing accredited maternity centre.* Introduction of nurse midwifery or midwifery does not alter this policy" (SOGC 1986, 4 [emphasis in original]).

Professional views on midwifery appear to be divided. The hegemonic view of birth as a medical event, requiring professional care within established guidelines, does not require that midwifery should be eradicated. Some observers point to differences of opinion among physicians over the value of midwifery. An obstetrician recalled the results of one survey of doctors in British Columbia: "It is my feeling, from talking to a lot of family physicians across the province, that you are probably looking at a 50–50 balance. Fifty per cent would be in support of some kind of midwifery ... either working with them in the office, or in the hospital, or in a referral pattern. Another 50 per cent would be either uneasy, or strictly opposed ... When I was involved in the Executive of the B.C. Medical Association section of Obstetricians and Gynaecologists, I at some stage sent out questionnaires to the obstetricians and gynaecologists in this province who were practising obstetrics. At that time, 75 per cent were in support of some type of midwifery in this province" (Bernd Wittmann, interview transcript from *Midwifery and the Law* 1991).

A statement in the *Canadian Medical Association Journal* provided little support for autonomous midwifery services in Canada. The statement followed a reformist line, suggesting that high-quality obstetrical care could be provided by existing personnel. Specifically, nurses could assume greater responsibility in obstetrical care, but under the direction of physicians (Baker 1990, 24).

The Registered Nurses' Association of British Columbia has also considered the possibility of implementing midwifery as an established health profession. In its 1978 *Position Statement on Midwifery*, the RNABC supported nurse-midwifery as an extension of nursing practice. The statement also indicated that qualified nurse-midwives could participate in care during pregnancy, labour, and delivery (and presumably in the post-partum period). The statement endorsed the sentiment of the Western Nurse Midwives Association that the health

care system in Canada is not able to support home births: specifically, it cannot provide "back-up support services for emergencies." It is especially significant that the RNABC board of directors continues to envision only nurse-midwifery as a health profession. In its 1987 statement, the RNABC acknowledged the work of "non-nurse midwives," but stopped short of endorsing them as bona fide midwives: "[RNABC] is not convinced that the non-nurse midwife is a viable concept in the British Columbia health care system at this time. RNABC does not therefore support the concept of midwifery as an autonomous and self-regulating health discipline ... RNABC is strongly opposed to the practice of midwifery by unqualified and unregulated persons who have neither the necessary education nor [the] legal authority to practice in the midwife role" (RNABC 1987, 22).

This "middle position" (Cutshall 1987) on midwifery has not been set in stone. Although the RNABC board has twice established a position more conservative than that recommended by two special committees that were struck to consider issues in midwifery, it is also on record as wishing to promote further discussion among its membership. As it stands, however, the RNABC's official position lends no support to autonomous midwifery practice, including out-of-hospital deliveries or deliveries by community midwives. Interestingly, in the 1987 position statement, the community midwife is recast as "non-nurse midwife," or a "lay midwife."

The status of midwives hinges in part on the perceived need for professional birth attendants. In Ontario and Quebec, with the highest proportion of obstetricians to population, less than one-half of all births are attended by family physicians (Anderson 1986, 12). As family physicians become less prominent in labour and delivery, the case for midwifery services rests on the need for specialized care (for uncomplicated labours and deliveries), and especially on the need for rapport and continuity of care between birth attendants and pregnant women. It is clear that most community midwives – active or "retired" – are not eager to have the implementation of midwifery controlled by nursing associations. The midwifery movement now stresses cooperation among various health professions, but in such a way that the integrity of autonomous midwifery practice is preserved. For example, in its presentation to the Health Professions Council of British Columbia, the Midwives Association of British Columbia (MABC) challenged the policy of the RNABC to try to "envelop" midwifery as a part of nursing. The MABC (1993, 2) drew a clear distinction between nursing and midwifery: "Nurses do not practice midwifery – they perform nursing functions that may overlap with midwifery practice." Anderson (1986, 12) reports that midwives'

associations in British Columbia, Ontario, and Quebec favour legislation that ensures the autonomy of midwives. Legalization that would place midwives in a dependent position below physicians or nurses has consistently been resisted. Flint (1986) draws an analogy to other professions, such as dentistry and law, in which formal education is centred on these disciplines, without "sidelines." In one hypothetical example – if, before becoming a lawyer, one would have to be trained as a police officer – she suggests: "It's very useful for you to be a policeman first – you learn about the criminal mind, you learn a lot of basics of the law, you learn about court procedure, you learn how law affects ordinary people." Flint's point is that while there may be advantages to adjunctive studies, midwifery stands as a discipline in its own right. Blurring the line between midwifery and nursing might be harmful in developing optimal care for mothers and newborns.

Flint (1986) argues for a rethinking of how midwives are trained, noting that while direct entry to midwifery practice is possible in the United Kingdom, most midwives have been trained as nurses first. Nursing training would not be a prerequisite for midwifery education.

In Canada, many midwives see the argument for nurse-midwifery as compromising the special relationship between client and midwife. Placing midwives under the supervision of physicians and within the compass of nursing would artificially restrict midwives' skills. It would also undermine continuity of care for expectant mothers, as midwifery would be assimilated within the conventional structures of the obstetrical team within hospitals. Baker (1990, 24–5) makes a strong argument against a compromised status for midwives. Midwives would be more restricted if they were regulated by provincial colleges of nursing than if they were a self-regulating profession. Without cooperation between physicians and midwives, "legalization and regulation would not be meaningful" (Baker 1990, 24).

MIDWIFERY INITIATIVES AND CONFLICTS

> The end of law is not to abolish or restrain, but to preserve and enlarge freedom. For in all states of created beings, capable of laws, where there is no law there is no freedom. For liberty is to be free from restraint and violence from others; which cannot be where there is no law; and is not, as we are told, a liberty for every man to do what he lists (John Locke, cited in Stein and Shand 1974, 184).

The equation of law with liberty has often been challenged, and certainly in this postmodern era. Throughout the review of the history and cultural variations of midwifery, the contradictory nature of

state regulation is crucial to an understanding of midwifery practice in Canada and elsewhere. These contradictions include the sense that western law is accepted in large measure because it provides a needed framework of rules and sanctions (Cotterrell 1984, 161–2). Yet this legal framework can serve to constrain initiatives that might equally receive public support, such as alternatives to established health services. The illegal status of many practising midwives in Canada does not clearly reflect a widespread consensus *against* community midwives and *for* physicians and obstetrical nurses. It is likely that public opinion strongly favours standards of care and certification of midwives, but there is no clear evidence that the midwifery conflict began with grave misgivings on the part of the populace. Indeed, folkways seem to protect the importance of local midwives. The point is that the redefinition of midwifery as a menace or, by way of faint praise, as a stepping-stone to obstetrical science, was generated within the predominantly male preserve of medicine and science, with considerable support from the nursing profession. While professing their monopolies to be in the general interest, these professions have failed to demonstrate that midwifery services are inherently inferior to their services, are more expensive, or are not preferred by a good number of expectant mothers. And there is ample evidence in support of the competency and affordability of certain midwifery services. A failing on the part of the midwives is that because of their uneven documentation of their own practices they have not always been able to demonstrate their competency or even the changes in their practices over time. Gaskin and Gaskin (1979, 935–42) noted that some practising midwives have maintained a careful record of out-of-hospital births they attend.

Two distinct forms of midwifery have appeared in British Columbia, Ontario, and other provinces in recent years. Nurse-midwifery as a practice separate from physicians' decisions has been aligned with projects based in hospitals. To date there has been little success in establishing out-of-hospital birthing centres in Canada, although there are models available in other countries and some nurse-midwives have sought funding to establish such centres. In contrast, community midwifery is an initiative rooted in spiritual aspects of birth and the home as a preferred site for birthing. Lacking legal status, these midwives have had greater scope of practice than professional nurse-midwives; however, unlike their professional counterparts, they have been liable to prosecution for alleged breaches of criminal and quasi-criminal law.

A conflict, then, has occurred with state officials administering provincial and federal laws. This conflict is intermittent in the sense that midwives are usually prosecuted only if there is an infant or

maternal death or an injury associated with a home birth. Furthermore, such injuries or deaths are often processed through coroners' inquiries and seldom through the criminal courts. State authorities in Canada have not been very proactive in prosecuting midwives for the quasi-criminal offence of practising medicine without a license. These intermittent actions should not obscure the importance of this struggle for control. The dominant approach has been to view state regulation of midwives as legitimate. Following the original conviction of Mary Sullivan and Gloria LeMay for criminal negligence causing death, a newspaper editorial advocated the need for state control to ensure standards of competence and safety. The journalist concluded that "a situation in which unlicensed midwives operate in a *sub rosa* atmosphere is extremely unhealthy" (Anonymous 1986a).

This pressure to regulate midwifery may reflect the limited informal sanctions brought against community midwives through existing associations. The regulations and principles currently being developed by local midwives may need to be situated within the state's ambit if the sanctions they recommend are to be implemented. These sanctions could include fines, suspensions from practice, and expulsion from the association. The larger theoretical question is whether legalization of midwifery is in fact a successful challenge to medical dominance. DeVries (1985, 129–30, 140) contends that licensed midwives are at greater risk of licence revocation or suspension. Furthermore, the state's sanctioning of midwifery practice can reinforce and formalize the dominance of physicians over licensed midwives. Jessica Mitford (1992, 239–40) chronicled the defeat of a midwifery bill in California in early 1992. Despite a coalition of nurses, midwives, and supporters, the California Medical Association mounted a successful lobby against the bill.

At the same time that there is a clear statist tendency in Canada regarding freedom in childbirth, there are anomalies in the containment of midwifery. Coroners' inquests in Ontario have resulted in recommendations that midwifery be granted legal standing, and none of the inquests into infant deaths after midwife-attended home births was followed by criminal prosecution of the midwives.

The tendency to prize state control over community control of birth may be offset by a central contradiction in health care in western nation-states. The fiscal crisis in these nations has prompted cutbacks in state expenditures in health and social welfare. The cap on the Canada Assistance Plan, known as the "cap on CAP," foreshadows greater efforts to reduce state expenditures and government indebtedness. Clearly, the growth of technological approaches to illness and to childbirth pose substantial costs to the state. One method of

reducing these costs is to discourage routine use of drugs and surgical interventions, and to promote the use of less expensive paramedical workers as health practitioners (Hanft and Eichenholz 1980, 151).

SELF-DETERMINATION IN REPRODUCTION AND WORK

> The basic freedom of the world is woman's freedom. A free race cannot be born of slave mothers. A woman enchained cannot choose but give a measure of that bondage to her sons and daughters. No woman can call herself free who does not own and control her body. No woman can call herself free until she can choose consciously whether she will or will not be a mother (Sanger, quoted in Rossi 1976, 533).

Margaret Sanger's observations in *Woman and the New Race* (1935) are pertinent to an understanding of midwifery initiatives today. The theme of interference with women's freedom to determine the nature of the birthing experience was consistently articulated by community midwives' clients when they stated their reasons for choosing home birth. The issue of unnecessary interference with midwifery practice recurred in interviews with practising midwives, in their presentations to government associations and tribunals, and in midwifery journals and newsletters.

These conflicts between practitioners, clients, and the state should not be restricted to the contemporary conflict. As noted earlier, there has been a centuries-long conflict between physicians, nurses, and lay midwives in Europe, a conflict that encompassed the prosecution of midwives and healers for witchcraft and that was marked by the superior position of the medical profession in managing deliveries in many countries. These historical conflicts continue in contemporary debates over the place of midwifery. The British Columbia College of Physicians and Surgeons has strongly discouraged its members from professional contacts with midwives practising outside of obstetrical nursing. The Registered Nurses' Association of British Columbia, the Ontario Nurses' Association, and the Alberta College of Physicians and Surgeons have declared that their members ought not to participate in planned out-of-hospital births.

The discourse of midwifery tends to be predictable. Proponents of various forms of midwifery provide various sets of statistics (usually from places other than Canada) favourable to midwifery. Nurses and physicians either object to midwifery initiatives or allow for midwifery only if it is hospital-based and medically supervised. A recent article on midwifery in British Columbia shows how community

midwifery is misrepresented by its critics. The possibility of multiple routes of entry to autonomous midwifery training is bypassed, and reappears, condesendingly, as "lay" midwifery. Consumers become invisible and voiceless; the importance of midwives' earning less than physicians is reinforced; and the continuity of care and intimacy of midwifery (key aspects of the work of many midwives in home, clinic, or hospital settings) are cast into doubt. The role of these legitimate sources of media authority is reinforced, as the midwifery initiative seemingly requires the imprimatur of physicians, nurses, and government authorities:

> [A Health Ministry representative] said the ministry plans to consult with the Registered Nurses Association of B.C. and possibly explore additional midwifery pilot projects such as the one currently in place at Grace Hosptial in Vancouver. But Dr. Mary Donlevy, B.C. branch president of the Federation of Medical Women of Canada, questioned whether the government will actually save money by using nurses as midwives ... She also questioned whether midwives would be involved with child delivery from pre-natal through to post-partum care. Sue Rothwell, president of the Registered Nurses Association of B.C., said Dunlevy is probably correct in saying that doctors can perform deliveries cheaper than nurses. But she emphasized that she had no facts to back up her position. But Rothwell praised the move toward designating trained nurses as midwives rather than using lay midwives. "There may be a place for lay midwives but we don't know yet" (Griffin 1988, C2).

The original research discussed in chapter four contributes to this discourse, for it appears that the idealized promotion of midwifery and its denunciation are inadequate for an understanding of its complex relations with clients, other professions, and the state. This research accents the discrepancy between what midwifery is in Canada, its more autonomous status in many other countries, and the form it might take in Canada. Internationally, midwifery has been well established as an integral part of maternity and infant care. In Canada, midwifery is only now being considered as an entity distinct from medicine and nursing.

The structuring of the conflicts between midwives (and midwifery proponents) and rival professions has occurred primarily through legal measures. These measures include the redefinition of lay midwifery as an offence under various Medical Acts. Various legal cases were mounted to prosecute these "irregular" practitioners, thereby protecting the income and status of physicians and surgeons. The Criminal Code has also been activated against Canadian midwives

since 1983. The conflict, originally structured in terms of the conserving power of law, tended to portray midwifery as unsafe, as an aberration in an evolving health network. In this respect legal measures have seemed part of a rational political order that is alleged to protect a general public interest (Burtch 1992). It is crucial to weigh abstract jurisprudential principles against the effect of law on social relations. In other words, how are abstract principles of jurisprudence actually translated into the "living law?" (Burtch 1992, 69). It is also important to note counter-definitions of how birth is managed; how, for instance, certified nurse-midwives (CNMs) and independent midwives alike have received considerable support from authorities in reproductive care (Boston Women's Health Collective 1992, 409–12).

It is argued here that the state has largely served to consolidate the power of the medical and nursing professions over childbirth. Indeed, the redefinition of birth and death (from natural events to processes where injuries or deaths can generate civil, quasi-criminal, or criminal charges) carries profound implications for the limits of social change with respect to midwifery. As Foucault (1977) noted of the disciplinary society, discourse and surveillance serve to produce "docile bodies." Obedience becomes normal, disobedience becomes suspect and may be dealt with punitively. The community of women thus is mediated through much larger structures of power and knowledge as these events become cast as medical events. At the same time, knowledge is fluid not fixed. New ideas can emerge to challenge the typecasting of power and deference.

An alternative way of perceiving birth was evident in many of the birth documents. Clients tended to weigh the risks of home birth against its benefits, and to anticipate congenital abnormalities that would not be linked to the midwives' care. The following excerpt from a birth record outlines one woman's feelings about preventable and unpreventable difficulties in a home birth situation: "Hemorrhage – feel it can be dealt with appropriately by midwife and doctor – it is a slight risk. Baby has trouble breathing – also feel you are prepared for this. Baby might be grossly deformed and die as a result of lack of support systems at home. We feel this would be a natural consequence and would not regret home delivery."

PROMOTING MIDWIFERY, PROSECUTING MIDWIVES

Understanding midwifery in its Canadian context requires a sense of its complexities, not just with respect to the management of births but with respect to its relationship to obstetrical science and the state.

Midwifery in Canada is an anomaly. Despite the legal presence of midwifery in other countries and the proven competence of trained midwives, midwifery is either illegal or of uncertain legal status in all provinces of Canada (except for Ontario and Alberta). Two puzzles – the resistance to independent midwifery practice, and recent initiatives to restore midwifery – have been addressed through the contradictions of the state. These contradictions include the promotion of safe maternity and infant care (and the lag in legal recognition of midwifery) and the promotion of women's choices in reproduction and work (and the contradictory promotion of mandatory hospitalization for birth and restrictions on midwifery as an occupation). The contradictions are fused in the promotion of midwifery worldwide through such agencies as the World Health Organization and health departments or ministries in many nations, and the intermittent prosecution of practising community midwives in Canada.

These contradictions are evident in media portrayals of midwifery. On the one hand, newsmaking tends to focus on the most dramatic aspects of midwifery and birth, especially when there is an infant death associated with an attempted home birth. The continual focus on public safety and the need for greater regulation of midwives thus presents midwifery as a social problem, an unhappy situation that merits greater discipline and accountability. On the other hand, the media does provide a forum for alternatives images of birth. Patricia Graham (1987, 37), then an editorial writer for the *Vancouver Province*, offered a detailed account of her reasons for giving birth at home: "Some might say that we were lucky, but I don't believe that. I say we were responsible. I thnk that if everyone who wanted a home birth followed the precautions we took there would be little chance of anything going wrong. I think we must all be cautious about judging home births on the basis of the unfortunate stories that make the news, for those are the ones where something has gone dreadfully and needlessly wrong. And obviously the province should act quickly to educate, license and regulate midwives."

To promote midwifery, one must have access to comparative analyses of midwifery practice in hospital and other settings. Such access requires the cooperation of practising midwives in documenting their work and charting the progress of labour and delivery. Standardized forms would be useful for comparisons within British Columbia, and might be extended to other provinces and to jurisdictions outside Canada. My experience has been that community midwives will share their documents, but few have time for or interest in compiling a systematic, statistical evaluation of their work. In contrast, there have been many published accounts of nurse-midwife projects, and these could be encouraged for purposes of comparison.

Public opinion must also be studied. It would be useful to document how many women would prefer to give birth in a hospital setting or an alternative setting, and how many have a preference for a particular caregiver or combination of caregivers (obstetricians, midwives, general practitioners). It is clear that many midwives believe that a majority of expectant women would prefer the services of a midwife to other caregivers, provided that midwifery was legally recognized and offered by qualified midwives. A community midwife lamented this gap between existing clienteles and what could be achieved if midwifery were established in British Columbia: "There is such a small percentage of women with access to midwifery care. If midwifery was legalized and midwives were in the mainstream, 80 per cent of the population would use midwives. I think that consumer support is the only way." Survey research would be useful in generating measures of public opinion (see Greater Vancouver Regional District 1993). These surveys could be supplemented by in-depth interviews about particular preferences and the logic underlying respondents' opinions. There is a need to explore earlier suggestions of substantial challenges to physicians' authority in certain areas of health care.

A number of reports have favoured the legal recognition of midwifery practice and the provision of a variety of settings for practice. The Quebec Social Affairs and Family Council, an advisory body, recently recommended that pilot projects be undertaken in a variety of settings (Pelletier 1988, 43). Not surprisingly, efforts to reintroduce midwifery in Quebec generated considerable and sometimes outspoken dissent on the part of medical association representatives.

BIRTHING CENTRES AND WOMEN'S CLINICS

The introduction of alternative birth centres (ABCs) as a compromise between domiciliary birth settings and obstetrical wards is one example of innovation that rests, in part, on consumer demand. This apparently neat equation of birth innovations and public demand does not take into account the historical rivalry between various professional and non-professional associations (Freidson 1972; Mitford 1992). It also must address evidence that ABCs do not in fact significantly alter the incidence of obstetrical interventions.

DeVries contends that the apparent freedom accorded parturient women in ABCs is used to consolidate the power of the birth centre staff. Notwithstanding the homelike decor and nods toward unmedicated births, where possible, ABCs are characterized by unjustifiably high rates of invasive treatment, including analgesia,

anaesthesia, episiotomy, and forceps delivery (DeVries 1980). DeVries (1984, 98) cites one study that documented a transfer rate of 46 per cent of patients from an alternative birth centre to a conventional labour and delivery suite. A documentary on home birth in the United States indicated that between 20 and 50 per cent of women entering an ABC will be transferred to operating rooms for a forceps delivery, caesarean section, electronic fetal monitoring, and so forth (CBS News 1982). Establishing birthing rooms in hospitals is another method of adapting settings to consumer demand. One difficulty that has been remarked on, however, is that in some hospitals the birthing rooms account for only a small proportion – in some cases as low as 3 per cent – of all births in hospital (Anonymous 1984, 14).

Some observers disagree that ABCs are in the best interest of pregnant women and infants. The growth of birth centres is tied to the professional interest of nurse-midwives, long subordinated to doctors' control through denial of hospital privileges and inadequate back-up services. Thus, hospital settings and birth centres pose disadvantages to pregnant women, although evidence on this point is not well substantiated and is at times contradictory. Rothman (1983) acknowledges that women giving birth in ABCs tend to be satisfied with their experience, and she appears to have a blind spot with respect to the limitations of home birth arrangements. There is evidence favourable to alternative birth centres. The transfer rate in a maternity centre in New York City is approximately 15 per cent, and most of the transfers are not for emergencies but rather for failure to progress in labour (ABC 1986). It has also been suggested that ABCs are less expensive to consumers and the state, and promote the safety of infants and mothers (Lubic 1983). Indeed, Lubic (1992) strongly endorses the work of family-oriented birth centres.

Another point of concern arises from the failure to establish out-of-hospital birthing centres. The recent denial of government funding to a Toronto-based group was ostensibly based on the lack of physician support for such a centre. An earlier proposal to develop an out-of-hospital clinic in Vancouver was not accepted by a federal funding agency. It was suggested that the lack of support for the clinic among physicians was a factor in rejecting the proposal. The resistance to such centres thus involves a measure of self-interest among more established institutional staff and professsions (Lubic 1983). It is important that ABCs be assessed in terms of who decides how birth is to be managed – the protocols for care, access of various caregivers, and expectant mothers' choices. DeVries's reservations – and he is not alone – provide a useful caution against innovations that are seemingly progressive but in fact reconsolidate professional power.

WOMEN'S CLINICS

A related initiative involves the use of women's clinics, which would provide a variety of health services for women, including maternity care. Currently, there is an attempt to develop such a clinic in Vancouver. Other models exist in the British National Health Service. In such clinics women are seen as "well" and not automatically as "sick." However, these clinics do not offer maternity services (Gardner 1981). These initiatives can be linked with the notions that women are to be cared for by women, and that available technology and knowledge can be applied in a setting conducive to the collective interests of women clients and practitioners. Services concerning obstetrics and gynecology would not be fragmented, and resources could be centralized. The women's clinic appears to be a reshaping of the former "community of women."

CONCLUSION

The initiatives of nurse-midwives and community midwives are far from a passing fashion, and should be taken seriously as instances of resistance and innovation in the interests of women and, more generally, of parents and health-care practitioners. In contrast to the stereotype of midwives as irresponsible and hazardous, and to the uncritical celebration of community midwifery as a service to women, this study underlines the differences between community midwives in various aspects of their work. Some are more willing than others to transfer women from home to hospital, to maintain thorough charts and other documentation, and to balance safe standards of practice against clients' wishes. Midwifery practice thus appears as a complex undertaking that has a collective base but is also rooted in some degree of idiosyncracy and disagreement over practices and the implications of legalizing and formalizing those practices.

A second contribution by midwives is their abiding interest in ensuring maternal and infant safety. My study and other studies of autonomous midwives provide some evidence in support of the safety of domiciliary midwifery and out-of-hospital settings, such as ABCs. These results are linked with a number of published articles and monographs from Holland, the United States, France, and England that report favourable birth outcomes in certain out-of-hospital settings.

On the basis of research reports published outside of Canada, and in the light of nurse-midwifery initiatives such as the Low-Risk Clinic and the Midwives' Project established at the Grace Hospital in Vancouver, it is argued that nurse-midwives have provided high-quality

care in hospital settings. Moreover, some believe that midwives can preserve their philosophy of compassionate and skilled care within hospital settings (Brennan and Heilman 1977).

Historical and crosscultural sources have been set in the context of gender-related struggles over childbirth as a woman's process, a community event, and a profession. It is suggested that contemporary community midwives have attempted to rekindle an ancient tradition of women caring for women and to resist modern attempts to "commodify" childbirth in the general interests of men. The control of childbirth and of human reproduction generally can be seen as a symbolic expression of male dominance in childbirth and in medical research and practice. It is suggested that these struggles are not simply about "men versus women," however. Some men have been active in supporting more autonomous midwifery practice and its legalization, and women practitioners have been of service to women giving birth. The crux of the midwifery debate is therefore not reducible to gender, just as it is not reducible to class relations or to biology.

The research also raises serious questions about who sets the agenda for women's reproductive choices. This issue carries tremendous significance for women's rights in law, and has been addressed by several feminist writers concerned about the control of reproduction (Oakley 1980; O'Brien 1981; Stanworth 1987). The nature of state mediation is central to an understanding of the midwifery debate in Canada and in other countries. The replacement of community control over childbirth was made possible only through substantial powers of sanction and subsidization through the state. The tangible effects of facilitating hospital construction and medical and nursing education, and of applying criminal and quasi-criminal prosecution to rival health practitioners, served to consolidate medical dominance in health services. An important qualification to this instrumentalist approach is that clients also have powers to complain about unsatisfactory practices to medical and nursing colleges. Clients may also initiate civil actions alleging malpractice against physicians or nurses, and lobby state officials for improved health services. Furthermore, criminal actions against community midwives have not been used routinely, nor are they always successful. Like chiropractors (Mills and Larsen 1981, 237; Eni 1991), community midwives have increased in number and gained in official recognition despite the resistance of the medical profession.

Theories of the state have been critically assessed with respect to lobbying by community midwives and nurse-midwives. The structuralist perspective is useful in appreciating the relative autonomy of

the state and the efforts of state agents to consolidate professional power and to "commodify" social relations in the interests of capital. The limits of the structuralist approach become apparent in the cultural pressures to resist statism and to preserve folk customs and civil liberties.

The status of modern midwifery in the Canadian provinces discussed herein becomes understandable in terms of the historical development of midwifery, from folk customs to professional practice, and in terms of the movement of the state as a mediator of long-standing conflicts between midwives, other practitioners, supply companies, and consumers. There is an enduring quality to midwifery practice, yet it becomes evident that the state has acted to constrain midwifery initiatives even as it helps to establish them. Again, this reflects the contradictory pressures on the state from outside and inside in formulating health-care policy.

The strong conflict between medical practitioners and midwives has its roots in the economic status secured by physicians. And it is clear that physicians are unlikely to endorse the introduction of other practitioners unless there is some material advantage to the profession – for example, if midwives are a source of referrals to physicians, or if the management of uncomplicated deliveries is not financially attractive to physicians.

The economic dimension in health care requires an appreciation of methods by which competitors can be constrained or eliminated when they attempt to provide health services: "Of course professional regulation can be used punitively by a dominant group of providers to discipline or suppress potential competitors. A policy of encouraging competitive forms of delivery which pose a real threat to 'mainstream' care markets must therefore include some monitoring and control of the professional self-regulatory process" (Evans 1984, 345).

The sphere of law is pertinent to this conflict. Community midwives practising in violation of the Medical Practitioners Act (in British Columbia) have been greatly constrained in establishing institutional supports for their work, most notably an out-of-hospital clinic or midwifery centre. While there have been only a few prosecutions of community midwives under the statute, and then only after an infant death following an attempted home delivery, more subtle constraints on autonomous midwifery practice are operating. These constraints have not been diminished greatly through the modern midwifery movement in Canada, despite the tension between the civil liberties of individuals versus the prohibitory powers of the state over human conduct. The restricted use of law

reflects, among other things, the general safety of infants and mothers in the great majority of home births documented here and in jurisdictions other than Canada. It also may reflect the custom of women assisting women in childbirth. Sumner (1960) contended that folkways were powerful norms that influenced the nature of social life, and the nature of legal regulation of social life.

As has been suggested earlier, the collision of these perspectives has not produced a very robust defence of midwifery in Canada. The state has reacted by proceeding cautiously to favour midwifery (usually under the direction and supervison of medical or nursing personnel), or by not establishing midwifery services except in remote areas. It appears that a blend of structural constraints and human agency is evident in the limited restructuring of maternity services provided by midwives. This represents not an isolated instance of restricted social change, but rather the continuing role of the state in rationalizing social conflicts. That role involves the subsidization of orthodox health services and supplies and, occasionally, the deployment of criminal law personnel to repress practices that are seen as dangerous.

It is suggested that the Canadian state is not simply an instrument of a particular class or dominant grouping, nor is its health policy clearly tied to a specific economic base. A structuralist approach seems most appropriate in order to understand continuing patterns of occupational stratification (by gender and class), but this is a modified structuralism that must account for the role of human agency. Lobbying by nurse-midwives and nurses' associations, consumer demand, and the individual efforts of various officials have encouraged a growing recognition of midwifery services by the state and are therefore integral to the midwifery debate.

Understanding midwifery requires an appreciation of the forces that oppose its implementation as a self-governing profession in Canada. Despite some differences of opinion in the more established professions of medicine and nursing, there has generally been little encouragement of midwifery by national or provincial medical or nursing associations. Those associations that have expressed support for midwifery have almost invariably expressed caveats about home birth and other facets of what is seen by Canadian midwives as independent practice. Opposition can take many forms: the very negative pronouncements against midwives in Quebec (Bantey 1989; Dunn 1993) and Alberta (including an explicit ban on physicians' assisting midwives in home births in Alberta), or the seemingly more reasoned arguments that midwifery can be readily absorbed into nursing practice. Materially, the economic power of these professions

seems to be threatened by the recognition of another health specialty in the area of obstetrics.

The discourse about midwifery is in large part mired in discussions of whether midwifery is really necessary, and if so, how it ought to be implemented. As noted above, midwives are being asked to take a considerable portion of water with their wine. The discourse nevertheless rests on a number of fundamental contradictions: first, how women can be denied options for birth when women are the carriers and deliverers of children; second, questions surrounding unfair restraint on freedom of choice in a democratic society; and, third, continuing concerns over the lack of intimacy and undue interference in childbirth on the part of many established professions and institutions. Difficulties women experience in arranging for VBAC deliveries are one example of limited options in birth; so also is the current statistic that 22 per cent of women currently giving birth in British Columbia are delivered by caesarean section.

The discourse against midwifery, once hegemonic in Canada, is challenged at every step on principle, and usually with supportive data on hand. This challenge to opponents of midwifery is rendered more acute by Canada's anomalous failure to legally recognize midwifery, a string of official recommendations to legalize midwives, and the example of a minority of provinces that have begun to establish midwifery as a distinct profession. The legacy of the community midwives, of the Grace Hospital Low-Risk and Midwifery programs in the 1980s and 1990s, and of Inuit midwives working with other practitioners in Povungnituk (Arctic Quebec) lend further weight to the viability of midwifery. The argument for midwifery is not set against the appropriate use of technology in obstetrics, but against an overshadowing of midwifery skills – and, not least of all, women's abilities to give birth – by an ideology of "machine-minding." Ironically, as medical and social science knowledge increase in the sphere of reproduction, there is a considerable body of literature that draws our attention to the limits of routine monitoring of birth, and many conventions surrounding birth as a medical event.

It may be anticipated that state initiatives will involve a gradual expansion of the qualified midwife's role and the legalization of midwifery as an occupation separate from medicine. This expansion of the midwife's role may stem from a number of pressures. These include the international and provincial lobbying for reinstatement of the midwife, research that supports the safety of qualified midwifery attendance (in hospital, clinic, and domiciliary practice), and the state's need to rationalize and legitimate health-care policies for consumers. It may be that the provincial governments in Canada will

differ in the pace and scope of legalization. This may reflect differences in political lobbying, consumer preferences, and the sensitivity of the government of the day to women's issues. The historical specificity of the state – whether local, provincial, or national – remains an important dimension in the evolution of midwifery practice and its future development. The historical development and extension of state powers in Canada has hindered the growth of autonomous midwifery practice. State control in the sphere of birthing cannot be separated from cultural stereotypes of birth as dangerous (and therefore in need of professional management), and the long-standing fear of women's self-determination as individuals and as a community. In this sense, contemporary midwives are struggling against a state structure and a cultural heritage that are intolerant of such concerted efforts to wrest control from the medical and nursing professions. Midwives are also struggling with the tangible discretionary powers of ministry officials, which may be applied to scrutinize midwifery practice and only reluctantly to promote its development other than through the hierarchy of medicine, or the ranking of professional over layperson (see Neilans 1992).

There are variations and contradictions in provincial policies, in the decisions of judicial and quasi-judicial bodies, in midwifery practice, and in public support, to name only a few. These variations undermine a monolithic portrait of the total domination of women's choices. Thus, contradiction and paradox are evident in the current structure of maternity and infant care in Canada. In the historical treatment of midwives and the near-elimination of the autonomous community midwife in Canada, powerful structural forces restrict women's self-determination, even when such self-determination and community support can be shown to be advantageous for women and their children. It is clear that the "ancient office" of the midwife is not well served by repressive legal enactments and policies. Under such conditions midwifery may endure, but it will not flourish. The struggle to broaden the range of choice for expectant mothers, and to reconstitute our modern communities along more intimate lines, remains at the heart of activism on behalf of midwives and their clients.

Glossary

The following terms are commonly used in maternity and infant care. More comprehensive glossaries are available in a variety of books including Margaret Jensen, Ralph Benson, and Irene Bobak, *Maternity Care: The Nurse and the Family* (St. Louis: Mosby, 1979), and Roger Tonkin, *Child Health Profile: Birth Events and Infant Outcomes* (Vancouver: Hemlock Printers).

abortion A spontaneous abortion is the expulsion of a non-viable fetus that occurs naturally. A therapeutic abortion is an intentional termination of a pregnancy under medical care.

afterbirth The placenta and fetal membranes expelled after delivery of the child.

amniocentesis A procedure used to assess fetal health and functioning whereby a needle is inserted through the woman's abdominal and uterine walls to obtain amniotic fluid.

analgesic Any drug or agent that relieves pain.

Apgar score A scale of measurement, developed by Dr. Beverly Apgar, by which a newborn's heart rate, respiration, muscle tone, reflex irritability, and skin colour are assessed. Assessments are conventionally made 1 minute, 5 minutes, and 10 (or 15) minutes after birth.

breech presentation Buttocks and/or feet of the child are closest to the cervical opening, and are born first. Breech birth occurs in approximately 3 per cent of all deliveries. A complete breech occurs when buttocks, legs, and feet are presented simultaneously. A footling breech involves presentation of one or both feet. A frank breech involves the presentation of

the buttocks, with hips flexed so that the baby's thighs are pressed against its stomach.

caesarean section A surgical incision of the abdominal wall and uterus for delivery of the infant.

episiotomy Surgical enlargement of the perineal area to facilitate delivery and avoid perineal lacerations.

intrapartum During birth.

infant mortality rate The number of deaths of infants under one year of age, excluding stillbirths, per one thousand live births.

lithotomy position Delivery position in which the woman lies on her back with her knees flexed and her abducted thighs drawn toward her chest.

meconium aspiration syndrome With fetal hypoxia (insufficient availability of oxygen to meet the infant's metabolic needs), the anal sphincter relaxes and meconium is released. Reflex grasping movements may draw meconium into the amniotic fluid and into the infant's bronchial tree, obstructing air flow after birth.

multigravida A woman who has been pregnant two or more times.

multipara A woman who has carried two or more pregnancies to viability, whether or not they ended in live births or stillbirths.

neonatal mortality rate The number of neonatal deaths during the first twenty-eight days after delivery, excluding stillbirths, per one thousand live births.

perinatal mortality rate The number of deaths of fetuses 20 or more weeks' gestation, plus the number of deaths of infants under seven days of age, per one thousand total births, expressed per one thousand live births.

perineum The area between the anus and the external genitalia.

placenta previa Abnormal implantation of the placenta in the lower uterine segment, resulting in the placenta's covering all or part of the cervical os (opening).

post-neonatal period The period of infancy between 28 days and 365 days.

premature Born after a gestation period of less than thirty-seven weeks.

prenatal period The period of pregnancy between conception and the onset of labor.

primigravida A woman who is pregnant for the first time.

primipara A woman who has carried one pregnancy to viability, whether or not the child is born alive or stillborn.

quasi-criminal offence An offence that is not a crime or misdemeanour, but that is in the nature of a crime, to which a penalty or forfeiture is attached.

retained placenta That part of the placenta that is retained in the uterus after delivery.

Schultze (Also known as "Schultze's mechanism.") Delivery of the placenta with the fetal surfaces (shiny in appearance) presenting. Also termed "shiny Schultze."

stillbirth rate The number of fetal deaths based on weight (five hundred grams or more), or on gestation (usually twenty to twenty-eight weeks).

term The time at which a pregnancy of normal length terminates (between thirty-seven and forty-two weeks).

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Table of Cases

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