

MIDWIFERY PRACTICE AND STATE REGULATION
A SOCIOLOGICAL PERSPECTIVE

By

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B.A., Queen's University, 1972
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A THESIS SUBMITTED IN PARTIAL
FULFILLMENT OF THE REQUIRE-
MENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

in

THE FACULTY OF GRADUATE STUDIES

Department of Anthropology and
Sociology, University of British Columbia

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

April 1987

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Midwifery practice in Canada is anomalous in that, unlike other industrialized nations, a distinct legal status for nurse-midwives and community midwifery has yet to be established. Despite this constraint, community midwifery has survived the lack of institutional support for home births and legal prohibitions directed against it. The manner of State regulation of midwives is a central issue in this study. It is shown that the State shapes the possibilities of midwifery in a contradictory manner, promoting midwifery on the one hand, and prosecuting and restricting midwifery practice on the other. A modified structuralist perspective on the State is developed with respect to midwifery. The Canadian State serves to limit possibilities for midwifery through various provincial enactments in quasi-criminal law, through the greater likelihood of criminal prosecution of midwives than physicians or nurses, and through funding of the established professions and hospitals.

This thesis then, offers a critical examination of the anomalous occupational and legal status of Canadian midwives, using historical materials on the development of midwifery practice and cross-cultural data on the role of midwives in traditional cultures. It is argued that many of the reservations about community (lay) midwives are no longer applicable, and that the containment of nurse-midwives reflects an historical accommodation between the nursing and medical professions in Canada. This accommodation meets the need for highly-skilled obstetrical nurses or nurse-midwives within the tradition of physician dominance in health care.

A major empirical focus of the study is a documentary analysis of birth records from community midwives, primarily in British Columbia and Ontario, between 1972 and 1986. Analysis of the data confirms that qualified community midwives, working under normal circumstances, manage births safely and with a minimum of interventions during labour and delivery, and during the prenatal and postpartum periods. Where comparisons with provincial

and national populations are available, women attempting home birth under the care of a community midwife tend to have lower rates of forceps delivery, caesarean section, and episiotomy. These women are also likely to deliver their babies in positions other than the standard lithotomy position or prone position, and to have a lower incidence of perineal tears. Nevertheless, difficulties associated with the unregulated and often idiosyncratic situation of community midwives are underscored, particularly with regard to establishing guidelines for domiciliary midwifery.

Data from the Low-Risk Clinic at Vancouver's Grace Hospital, together with reports on other nurse-midwifery programmes, reinforce the claim that nurse-midwives can practice autonomously in providing prenatal care, assistance in labour and delivery, and postnatal care. The likelihood of realizing autonomous midwifery practice depends upon the particular agendas of the State, the structural interests of the professions, and the initiatives of midwives and health consumers who lobby for certification of safe alternatives in maternal and infant care.

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ACKNOWLEDGEMENTS

This research has developed through the efforts of many individuals. My Dissertation Committee provided constructive criticism and generous support over the years. I am grateful to my Thesis Advisor, Dr. Bob Ratner, for his perennial support and his useful criticisms of the manuscript. Dr. Helga Jacobson provided insightful observations on the research, and Dr. Neil Guppy was very helpful throughout the writing of the study.

I am thankful for the materials and encouragement provided by other colleagues during the writing of this study. The Department of Anthropology and Sociology at U.B.C. provided computer resources and office space. The Alumni Association at U.B.C. provided a travel subsidy to facilitate the presentation of a Conference paper on midwifery in 1984. The School of Criminology, Simon Fraser University, provided ample computer support and the opportunity to teach during the final two years of completing the research. The efforts of research assistants Debbie Nickle and Maureen Gabriel in coding birth records, proofreading, and updating various tables are greatly appreciated. Data Entry Services at the University of British Columbia were a great resource for transposing codesheet data onto the computer system. The efforts of the staff are gratefully acknowledged.

I wish to thank the Social Sciences and Humanities Research Council of Canada for granting a Doctoral Fellowship during my first four years of doctoral studies. I am especially grateful to Jocelan Coty for her encouragement and for suggesting that I undertake this project on midwifery. The efforts of Carol Hird, Stan Howard, Cheryl Anderson, Gary Brown, Bruce Arnold, and many others are also acknowledged. The research was possible only through the interest and trust of many community midwives and nurse-midwives who discussed their practices and provided documentation. Most of all, I wish to thank the women whose births have been discussed herein.

CHAPTER I INTRODUCTION

Preface: The Proper Person

"Midwives were in demand among the settlers in Nova Scotia, for in 1755 a request came from Colonel Sutherland, in command at Lunenburg, for '...two proper persons to reside there as midwives at a salary of two pounds a year, as the inhabitants were losing so many of their children'...." ¹

This request reflects the sense of propriety that had been vested in midwifery: that midwives must be of sound moral character, responsible and of service to women during childbirth and thereafter. Other documents attest to the importance of community midwives in coastal settlements in British Columbia and Newfoundland, on the Prairies, and in urban centres during the 18th and 19th centuries in Canada. ²

The central place of the community midwife in Canada has since changed dramatically. The status of the midwife as healer, neighbour, and mother has changed in two ways: first, the near-eradication of the lay midwife; and second, the development of professional nurse-midwives who are responsible in varying degrees for childbirth attendance. Once sought after as a resource for the State, community midwives have recently been subject to prosecution under criminal statutes or for quasi-criminal offences such as practicing medicine without a license.

Dramatic changes have also occurred within family structures and community organization in Canada and on a global scale. The family as the locus of childbirth and of childrearing has become diffuse, with institutions such as the hospital, the school, and childcare centres

¹ Jan Gibbon and Mary Matthewson, *Three Centuries of Canadian Nursing*, Toronto, MacMillan, 1947, p. 237.

² In colonial America midwives were well-regarded for their skills in managing births. Two writers mention how the Dutch West India Company paid for the passage of one midwife in 1630. See Margot Edwards and Mary Waldorf, *Reclaiming Birth: History and Heroines of American Childbirth Reform*, 1984, Trumansberg, The Crossing Press, p. 148.

taking more responsibility and control. The sense of community has also been altered, particularly in terms of a community of *women*. Historically, women formed communities of interest that included pregnancy, childbirth, and health care, and these communities thrived well into this century in some regions of Canada. ³ Kitzinger adds that midwives in peasant societies had high prestige and considerable power as their healing powers, childbirth attendants, and for presiding over the forces of fertility. ⁴ Structural changes in midwifery, families, and communities are brought forward in the discussion of Community Midwifery and Nurse-Midwifery in Chapter Five. At this point, it is important to define the central concept of midwifery and the implications of current definitions.

There are a variety of definitions of midwifery and nurse-midwifery. A generic definition of midwifery includes anyone, male or female, who assists a woman in childbirth. This comprises certified nurse-midwives, lay midwives, neighbours and spouses who assist at birth, obstetricians, general practitioners, obstetrical nurses, and those compelled to assist at unexpected births such as police officers. A more restrictive definition of midwifery includes only female birth attendants. In this usage, "wife" (originally, "wyfe", or woman) and "woman" are linked. There is some debate over whether the term "midwife" includes *all* women who are present with the mother at birth, or only "...a woman by whose means the delivery is effected". ⁵

Another definition includes spouses. As set out below, the labouring woman is defined

³ Outport in villages in Newfoundland are one example of the importance of midwives and the community of women. See Cecilia Benoit, "Midwives and Healers: The Newfoundland Experience", *Healthsharing*, (1983), pp. 22-26. For a discussion of the weakening of female and community control over childbirth see Barbara Ehrenreich and Deidre English, *Witches, Midwives and Nurses*, 1973, Old Westbury, N.Y.: The Feminist Press; and Ann Oakley, "Wisewoman and Medicine Man: Changes in the Management of Childbirth" in Juliet Mitchell and Ann Oakley (eds.), *The Rights and Wrongs of Women*, 1976, Harmondsworth, Penguin, pp. 17-58.

⁴ Sheila Kitzinger, *Women as Mothers*, London, Fontana, 1978, pp. 125-126.

⁵ Oxford English Dictionary, 1979: p. 1792.

as a midwife (midwives are conventionally defined as separate from labouring women):⁶

"...the midwife is defined as any individual who, by choice, assists a woman in the process of delivering her baby, and who consciously assumes some degree of responsibility for the health and well-being of mother and child. This is the broadest possible definition, and includes trained nurse-midwives, traditional midwives or birth attendants in all cultures, as well as trained obstetricians. *It also includes men and women who together decide to deliver their child at home.* It excludes firemen, policemen, emergency service personnel and random individuals who fortuitously deliver an occasional baby as the result of idiosyncratic circumstances."

This definition ironically combines the requirement that midwifery is a calling which embraces obstetrics and general practice with provision of midwifery status for occasional attendants such as spouses. A major issue is that some midwives would interpret midwifery training and practice as quite distinct from medical specialties and general practice. For them, this incorporation of midwifery and obstetrics is misleading since it obscures significant differences in practice and philosophy between midwives and other birth attendants.

A *Community Midwife* may be defined as a birth attendant who regularly participates in labour and/or delivery without the protection accorded medical practitioners. Lay midwives do not have certification or official training. Some are self-taught, referring to available texts and other materials, often apprenticing with more experienced midwives. The term "community" midwife is becoming more commonplace: first, because "lay" midwife has a connotation of inferiority; and second, because many community midwives have nursing training, hospital experience, and so forth. Unlike the majority of practicing nurse-midwives, their practice in British Columbia is primarily out-of-hospital. This includes primary care prenatally and postnatally and assistance during labour and delivery. Community midwives may also provide birth control counselling, advice on breastfeeding, prenatal classes, and labour coaching in hospital.

⁶ Ann Kuckelman Cobb, "Incorporation and Change: The Case of the Midwife in the United States," *Medical Anthropology*, 1981, 5(1), p. 75 (italics added).

A *Nurse-Midwife* is a birth attendant who has completed nursing training, is registered with the local (national, State, provincial, where applicable) Nursing Association, and has completed additional midwifery training in an accredited programme. The sphere of practice of certified nurse-midwives (C.N.M.s) can be very broad. Nurse-midwifery may involve continuity of care beyond attendance at labour and delivery: ⁷

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

Lang's definition encapsulates several major themes concerning the redefinition of midwifery in contemporary medical care. First, the C.N.M. is usually not an independent practitioner, working out of her home or private office, for instance, but instead an employee or partner in a practice. An earlier report indicated that: "Nurse-midwives are never independent practitioners; they always function within the framework of a physician-directed health service". ⁸ This assumption of the subordination of nursing deserves critical scrutiny for it underestimates the role of the nursing profession in maternity and infant care. Chapter Five provides a theoretical framework for this discussion of the power of the nursing profession. A second theme is that non-medical personnel (such as lay midwives) are excluded from the C.N.M.'s network of collaborating birth attendants. Third, the premise of "readily available" medical consultation obscures the very tangible conflicts between the sphere of practice of nurse-midwives and that of other birth attendants. ⁹

⁷ Dorteia Lang, "Modern Midwifery" in Dickason and Schult (eds.), *Maternal and Infant Care*, 1979, New York, McGraw-Hill.

⁸ Barry S. Levy, Frederick S. Wilkinson, and William M. Marine, "Reducing neonatal mortality rate with nurse-midwives," *American Journal of Obstetrics and Gynecology*, 1971, 109(1), p. 51.

⁹ For a statement of the integral nature of nursing training to midwifery see Judith Bourne Rooks and Susan H. Fischman, "American Nurse-Midwifery Practice in 1976-1977: Reflections

The International Federation of Gynaecology and Obstetrics along with the International Confederation of Midwives established a widely-accepted description of midwifery that encompasses nurse-midwifery and other forms of midwifery.¹⁰

"A midwife is a person who, having been regularly admitted to a midwifery education programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventive measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency services in the absence of medical help.

She has an important task in health counselling and education, not only for her patients but also within the family and the community. The work should involve ante-natal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care."

These definitions of midwifery practice underscore the division of Canadian midwives into community midwifery or hospital-based, nurse-midwifery. **Community midwives** tend to be self-employed, to practice their skills outside of hospitals, to provide continuity of care throughout the pregnancy, labour and delivery, and the postpartum period. They also practice without the benefit of law and only recently have begun to develop a theoretical and clinical training programme in B.C. **Nurse-midwives** are not independent practitioners: they are usually employed in the capacity of obstetrical nurses, although some also serve in northern regions as outpost nurses. Since nurse-midwives operate on shifts within the hospital, they do not always remain with women from the time of admission to delivery, nor do they provide prenatal and postnatal care in the same, continuous manner as community midwives. Nurse-midwives are legal practitioners under the B.C. *Registered Nurses' Act* but as shall be

⁹(cont'd) on 50 Years of Growth and Development," *American Journal of Public Health*, 70(9), p. 990.

¹⁰ J.M.L. Phaff et al., *Midwives in Europe: Present and Future Education and Role of the Midwife in Council of Europe Member States and in Finland*, 1975, Strasbourg, Council of Europe, p. 2

demonstrated, this legal status has been accompanied by the containment of nurse-midwifery skills within many obstetrical settings.

Central Problem of the Research

Much contemporary research on childbirth has been medically oriented, addressing obstetrical techniques and birth outcomes. This approach is closely allied with demonstrable improvements in the management of high-risk pregnancies and refined methods of treating newborns suffering from low birth weight, genetic deformities, fetal alcohol syndrome and the like. Technical discussions of prevention and treatment of mortality and morbidity are central to this literature, along with a growing interest in health promotion for expectant mothers and fetuses.

Other approaches to childbirth present a less clinical or technical portrait of childbirth. For instance, there has been renewed interest in the history of birthing practices in North America and elsewhere, in cross-cultural variations in birth, in sociological studies of pregnancy and childbirth ¹¹ and in the regulation of birth attendants by professional associations such as Colleges of Physicians and Surgeons and Nursing Colleges, as well as through direct involvement of the legal apparatus of the State.

The central problem of this dissertation arises out of the renewed interest in midwifery and the growing interest in theories of the State. Specifically, the central problem is how the manner of State intervention in childbirth attendance in British Columbia has contributed to the outlaw or subordinate status of the midwifery profession, and whether midwives are competent caregivers for parturient mothers and children. The central thesis to be examined begins with the theoretical assumption that the State serves to maintain or extend patterns of domination and subordination. This encompasses patterns of male dominance over women (as

¹¹ Ann Oakley, *Women Confined: Towards a Sociology of Childbirth*, 1980, New York, Schocken Books.

employees and patients) within the medical sphere, of professionals over non-professionals, and of routine interventions in childbirth over the more judicious use of childbirth technology. Specifically, State expansion via the regulation of childbirth, historically rooted in a legal monopoly of practice for male physicians and surgeons, was designed to protect the interests of the then-emergent, now dominant profession of medicine. The exclusion of non-medical practitioners by the intervention of the State thus enabled medical practices to develop with limited competition from "irregular" practitioners.¹² It is evident that this historical take-over of birth attendance, including the complicity of State officials with professional interests, remains largely intact today; i.e., with close to 100% of births in North America involving hospital-based deliveries supervised by medical personnel.¹³ It is important, however, to critically assess the value of midwifery practice and to consider the benefits that have accrued through the development of maternity and infant services. To do otherwise is to oversimplify the complexity of the midwifery debate and the directions of future policies for midwifery education and practice.

This study will examine the alleged occupational inferiority of midwives as birth attendants. If this allegation is disproven, then the existing legal encumbrances on consumer choice in childbirth and in women's freedom to attend births as an occupation must be recast as serving specific interests, not a putative general interest.

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

¹² This conflict in Ontario is traced in Lesley Biggs, "The Case of the Missing Midwives: A History of Midwifery in Ontario from 1795-1900", 1983, *Ontario History*, 75 (1), pp. 21-35.

¹³ Suzanne Arms, *Immaculate Deception*, 1977, New York, Bantam Books; Roger Tonkin, *Child Health Profile: Birth Events and Infant Outcome*, 1981, Vancouver, Hemlock Printers.

transformed midwifery from a local practice into an illegal act, thereby effectively transferring power from the midwives and their clients into the professional sphere of physicians and nurses. Other constraints include the corresponding powers of discipline and legal redress that physicians can employ against midwives for the quasi-criminal offence of "practicing medicine without a license", and the greater likelihood that legal officials – police and prosecutors – will initiate Criminal proceedings against non-medical birth attendants in the event of injury to the mother or child.

One problematic aspect of this legal delineation is whether this monopoly status is in the public interest. A growing body of research is available in support of the argument that midwifery attendance is safe and appealing to parturient women. This finding is not fully established, partly due to methodological problems in the existing literature as well as contrary findings (i.e., where lay midwives appear to have greater rates of mortality and morbidity among their clients). Nevertheless, if midwifery attendance appears comparable to, or superior to, obstetrical attendance then the question remains: why is midwifery excluded or marginalized while the profession of medicine is entrenched? It will be suggested that the State maintains legal barriers to midwifery practice to support the professional interests of organized medicine, at the same time containing radical feminist initiatives, including demands for legal status extended to alternative practitioners.¹⁴

The central problem investigated in this study is developed through a specific instance of "statism". Statism is defined as the transfer of activities from particular organizations in civil society to State regulation.¹⁵ The concept of *statism* is synonymous with "statisization".

¹⁴ See Zillah Eisenstein, *The Radical Future of Liberal Feminism*, 1981, New York, Longman, p. 220. Midwifery is not wholly a "radical feminist" initiative. It does however stem from the feminist critique of patriarchy in law and health care. Radical associations have also been formed, for example, the Association of Radical Midwives. Other groups in England include the National Childbirth Trust and the Association for Improvements in the Maternity Service. See Caroline Flint, *Sensitive Midwifery*, 1986, London, Heinemann, pp. 238–240.

¹⁵ Arian Asher, "Health Care in Israel: Political and Administrative Aspects", *International Political Science Review*, 1981, 2 (1), pp. 43–56. Miliband speaks of the "vast inflation" of the power and activities of the State such that "...more than ever before men now live in

Panitch illustrates this expanded role of the State through State subsidization of political parties' expenditures and State influences on trade union activities.¹⁶ This instance serves to illustrate the structural constraints on human action reinforced by the State. Nevertheless, it is anticipated that structuralist theorists of the State – Althusser and Poulantzas, for example – provide a theoretically incomplete framework. They fail to take into account instances of sustained, counter-hegemonic resistance to State control of social action. Structuralists question the separation between State agencies and non-State organizations favoured by Miliband, substituting a broader definition of the State. This connects *formal* State structures (the judiciary, the civil service, the police, the military, and so forth) connected with *ideological* structures: political parties, the Churches, trade unions, specific interest groups (including the Medical profession and related bodies).¹⁷ The structuralist approach allows for distinct lines of authority between the professions, rival occupations, and State officials, as well as competing objectives among them.

The initial encroachment of the State in permitting a monopoly status to medical practitioners in 19th century Canada was largely instrumentalist (serving the interests of members of a dominant class). It was also tied to patriarchal ideology by excluding, where possible, nonprofessionals (invariably women) from birth attendance. It has been established that the monopoly status of doctors in pioneer Canada was not enforceable in regions that did not have sufficient medical attendance. In such cases lay midwives were allowed to practice until medical and nursing personnel were present.¹⁸

¹⁵(cont'd) the shadow of the state". See Ralph Miliband, *The State in Capitalist Society*, London, Quartet Books, p. 1.

¹⁶ Leo Panitch, "The Role and Nature of the Canadian State" in L. Panitch (ed.), *The Canadian State: Political Economy and Political Power*, Toronto, University of Toronto Press, 1979, p. 10.

¹⁷ Ralph Miliband, op cit.; Nicos Poulantzas, *Political Power and Social Classes*, London, Verso, 1978. Miliband retains a greater distinction between the State and Civil Society, while recognizing the interaction of the two spheres.

¹⁸ See Biggs, op cit., note 2; and Henry Sigerist, *Saskatchewan Health Services Survey Commission, Report of the Commissioner*, 1944, Regina, King's Printer.

The contemporary focus of this thesis, while linked with this instrumentalist framework, will address the complexity and vagaries of State enactments and occupational action through a "relative autonomy" theoretical framework. The modern State is not simply an instrument of a particular class or set of classes, nor is it a determined set of objective relations. Rather, the State maintains a degree of autonomy in initiating legal reforms and constraining the actions of dominant, privileged groupings. This feature, it is argued, reflects in part the vitality of struggles "from below". Attention is also directed to initiatives by State personnel that influence reforms in social justice and changes in criminal justice policies.¹⁹

The central problem of State expansion into maternal and child care is the common ground against which a number of related sub-problems can be assessed. These sub-problems include the nature of accommodation to – or resistance against – State expansion. Resistance and accommodation are evident in the occupations of nurse-midwifery and community midwifery in British Columbia and elsewhere. Both occupations seem to manifest degrees of accommodation. Nurse-midwifery appears more allied with medical practitioners, while lay midwives challenge the hegemonic status of medical personnel in women's health care. It is hypothesized that these alliances affect the nature of midwifery practice. It is plausible that lay midwifery practice is associated with lower rates of intervention – episiotomy, medication, electronic monitoring, and so forth – than is nurse-midwifery practice. This differentiation is linked with structural pressures on nurse-midwives to defer to physicians during labour and delivery procedures, to utilize hospital equipment and personnel, and the like. This sub-problem is in turn linked with women's status and the State, especially the concept of patriarchy – e.g., the historical exclusion of women from participation in public life, the barring of women from medical education,²⁰ and the gradual dichotomy established between

¹⁹ See R.S. Ratner et al., "The Problem of Relative Autonomy and Criminal Justice in the Canadian State," in R.S. Ratner and J.L. McMullan (eds.), *State Control: Criminal Justice Politics in Canada*, 1987, Vancouver, University of British Columbia Press.

²⁰ See Veronica Strong-Boag, "Canada's Women Doctors: Feminism Constrained" in Linda Kealey (ed.), *A Not Unreasonable Claim: Women and Reform in Canada, 1880s – 1920s*, 1979, Toronto, The Women's Press, pp. 109–129.

men (as doctors) and women (as patients or as nurses, both subject to medical authority).²¹ The major theoretical question addressed in this dissertation concerns power, particularly the political dimension of power whereby a group or groups vie to secure their interests or to establish a general interest. Crucial to this thesis, then, is an articulation of the limitations of the dominant liberal conception of the State as pluralist, democratic, and quintessentially unbiased.

Scope of the Research

This study of midwifery in Canada addresses the contemporary debate on childbirth attendance and its regulation in a number of ways. First, a systematic search of the available literature on childbirth identifies the parameters of debate and discusses some of this literature regarding specific issues in contemporary maternity care. While there are omnibus approaches to specific aspects of maternity care – for instance, infant mortality and morbidity – few studies seek to integrate the detailed literature on obstetrical procedures and midwifery with the empirical and theoretical perspectives of social science.²² Second, published studies of the history of midwifery and the advent of obstetrics is discussed to place contemporary debates in historical context. Third, an empirical study of the practice of nurse–midwives and lay midwives in British Columbia will constitute an original contribution to our knowledge of childbirth attendance in a Canadian jurisdiction.

²¹ Judith Lorber, "Women and Medical Sociology: Invisible Professionals and Ubiquitous Patients" in Marcia Millman and Rosabeth Kanter (eds.), *Another Voice: Feminist Perspectives on Social Life and Social Science*, 1975, Garden City, Anchor Books, pp. 75–105.

²² Two exceptions are P. Anisef and P. Basson, "Institutionalization of a Profession: Comparison of British and American Midwifery", *Sociology of Work and Occupations*, 1979, 6(3), 353–372 and Gernot Bohme, "Midwifery as Science: An Essay on the Relation of Scientific and Everyday Knowledge", in Nico Stehr and Volker Meja (eds.), *Society and Knowledge: Contemporary Perspectives in the Sociology of Knowledge*, 1984, New Brunswick, Transaction Books, pp. 365–385.

Medical and nursing terminology is consolidated into a Glossary appendix (see Appendix A). Brief definitions of numerous terms are incorporated into this Glossary: *placenta previa*, Caesarean section, breech presentation, neonatal mortality, primigravida, and so forth. Reference is made throughout the text to specific research reports: e.g., recent overview articles on Caesarean section rates, studies of induction procedures and episiotomies, electronic fetal monitoring, and evaluation studies of nurse-midwifery and community midwifery.²³ Reference has also been made to standard Medical and Midwifery Dictionaries and Textbooks.²⁴ In addition, definitions of other terms such as infant and maternal morbidity and mortality, perinatal statistics, are provided in the text.

The empirical study is divided into three parts. The first is a comprehensive documentary analysis of birth records and charts pertaining to attempted home births with *community midwives*. The researcher asked all community midwives if they had compiled birth records or charts or had access to them. The researcher then requested access to these records to compare outcomes of midwifery attendance with obstetrical outcomes in this province. This documentary analysis provides crucial data on various aspects of birth attendance and birth outcomes in British Columbia. These findings are linked with the extant literature on birth attendance. Birth records and charts associated with births attended by certified *nurse-midwives* include documents linked with a midwifery demonstration project at the Grace Hospital in Vancouver between 1981 and 1984. Four nurse-midwives provided prenatal care, attendance at labour, and post-natal care for 61 women. This was the only demonstration project of its kind in Canada, although others have been reported in the

²³ See Paul Placek and Selma Taffel, "Trends in Cesarean Section Rates for the United States, 1970-1978", 1980, *Public Health Reports*, 95(6), pp. 540-561; Carol Brendsel et al., "Episiotomy: Facts, Fictions, Figures, and Alternatives" in David Stewart and Lee Stewart (eds.), *Compulsory Hospitalization or Freedom of Choice in Childbirth: Volume One*, 1979, Marble Hill, NAPSAC, pp. 139-144; Student Nurses Association of Illinois, "Episiotomy as an American Phenomenon", *Journal of Nurse Midwifery*, 1979, 24(1), p. 31; Lewis Shenker et al., "Routine Electronic Monitoring of Fetal Heart Rate and Uterine Activity During Labor", *Obstetrics and Gynecology*, 1975, 46, pp. 185-189.

²⁴ V. da Cruz, *Bailliere's Midwives' Dictionary (fifth edition)*, 1969, London, Bailliere Tindall and Cassell; M. Myles, *Textbook for Midwives*, 1975, Edinburgh, Churchill.

United States and other countries, and a second project has been implemented at the Grace Hospital in Vancouver. These two documentary analyses are combined with the third focus, information gleaned from *in-depth interviews* with samples of practicing nurse-midwives and community midwives, as well as other people concerned with maternity and infant care and pertinent legislation (defence attorneys and prosecutors, educators, consumer advocates).

These three parts of the research study are integrated with the fundamental question of State expansion into birth attendance. Specifically, the results of the sociological approach - documentary analyses, interview data, State theories - are interpreted in conjunction with research reports by nurses, physicians, midwives, and health care researchers. The original research and the available literature are used to discuss how particular groups develop accounts of society and their contributions to a given society. Explanations which will be considered include the following:

1. the interest of professional organizations in ensuring a supply of patients and above-average income;
2. the division of work along gender-related lines as well as along class-related lines;
3. the use of legal prohibition to discourage midwifery practice;
4. the role of the judiciary in rationalizing State policies;
5. serious concerns about the safety of lay midwifery attendance and the need for formal regulation of birth attendance;
6. and the role of the judiciary in rationalizing State policies.²⁵

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

²⁵ For a discussion of the role of judges in rationalizing government policy see Roger Cotterrell, *The Sociology of Law: An Introduction*, 1984, Toronto, Butterworth, Chapter Seven.

This sequence of analysis will culminate in the application of this instance of State intervention in social and economic life (specifically, childbirth and the occupation of midwifery) to the continuing debate over the implications of State authority in advanced capitalist societies. It is expected that this instance of statism will illustrate features of the way in which structured patterns of authority and domination are mediated through the State apparatus in capitalist society. At the same time, it reveals the pressures for alternative approaches to childbirth and women's occupational freedom, the limited impact of these pressures on legislative enactments and professional policies (e.g., birthing practices), and the attempts of the State to contain these pressures through legal repression and ideological persuasion. The theoretical framework in which the above assumptions are explored involves the role of the State as "relatively autonomous" of specific interests of dominant groupings – such as organized medicine – as responsive to countervailing pressures, yet integral in the promotion of dominant interests as a whole.

The debate over midwifery practice in British Columbia can be identified as a fundamental dispute about the desirability of granting midwives more independent, legal status as birth attendants. This debate highlights the contradiction between (1) the ostensible "general interest" served by professional birth attendance, and (2) the radical tenet that legal regulation primarily serves dominant class interests while undermining women's rights to self-determination as mothers and as birth attendants. Specifically, the outlawing or marginalization of lay midwives as well as the subordinate status of certified nurse-midwives reflects a consolidation of professional occupational interest that is largely intact despite challenges to its hegemonic status. ²⁶ This consolidation of interest is made possible through legal sanctions that may be directed toward birth attendants "poaching" on the medical monopoly: first, through civil actions against midwives; and second, through criminal prosecution of midwives in the event of injury or death to mothers or newborns (while

²⁶ Paul Starr, *The Social Transformation of American Medicine*, 1983, New York, Basic Books.

criminal prosecution is largely eschewed in instances of injury or death occurring in hospital-situated, professionally-attended births). These legal encumbrances on independent midwifery practice have been interpreted as protecting citizens from incompetent or dangerous birth attendants, and as a way of maintaining professional self-determination, status, and income. The B.C. College of Physicians and Surgeons has the statutory power to register doctors for the practice of medicine and to restrict the practice of medicine and midwifery by other birth attendants. An exception to this general rule involves outpost nurses working in areas that have few or no doctors; e.g., the Northwest Territories, the Yukon, and remote areas in the Provinces. Accordingly, the dominant method of birth attendance is for labour, delivery, and immediate post-delivery to be supervised by doctors, usually with the assistance of obstetrical nurses in maternity wings or maternity hospitals. There have been precedents in British Columbia whereby a person attending a birth has subsequently been convicted of practicing midwifery without a license: the conviction of Margaret Marsh in 1980 is a recent example. ²⁷

There are nevertheless a number of problems with what appears to be a clear prohibition of midwifery practice and the dominant status of obstetrical personnel. First, the very definition of midwifery is not clearly set out in law. Second, despite the general legal prohibition, it has been estimated that there are up to 100 lay midwives attending births in British Columbia ²⁸ and there have been recommendations to expand the role of the certified nurse-midwife with respect to hospital-situated births. ²⁹ Third, this point is connected with the largely contradictory international phenomenon of what appears to be growing support for midwifery training, licensing, and practice on the one hand, and structural changes in

²⁷ [Judge] Peter Millward, "Reasons for Judgement" *Regina versus Marsh*, 1980, Victoria, County Court of British Columbia.

²⁸ See Andreas Schroeder, "Birthright", *Today Magazine*, October 4, 1980, pp.10-13.

²⁹ Registered Nurses Association of British Columbia, "Policy Statement - Nurse Midwifery" 1979, [Typescript mimeo], 2 pp.

obstetrical practice that seek to eliminate midwifery or to "medicalize" it on the other.³⁰ Fourth, the historical development of midwifery, the implementation of legal obligations to register births through Provincial Vital Statistics Acts, and the advent of physician-dominated childbirth in Canada, are not understandable through direct reference to case law and statute law alone.

The legal status of midwifery in British Columbia is salient to this thesis since prosecution of midwives for alleged transgressions of section 203 of the Criminal Code of Canada, criminal negligence causing death,³¹ has been undertaken in recent times in British Columbia and Nova Scotia. Moreover, the civil status of midwives in the provinces is the subject of lobbying on behalf of lay midwives and consumer advocates.

The nature of midwifery practice, as argued in this thesis, is inseparable from the central problem of accounting for its legal regulation or prohibition in many North American jurisdictions. Arguments against establishing a legal footing for the practice of midwifery are almost invariably pitched on the basis that midwifery practice is unsafe, or not as safe as physicians' management of labour and delivery. Nevertheless, several short-term, demonstration projects in many countries have challenged this critique of midwives.³² These demonstration projects are bolstered by longer-term midwifery services such as the Frontier Nursing Service

³⁰ Robert Crawford, "Healthism and the Medicalization of Everyday Life", *International Journal of Health Services*, 1980, 10(3), pp. 365-388. An extended treatment of the myriad ways in which social issues have become the bailiwick of physicians is provided by Ivan Illich, "The Medicalization of Life" (Ch. 2), *Limits to Medicine*, 1977, Harmondworth, Penguin.

³¹ Paul Bourque, "Proof of the Cause of Death in a Prosecution for Criminal Negligence Causing Death", *The Criminal Law Quarterly*, 1980, 22(3), pp. 334-343.

³² Accounts of these projects are available in Doris Haire, "Improving the Outcome of Pregnancy Through Increased Utilization of Midwives", *The Practicing Midwife*, 1981 (summer); Barry Levy et al., "Reducing Neonatal Mortality Rate with Nurse-Midwives", *American Journal of Obstetrics and Gynecology*, 1971, 109(1), pp. 50-58; Anne Scupholme, "Nurse-Midwives and Physicians: A Team Approach to Obstetrical Care in a Perinatal Center", *Journal of Nurse-Midwifery*, 1982, 27(1), pp. 21-27; Richard Stewart and Linda Clark, "Nurse-midwifery Practice in an all-hospital Birthing Center: 2050 Births", *Journal of Nurse-Midwifery*, 1982, 27(3), pp. 21-26.

in Kentucky.³³ As set out in Chapter Five, some observers maintain that skilled midwives can lower rates of maternal morbidity and of operative delivery (i.e., anaesthesia, analgesia, forceps delivery, vacuum extraction, and Caesarean section).

It is also important to consider how the midwifery movement emerges and is sustained. Information on patterns of recruitment and apprenticeship by lay midwives and nurse-midwives, on the practice of midwifery itself, data on why midwives may discontinue practice indefinitely or temporarily, and midwives' reflections on the optimal place of midwifery alongside obstetrical care is gathered through a semi-structured, interview frame. This information, which is linked theoretically with general works within the Sociology of Work and Occupations, especially those centering on women and the work-force,³⁴ will be applied directly to the central issue of the competency of midwives to attend births. If their competency or superiority is confirmed as hypothesized, this finding will challenge the rationale underlying the protected legal status of doctors in childbirth. This focus is useful inasmuch as midwives are overwhelmingly female. It is only recently that men have been admitted to midwifery training in Britain for example. Considering the near-segregation of work along gender lines historically, it is not surprising that in 1979, only four of the 24,000 midwives in Britain were men.³⁵

The theoretical linkage with work and occupations depends upon an understanding of the modern State. The assumption here is that historical and contemporary conflicts among birth attendants, as well as conflicts between these attendants and State officials, are best understood with reference to the movement of the State into this aspect of health care. By taking criminal action against lay midwives, by transferring licensing powers to medical and

³³ Suzanne Arms, *op cit*.

³⁴ Helen Marieskind, *Women in the Health System: Patients, Providers, and Programs*, 1980, Toronto, C.V. Mosby; Susan Wilson, *Women, the Family, and the Economy*, 1986, Toronto, Prentice-Hall (second edition).

³⁵ Leslie Plommer, "Male Midwives Meet Opposition in Britain", *The Globe and Mail*, February 15, 1979.

nursing Colleges, the State reinforces the dominance of medical attendance at birth while discouraging the growth of a more pluralistic birthing system. As will be outlined, however, there is evidence that State measures have contributed to maternal and infant safety and that this instrumentalist portrait of the State is not sufficient for understanding the complex struggles for reproductive freedom and safety of infants and mothers.

The State and Health Care

A common problem in sociological research is a tendency toward empiricism that divorces data from theory.³⁶ This promotes descriptive research and the pursuit of correlations without extensions into causal relationships among the variables under study. Reference to the available literature on health care and the State confirms that for the most part policy-oriented research has tended toward descriptive and atheoretical analyses in contrast to the growing, critical literature on the State and health care.³⁷

This study combines empirical research with a broader theoretical discussion of the State movement into Civil Society and the interests served by this movement. The growing literature on the Sociology of the State includes preeminent liberal-pluralist theories of the State and society, structuralist theories that emphasize the play of objective forces autonomously from human agency, and a growing recognition of the functions served by the State in meeting demands of accumulation, legitimacy, and social control. Critical theories of the State have been generated by Marxist and neo-Marxist scholars, primarily in Europe.

A central difficulty with this research is the limited attention given to health care issues. There have nevertheless been a number of recent articles and books addressing the pivotal role of the capitalist State in containing struggles surrounding health care services and

³⁶ C. Wright Mills, *The Sociological Imagination*, 1959, Oxford, Oxford University Press.

³⁷ For an overview see Andrew Twaddle, "From Medical Sociology to the Sociology of Health: Some Changing Concerns in the Sociological Study of Sickness and Treatment" in Tom Bottomore et al., *Sociology: The State of the Art*, 1982, London, Sage, pp.323-358.

social class, race, and gender.³⁸ One major inadequacy in this work is the focus on theorizing at the expense of empirical work on particular "instances" of State regulation and struggles against such regulation.

The study of State involvement in health care is applied through an evaluation of concrete instances of the intrusion of the State into childbirth. In many countries childbirth was a community event that was later regulated by ecclesiastical authorities.³⁹ With reference to birthing practices and State regulation in British Columbia, it is argued that the State's designation of birth as a medical matter has promoted a clientele for Canadian medical practitioners by eliminating competing practitioners such as lay midwives. Furthermore, the State's provision of massive expenditures for medical training, hospitals, supplies, medical insurance plans, and so forth has enabled physicians to consolidate their practices and augment their income relative to other wage-earners. Doctors' incomes in Canada have been over three times greater than the average income of other workers since the 1950s.⁴⁰ A clearer profile of Physicians' incomes is set out below in Table 1.

State complicity in establishing medical attendance may in turn be linked with a number of motives: the importance of establishing a healthy work-force; the largely reciprocal interests of the professions and the State in reinforcing patterns of hierarchy and obedience; and the need to redefine childbirth as a medical matter, dependent on technological interventions, in order to bolster demands for drug manufacture and obstetrical

³⁸ For example, see Sander Kelman, "Toward the Political Economy of Health Care", *Inquiry*, 1971, 8(3), pp. 133-144; Colin Thunhurst, *It Makes You Sick: The Politics of the NHS*, 1982, London, Pluto Press.

³⁹ For the history of municipal regulation of midwives in Germany see Thomas Benedek, "The Changing Relationship Between Midwives and Physicians During the Renaissance", *Bulletin of the History of Medicine*, 1977, 51(4), pp. 550-564.

⁴⁰ C.D. Naylor, "A Feeling of Deja Vu: The CMA and Health Insurance", *The Canadian Forum*, 1981, 60(708), p. 11.

Table 1: Average Income of Self-Employed Physicians, Dentists, Lawyers, and all Taxpayers in Canada

Year	Physicians	Dentists	Lawyers	All Taxpayers
1951	9,975	6,287	10,214	3,149
1961	17,006	14,692	15,718	4,348
1971	39,555	27,862	25,828	7,237
1976	49,310	43,336	44,858	13,319
1981	66,722	60,139	53,123	15,415
1983	89,124	76,690	61,457	17,333

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

equipment.⁴¹

The thesis developed through the study of midwifery in British Columbia will go beyond the instrumentalist perspective denoted above. While there is merit in the political focus of instrumentalism, as an explanation of social and economic relations it requires modification with respect to the production and reproduction of class relations through struggle, including legal struggles.⁴² The instance of midwifery in B.C. appears to reflect self-direction (in decision-making and recommendations) by legal officials (police, judges, prosecutors). This self-direction by officials is less apparent in civil actions under the British

⁴¹ For instance, Gough refers to "...Marx's own study of the British Factory Acts in the nineteenth century. He demonstrated how the Ten Hours Act and other factory legislation was the result of unremitting struggle by the working class against their exploitation, yet ultimately served the longer-term interests of capital by preventing the over-exploitation and exhaustion of the labour-force....". He also refers to the role of the 1906 *Schools Act* in improving the fitness of the working class. See Ian Gough, *The Political Economy of the Welfare State*, 1979, London, MacMillan, pp. 55 and 62. See also Magali Larson, *The Rise of Professionalism: A Sociological Analysis*, 1977, Berkeley, University of California Press.

⁴² Colin Sumner, "The Rule of Law and Civil Rights in Contemporary Marxist Theory", *Kapitalistate*, 1981, #9, pp. 63-91.

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

The theoretical framework centres on the structuralist principle of the "relative autonomy" of State officials, including legal actors. Relative autonomy — a feature of State action in which the collective interests of capital are safeguarded against the interests of particular capitals — has been associated with various theories of the State, including instrumentalism and State Monopoly Capital theories. Nevertheless, such theories are incomplete in themselves, and require greater attention to the processes by which State enactments are reversed or modified through struggle, including legal struggles. The theoretical framework, therefore, moves beyond an instrumentalist approach in assessing the consolidation of obstetrics and general practice (and the near-elimination of the non-professional birth attendant) in the 18th and 19th centuries in Canada.

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

The autonomy of the State thus appears to be indeed relative to dominant interests. Given the ambit of State control via prohibitions of alternative practice and through enabling actions on the part of the State (billing through the Medical Services Plan, certification for midwifery instruction, and so forth), the role of the State in preserving patterns of occupational dominance is inseparable from the nature of midwifery practice and the legal forces that encumber it. The relative autonomy of the State, as a plausible sequel to what may have been the instrumentalist character of the Canadian State in the 19th century, thus implies State recognition of counterclaims along with claims from dominant groupings, as well as State action that intervenes against specific interests of these dominant groupings. This framework may be more applicable to the issue of midwifery regulation than purely instrumentalist explanations of health care or the established literature on professional dominance in health care that largely restricts analysis to interprofessional conflicts, with limited attention to historical antecedents or larger, economic factors.⁴³

Methodology

As described in Chapter Four, several analytic techniques were applied in this study. Literature searches helped to establish the general parameters of discussion surrounding midwifery practice and regulation. In-depth interviews using a semi-structured interview frame were conducted with practicing midwives in British Columbia. The semi-structured aspect of interviews allows for disagreements and elaborations of general or specific questions culled from the literature review. The interview format permits probes of respondents' answers; the semi-structured format is suited to an exploratory study, especially since closed formats are typically not congruent with the range of respondents' answers. Third, documentary analysis of midwives' birth charts or records provides a reference-point for interviews, where possible, and affords a data base for statistical analysis for aggregate births during the study period. Again, the point is to collect data on the nature of midwifery practice, to compare lay midwifery

⁴³ Eliot Friedson, *Professional Dominance: The Social Structure of Medical Care*, 1980, Chicago, Aldine.

practice with nurse-midwifery practice, and to contrast these practices with conventional obstetrical outcomes.

The research design consists of a snowball sampling technique to outline the study sample. Snowball sampling is especially advantageous for this research. On the one hand, the practice of lay midwifery in British Columbia is essentially outlawed with few midwives advertising their practice; on the other hand, the available roster of Registered Nurses is not sufficiently sensitive to current practice to isolate currently practicing nurse-midwives. Reference to this Registry, membership lists of such organizations as the Midwives Association of B.C., and adjunctive sources of information will serve as a safeguard against overly skewed samples that may result from snowball sampling.

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

Community midwives from British Columbia and Ontario provided the bulk of birth-related data. Documents from Saskatchewan and Manitoba also were included in the analysis of birth records. The sample of practicing nurse-midwives was composed of two of the four nurse-midwives active in the Low-Risk Clinic at the Grace Hospital (61 clients between 1981 and 1984) as a core group of informants. Reference was then made to other certified nurse-midwives known to these four informants, along with a province-wide register of nursing specialties. The objective was to record features of midwifery practice so as to allow comparisons between midwife groupings and province-wide and nation-wide birth statistics.

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

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

Ethical Considerations

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

Studies of midwifery in Canada are further complicated by their legal status. While midwifery is not expressly prohibited in Nova Scotia statutes, midwifery is clearly set out as within the bailiwick of medicine in British Columbia. Section 72 of the *Medical Practitioners*

Act thus stipulates that midwifery can only be legally practiced by members in good standing with the College of Physicians and Surgeons. This places a serious responsibility on the researcher. Knowing that community midwives who are being interviewed and who supply birth records are in violation of the Act, the researcher took a number of steps to avoid jeopardizing these midwives.

Community midwives interviewed by the researcher were asked to speak in the third person rather than identifying themselves as birth attendants. This procedure was taken in case the researcher might be called as a witness to some future legal proceeding. While this was improbable – experts consulted on this matter believed that researchers were not subpoenaed for childbirth-related litigation – the protection of research subjects was paramount.⁴⁴ If subpoenaed, the researcher could testify that no midwife directly identified their practice to him. As such, information supplied to the researcher via interviews could be interpreted as hearsay evidence and would likely be inadmissible under Canadian evidentiary rules.

A similar precaution was taken with birth records provided by midwives. The researcher asked that these records not be identified as the property of any particular midwife and that discussion of missing data, clarification, and so forth not be tied to any midwife. A second precaution was that the interview tapes, notes, and transcripts were kept in a locked area. Third, upon completion of the study, the collected tapes would be destroyed.

Another ethical consideration that surfaces during the study is the accuracy of research. Where possible, the author recorded data as presented when compiling birth record variables; likewise, excerpts from interviews are presented verbatim or with ellipses to indicate missing words. Assertions by interview subjects were also critically examined and the comparison of

⁴⁴ Under the *Canada Evidence Act*, the researcher–subject relationship is not privileged. Researchers can be ordered to divulge information. If a researcher refuses, a contempt of court order can result in incarceration for the researcher. See John Hagan, *The Disreputable Pleasures: Crime and Deviance in Canada*, 1984 (second edition), Toronto, McGraw–Hill. This situation has occurred in several American cities.

home birth statistics with hospital birth statistics was conducted systematically. In dealing with community midwives, nurse-midwives, lobbyists, physicians, the researcher adopted a helpful stance with respect to materials he had access to, sometimes alerting the interviewees about developments in other jurisdictions, pertinent research studies, and so forth.

Significance of the Research

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

The evidence from the Canadian experience of midwifery practice, whether in institutions or at home, extends the generally favourable reputation midwives have established in other countries. As is demonstrated, the practices of nurse-midwives and community midwives have roughly comparable rates of infant mortality, and both groupings appear to have lower rates of obstetrical intervention (e.g., Caesarean section, forceps delivery, induction), especially the community midwives.⁴⁵ Nevertheless, there remain disquieting questions about adequate standards of care in some instances of community midwifery, and these will have to be addressed in formulating regulatory policies for midwifery.

This study also provides findings that underscore the complexity of midwives' approaches to childbirth attendance. There are philosophical and policy differences within the midwifery movement, perhaps most dramatically with respect to the viability of out-of-hospital birthing,

⁴⁵ It is important to note, however, that many high-risk pregnancies are managed in hospitals and the home birth clients may be a self-selected, healthier grouping. This issue will be developed further in Chapter Five.

and also surrounding the lay midwife versus nurse-midwife distinction.

The theoretical implications of the study are connected with the longstanding debate over State regulation in general, and the regulation of women specifically. Midwifery practice is a crucible in which the freedom of women to birth as they wish, and of women to work freely as birth attendants, has been historically contained and continues to be challenged. This study thus excavates the nature of the challenge to midwives and their clients – the threat of legal prosecution, barriers to hospital practice and to independent billing under the Medical Services Plan, sanctions against physicians collaborating with community midwives, possible co-option of nurse-midwives, and pairs this with the kinds of solutions forged by midwives in British Columbia. As such, a quite intentional form of deviance⁴⁶ and political lobbying for legal recognition of midwives is examined in the context of civil disobedience.

Midwifery, Medicine, and the State

The following Chapters serve to develop the themes identified in this introduction. The theoretical discussion in the introductory Chapter shows how the nature of midwifery practice is not reducible to inter-professional conflicts, including ideological disagreements. Instead, the manner of State intervention in these conflicts, through legislation and subsidization, is critical in designating spheres of power in childbirth. The Canadian State is not presented as an instrument of wealthy, privileged interests, but as a structure that has a degree of autonomy in responding to broader interests. This is not to claim that the *material* basis of the State is unimportant, especially in maintaining patterns of economic inequality between men and women in health care.

Chapter Three brings together historical and cross-cultural documentation to trace the development of midwifery in global perspective. The redefinition of childbirth as the bailiwick

⁴⁶ Rose Weitz and Deborah Sullivan, "Virtuous Deviance and Identity Management Among Midwives" (no date), unpublished paper.

of physicians, the relocation of birth in hospital settings, technological advances in monitoring and influencing pregnancy, and the creation of the professional nurse and nurse-midwife are major themes in this Chapter. Claims that the incorporation of midwifery into the obstetrical team has been beneficial are questioned, including the assertion that obstetrical techniques (more so than diet and hygiene) have dramatically reduced infant and maternal mortality. Another point is the great variation in birthing practices across (and within) cultures, as set against the often monistic premises of obstetrical training (e.g., restrictions on delivery positions, length of the second stage of labour, and increases in the rate of caesarean sections).

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

Chapter Four offers a detailed examination of the research methods adopted in studying midwifery. Midwifery records are often unavailable from the past, and many are no longer retrievable through oral histories. Accurate documentation of *contemporary* midwifery practices is essential. There are problems associated with the lack of standardized record-keeping among community midwives, although many variables are usually recorded as part of midwifery documentation. A major difficulty is securing access to records and the time required to code information and to verify or supplement the documentary analysis. Nevertheless, a combination

of statistical and non-statistical data was sought in this research. These studies are linked with in-depth interviews with midwives and others, together with reference to much of the world literature on midwifery regulation and practice.

Chapter Five presents the major findings from the research. A statistical review of over 1,000 attempted home births in Canada is contrasted with nurse-midwifery initiatives and earlier studies of home births in the United States and Canada. The home birth study confirms the safety of attempted home deliveries relative to hospital deliveries, while raising the criticism that some neonatal deaths were avoidable if care had been provided in hospital. Rates of Caesarean section, episiotomy, induction and augmentation of labour, and perineal tears are lower, sometimes dramatically lower, than hospital outcomes. There is also a substantial diversity in delivery positions adopted by women giving birth at home.

The praising of contemporary community midwifery often overlooks problems with some practices. There are instances where the midwife misses the birth or is unable to attend simultaneous labours. There is sometimes an "oppositional" ideology that decries heroic, invasive obstetrics while ironically substituting mystical properties to birth, possibly to the detriment of neonates and parents. The *material* basis for practice is also discussed in the context of an emergent profession (or calling) and the protectionism engendered by the struggle for midwifery.

While the data on nurse-midwifery initiatives presented in this Chapter are less substantial, nurse-midwifery is an integral part of the research. The containment of nurse-midwifery within the hierarchy of doctor-nurse interactions is a central theme. The evidence to date indicates that nurse-midwives are quite capable of managing pregnancy and labour and delivery, but in Canada there has been a very limited sphere of practice for most trained nurse-midwives: most operate as obstetrical nurses, providing valuable assistance to mothers, but seldom are they permitted to practice independently or to assume responsibility at the time of delivery. Attempts to establish non-hospital settings have not yet

succeeded in major centres, and the home has become the dispersed site for independent (community) midwifery practice.

Chapter Six, "Critical Reflections on Midwifery Practice", elaborates on concerns voiced about modern nurse-midwifery practice and community midwifery practice. These themes include the possibility of cooptation of nurses by the medical profession and hospital administration. For community midwives, serious concerns include variations in training and skill, willingness to transport mothers from home to hospital, and levels of prenatal and postnatal care, especially when the mother is transferred to hospital.

These themes and related points are brought together in Chapter Seven. The theoretical implications of State control over liberties are redeveloped in the context of the data analysis and the recent prosecutions of midwives under Criminal and Quasi-Criminal statutes. Greater attention is given to future research possibilities regarding midwifery practice and to policy development regarding the training, licensing, and discipline of midwives in Canada. The issue of control is central here: to what extent will midwives be self-determining? To what extent will State forces shape the nature of midwifery practice?

CHAPTER II

STATE, HEALTH, AND JUSTICE

Introduction

The formal exclusion of independently practicing midwives was presented as a central concern in the introductory chapter. There are several possible explanations for this exclusion, among them the technical superiority and safety of the professions (medicine and nursing), sexism, and intolerance of ethnic minorities.¹ A common interpretation draws on the self-interest of the medical and nursing professions in protecting their income and status against rival health care workers. This chapter places the State as a central figure in the origin of the midwifery debate. It is also a central figure in mediating contemporary conflicts between community midwives, nurse midwives, other health care workers, and parents.

The evolution of midwifery as a social movement is analytically inseparable from the manner of State intervention in British Columbia and other jurisdictions. In all Canadian jurisdictions the provincial and federal State sectors have been directly involved in the development of maternity and infant care. Medical insurance programmes, hospital construction, and medical education constitute major structural changes realized through the State. The monopoly practice accorded provincial Colleges of Physicians and Surgeons is a significant feature of legal power, while prosecutions under the federal *Criminal Code* underline the extensive State powers that can be brought against birth attendants in the event of damage to women or infants. Not only does the State wield these powers; it also is the site of lobbying efforts by midwives (and other health care practitioners) to secure a legal status. In

¹ Some of the complaints against 19th century midwives in Canada have been tied with ethnic prejudices. See Suzann Buckley, "Ladies or Midwives? Efforts to Reduce Infant and Maternal Mortality" in Linda Kealey (ed.), *A Not Unreasonable Claim: Women and Reform in Canada, 1880s - 1920s*, 1979, Toronto, The Women's Press, pp. 131-149. Conversely, it can be argued that by virtue of its multicultural policy, the contemporary Canadian state promotes ethnic and cultural diversity.

short, legitimacy through the State is a central goal for many alternative health care practitioners, and their success or failure can reveal the manner of State regulation and the interests served by such regulation.

In this chapter three main concepts will be defined and elaborated. The concept of the State will be drawn out with respect to various theoretical outlooks on State control; the concept of Health is directly relevant to the issue of midwifery and childbirth and is interconnected with major State expenditures and policies in health care; and the concept of Justice is applicable to the mandate of State authorities in regulating health care and permitting criminal and quasi-criminal prosecutions of birth attendants.

Theoretical work on the State is complex, usually grouped within the three main political philosophies of conservatism, liberalism, and radicalism. Even within these philosophies substantial debates continue regarding the implications of State power. The conservative interpretation of the State will be outlined, followed by liberal and radical contributions to State theory. These theoretical approaches are then assessed against the phenomenon of midwifery practice and initiatives to legalize midwifery in British Columbia.

Theoretical Approaches to the State

Debate over the nature of the State, the manner of its growth, and implications of State influence on social and economic life illustrates a vital epistemological issue in sociology, and in science generally: whether human action is determined (and to what degree) by structures outside of individuals, or whether social life is altered through "human agency" (thought, consciousness) and is therefore not wholly or mostly determined by structures or forces external to the individual. Does the State emerge as a necessary force to ensure stability, does it emerge and survive as a means of domination by one group or set of groups over others, or does it reflect a contradictory mix of forces and interests? State

policies with respect to midwives in B.C. will be interpreted in the latter sense: while defending special, powerful interests, there is a relative autonomy of the State from these interests in liberal democratic States. The nature and fate of midwives hinges in large measure on this degree of autonomy and the pressures brought to bear on State officials.

The power of conservative philosophy is also evident in Western democracies, for example, the electoral successes of Conservative politicians in a number of Western countries, including Canada, England, and the United States.² Conservative approaches to the State highlight social order and the authority vested in the legal order. Order is paramount for without social, economic, and political stability, civil life becomes more war-like, industrial and cultural development is impaired, and life is jeopardized through domestic and international conflicts. Hobbes articulated this sense of a common interest in social order that is met through a strong central authority. Commerce, the arts, the very fibre of civilization were dependent on a social covenant between individual citizens and the State.³ In 1652, in *De Cive* Hobbes interpreted the State as a public power, a supreme political authority that was separate from the ruler (i.e., the Monarch) and the public.⁴

A key issue with respect to State policy is the intolerance of minorities that has often been associated with conservatism. Discrimination in immigration policy, law enforcement, and work is more likely to appear under a conservative approach than a liberal State policy.⁵ The Conservative approach is open to criticism for its emphasis on tradition and order, even

² Ian Taylor, "The Law and Order Issue in the British general election and Canadian federal election of 1979; crime, populism and the state", *Canadian Journal of Sociology*, 1980, 5(3), pp. 285-311.

³ Thomas Hobbes, *Leviathan*, (orig. 1651), Harmondsworth, Penguin. A contemporary restatement of the State obligation to maintain order, even at the expense of justice, is set out in Ernest van den Haag, *Punishing Criminals: Concerning an Old and very Painful Question*, 1975, New York, Free Press.

⁴ See David Held, "Introduction: Central Perspectives on the Modern State" in David Held et al., *States and Societies*, 1983, Oxford, Martin Robertson, p. 2

⁵ See Paul Gordon, *White Law: Racism in the Police, Courts and Prisons*, 1983, London, Pluto Press for a critique of State discrimination in Britain from a civil liberties viewpoint.

in the absence of convincing evidence that far-reaching measures and powers are needed. The abstract value of the "general good" is likewise overemphasized, appearing often in generalizations about the Public or the General Will. Another criticism is the reliance on penalties and force as standard reactions to deviancy.

Contemporary discussion about the capitalist State has been dominated by liberal pluralism principles. ⁶ *Liberal* perspectives on the State often involve the concept of pluralism and tolerance. It is significant that while liberal ideology emphasizes multiculturalism and diversity, it does not necessarily follow that racial or ethnic stratification is in fact reduced under a liberal State regime. ⁷ For some liberals this requires a reconciliation between substantive social inequality and formal guaranteed freedoms. This can take the path of abolishing aristocratic privileges, unchecked bureaucratic discretion, and racial and sexual supremacy. Programmes to reduce inequality in access to education and legal representation for people charged with crimes are emblematic of the liberal response to inequality. There is also an appreciation of spheres that are not rightfully controlled by the distributive powers of the State: kin relations and love are two examples. ⁸ The emphasis conservatives place on social order is leavened through liberalism. Social order is thus balanced against fundamental freedoms and the State is entrusted with protecting constitutional freedoms as well as meting out sanctions.

The emphasis conservatives tend to place on public order and discipline is replaced with a clear delineation of *private* spheres by liberals. The value of these private spheres is consistent with the liberal emphasis on toleration and pluralism. The liberal tradition thus

⁶ Milton Mankoff, "Power in advanced Capitalist Society: A Review Essay on Recent Elitist and Marxist Criticisms of Pluralist Theory", 1970, *Social Problems*, 17(3), 418-430.

⁷ See Kenneth Bagnell, *The Little Immigrants: The Orphans Who Came to Canada*, 1980, Toronto, MacMillan.

⁸ See Michael Walzer, *Spheres of Justice: A Defense of Pluralism and Equality*, 1983, New York, Basic Books, p. xii.

favours limits to sovereignty while protecting various rights of citizens.⁹

Marxist theories of the State present a very different portrait. Unlike the conservative sense of the legitimacy of the State or the liberal watchdog function with respect to excessive State powers, Marxist theories invariably reword the necessary powers of the state as forms of domination. The maxim of "The greatest good for the greatest number" is recast as the State actually serving the interests of the few while claiming to represent the Commonwealth. The Marxist theories are important with respect to health care, including midwifery attendance, since they incorporate differentials in illness and longevity, along with occupational stratification, in analyzing race, gender, and class. Major branches of Marxist and neo-Marxist theory include instrumentalism, structuralism, class conflict, and capital-logic.

Instrumentalists claim that there is a direct correspondence of economic power and political rule such that the State is linked with a dominant class or set of classes. In a famous passage by Marx and Engels, the Executive of the modern State is portrayed as a committee for managing the common affairs of the bourgeoisie.¹⁰ The State is thus conventionally defined as a system which comprises the government (e.g., federal, provincial, and municipal levels in Canada), the administration, the military and the police, the judiciary, sub-central governments, and parliamentary assemblies.¹¹ Empirical studies of instrumentalism thus focus on the class composition of those in State command positions and also on the differential implementation of sanctions through the State.

⁹ For a discussion of liberalism and liberal democracy see David Held, "Central Perspectives on the Modern State" in David Held et al.(eds.), *States and Societies*, 1983, Oxford, Martin Robertson, pp. 2-3.

¹⁰ Karl Marx and Friedrich Engels, *The Communist Manifesto*, 1979, London, Harmondsworth, p. 82.

¹¹ Ralph Miliband, *The State in Capitalist Society: The Analysis of the Western System of Power*, 1973, London, Quartet, p. 50.

Instrumentalism has been widely criticized for oversimplifying economic and political developments in capitalist societies. A common criticism is that instrumentalism reduces the relation of State to civil society to actors' intentions, backgrounds, and affinities, thereby limiting the appreciation of structural influences.¹² This interpretation also fails to account for state interests in controlling its budget, in maintaining legitimacy (for electoral reasons), and the ability of state officials to initiate reforms in the interest of equity and justice. Nevertheless, instrumentalism provides an important emphasis on class struggles and the central role of the State apparatus in disguising and managing struggles.¹³

Structuralist approaches to the State emphasize the total integration of power and domination in social and political life. Structuralists have also emphasized the play of structures external to the will of individuals. Foucault writes of the takeover of human consciousness by technologies of control in various sites – the factory, the schools, the military, and penal settings. In his words, bodies become "docile", and human action is increasingly monitored, measured, and controlled.¹⁴ His work is especially important in reconceptualizing the joining of power as knowledge. The "clinical gaze" of medicine is especially pertinent to the midwifery debate.¹⁵ For the power secured by physicians through scientific research and clinical practice *and through monopolistic powers of practice under State auspices* poses serious obstacles to others seeking official recognition as health care workers.

¹² John McMullan and R.S. Ratner, "State, Labour, and Justice in British Columbia" in Thomas Fleming and Livy Visano (eds.), *Deviant Designations*, 1983, Toronto, Butterworths, pp. 5–36.

¹³ Charles Grau, "Whatever Happened to Politics? A Critique of Marxist Structuralist Accounts of State and Law" in Piers Beirne and Richard Quinney (eds.), *Marxism and Law*, 1982, San Francisco, Jossey-Bass, p. 207; Bob Jessop, *The Capitalist State*, 1982, London, Martin Robertson.

¹⁴ Michel Foucault, *Discipline and Punish: The Birth of the Prison*, 1979, New York, Pantheon.

¹⁵ Michel Foucault, *The Birth of the Clinic*, 1975, New York, Vintage.

This sense of a social totality that largely determines human action is clearly set out in the work of Poulantzas. He reconceptualized the State to include the schools, trade unions, media and other (ideological) apparatuses along with formal State (repressive) apparatuses. An abstract, complex structuralist approach was developed in which political struggles are properly directed against the State. The State serves as the "factor of cohesion" between various levels in constituting a given social formation. Thus, it is not sufficient to seek to transform civil society or to alter the mode of production without political struggles against the juridico-political superstructure of the State. The distinction between the private sphere of the family and the public sphere of the State is artificial according to Poulantzas. His position is that the State assigns the site of the family, that the family is largely unable to resist or evade this power of the State.¹⁶ His approach is opposed to strict economic determinism or historicism, and yet the precise contours of structural determinism are not identified in his writing.¹⁷

Structuralist-Marxists have been criticized on several grounds. For example, Poulantzas has been faulted for overemphasizing the power of political institutions, and Miliband has commented on the lack of data to develop and ultimately verify structuralist theory.¹⁸ The need to bolster theorizing with careful empirical work has also been recognized by Marxists and their critics. Retrospective "explanations" of economic and political developments, and abstract theorizing without reference to a data base are not uncommon. Indeed, some writers point to the frequent clash between "essentialist" Marxist assumptions and the lack of empirical substantiation of these assumptions.¹⁹

¹⁶ Nicos Poulantzas, *State, Power, Socialism*, 1978, London, New Left Books, p. 66.

¹⁷ See Nicos Poulantzas, *Political Power and Social Classes*, 1973, London, New Left Books.

¹⁸ Bob Jessop, *op cit.*, pp. 181-191; Ralph Miliband, "The Problem of the Capitalist State" in Robin Blackburn (ed.), *Ideology in Social Science*, 1972, London, Fontana.

¹⁹ A brief discussion of this dichotomy is made by Nicos Mouzelis, "On the crisis of Marxist Theory", *British Journal of Criminology*, 1984, 35(1), 112-121. See also Ivan Jankovic, "Social Class and Imprisonment", in T. Platt and P. Takagi (eds.), *Punishment and Penal Discipline*, 1980, Berkeley, Crime and Justice Associates, p. 104.

E.P. Thompson concludes that *cultural* forces limit the deployment of power and that attempts to use the legal apparatus are subject to reversals (e.g., jury acquittals) and due process safeguards. Thompson's writing has been directed against the reduction of human action to mere "vectors of ulterior structural determinations". As such, Thompson has affirmed the viability of historical understanding against the dismissive approaches of Hindness and Hirst, Althusser, and others.²⁰ His work combines an appreciation of resistance and human agency with a sober assessment of the increasing movement of the State into spheres that were either unregulated or weakly regulated by State authorities. The growth of technological surveillance and the punitiveness of policing policies in Britain, for instance, illustrate this Statist movement.²¹

Another theoretical approach closely allied with the cultural paradigm is the Gramscian outline of human agency. Human agency refers to the will and initiative of people and stands in contrast to the more deterministic theories of the State outlined above.²² Gramsci coupled the elements of will and initiative with the historical development of the State and civil society. Ideological and political practices enable a dominant class (or class fraction) to maintain its hegemonic status so that dominated classes and groupings *consent* to oppression and exploitation.²³ Accordingly, Gramsci emphasized the complexities of ideology, class, and law and the potential for counter-movements within the State superstructure. Gramsci also encouraged the role of "organic intellectuals" of the political left, skilled workers who would develop social and political policies. As such, this would bridge the distinction between

²⁰ E.P. Thompson, *Whigs and Hunters: The Origin of the Black Act*, 1977, Harmondsworth, Penguin; E.P. Thompson, *The Poverty of Theory and Other Essays*, 1978, London, Merlin. A general outline of this cultural explanation is available in Michael Ignatieff, "State, Civil Society, and Total Institutions" in Michael Tonry and Norval Morris (eds.), *Crime and Justice: An Annual Review of Research (Volume Three)*, 1981, Chicago, University of Chicago Press.

²¹ E.P. Thompson, "The Secret State", in David Held et al., (eds.) *States and Societies*, 1983, Oxford, Martin Robertson, p. 479.

²² Antonio Gramsci, *Selections from the Prison Notebooks*, 1971, London: London and Wishart.

²³ See Jessop, *op cit.*, note 12, p. 18.

intellectuals and manual workers. A synthesis of intellectualism and populism was favoured: ²⁴

"...The intellectual's error consists in believing that one can know without understanding and even more without feeling and being impassioned (not only for knowledge in itself but also for the object of knowledge): in other words that the intellectual can be an intellectual (and not a pure pedant) if distinct and separate from the people-nation, that is, without feeling the elementary passions of the people, understanding them and therefore explaining and justifying them in the particular historical situations and connecting them dialectically to the laws of history and to a superior conception of the world, scientifically and historically elaborated...."

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

There is also an appreciation of Civil Society as a source of political change. Even though there has been a *statist* tendency, the power of the State is limited by the resistance shown by various groupings. ²⁵ These forms of resistance bring Gramsci's work directly into the debate between determinism (structure) and free will (human agency), since Gramsci, himself incarcerated as an enemy of the people in Italy, was well aware of the structural forces that limit human action.

Claus Offe has attempted to synthesize instrumentalism, relative autonomy, and structuralism. For Offe, the capitalist State is caught in the contradictions of a capitalist economy. Following O'Connor's approach, ²⁶ Offe presents the contradiction between the

²⁴ Gramsci, *op cit.*, note 21, p. 418. Gramsci described the formal, bureaucratic method of intellectual work as "organic centralism". The nexus between intellectuals and the people is absent in this method.

²⁵ *Ibid.*, pp. 120-125.

²⁶ John O'Connor, *The Fiscal Crisis of the State*, 1973, New York, St. Martin's.

State's interest in preserving accumulation and favouring private appropriation of resources, on the one hand, and the requirement that the State appear to be a neutral force operating in the general interest. Just as the State depends on a vital private sector for its revenues, so also does the Capitalist State depend on legitimacy of the public. It is important to note that Offe does not agree with the instrumentalist tenet that the State is directly interlocked with capitalist interests; limits are set on the State by law and by pressures from "strategic groups" such as organized labour and oligopoly capitalists.²⁷

Difficulties are evident with Marxist and non-Marxist theories of the State. Perhaps most evident in the Poulantzas-Miliband debate,²⁸ there is a tendency for some writers to resist useful criticisms in developing their particular paradigms. A second difficulty involves the validity of claims. Many of the theoretical works do not include empirical evidence, remaining instead at the level of theorizing. Accordingly, there is no clear methodology for assessing how accurate these claims are nor is there a clear sense of refining hypotheses or statements.²⁹

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

²⁷ See David Held and Joel Kreiger, "Accumulation, legitimation and the State: the ideas of Claus Offe and Jurgen Habermas" in David Held et al., (eds.) *States and Societies*, 1983, Oxford, Martin Robertson, pp. 487-497.

²⁸ See Robin Blackburn, *op cit.*, note 17. This debate dramatized the gulf between the largely empiricist approach adopted by Miliband and the theorizing of Poulantzas.

²⁹ This criticism of Marxist abstraction and dialectical methodology is often associated with positivist epistemology. In *The Disreputable Pleasures*, 1984, Toronto, Prentice-Hall, John Hagan is critical of theoretical positions that are nonfalsifiable; that is, not subject to measures and standards of proof. See also Austin Turk, "Analyzing Official Deviance: For Nonpartisan Conflict Analyses in Criminology", in James Inciardi (ed.), *Radical Criminology: The Coming Crises*, 1980, Beverly Hills, Sage, pp. 78-91.

The State and Health Care

The instrumentalist approach within health care emphasizes the benefits of State intrusion (statism) into civil society for dominant economic groupings. This benefit is evident in early legislation in Upper Canada. The *Parker Act* of 1865 gave physicians a licensing monopoly, including the power to regulate the supply of physicians and qualifications for the practice of medicine. In the twentieth century, with the advent of medical insurance, physicians were guaranteed payment for their services, usually about 90 percent of the profession's fee schedule.³⁰ Physicians' incomes in the United States are highest (on average) among the professions. Waitzkin associates this financial dominance with a monopoly control that is bolstered through State legislation. Ehrenreich and Ehrenreich add that the average income of doctors in the United States rose proportionately from about twice the average family income (in the 1920s and 1930s) to approximately four times the average family income in the United States.³¹

The economic underpinnings of the relationships between the health care sector and the State have been developed through Marxian structural analyses. For example, Navarro has developed a theoretical framework in which health services are governed, for the most part, by considerations of political economy at regional, national, and international levels.³² The contradiction between patients' needs and profit-orientation in health services is also developed by Waitzkin. He criticizes Coronary Care Units (C.C.U.s) in the United States for their expense and inefficiency. These Units ostensibly serve the public interest through improved

³⁰ Donald Swartz, "The Politics of Reform: Conflict and Accommodation in Canadian Health Policy", in Leo Panitch (ed.), *The Canadian State*, 1979, Toronto, University of Toronto Press, p. 328.

³¹ See Howard Waitzkin, *The Second Sickness: Contradictions of Capitalist Health Care*, 1983, New York, The Free Press, pp. 36-37; and Barbara Ehrenreich and John Ehrenreich, "Medicine and Social Control" in Ehrenreich and Ehrenreich (eds.), *The Cultural Crisis of Modern Medicine*, 1978, New York, Monthly Review Press, p. 57.

³² See Vicente Navarro, *Medicine Under Capitalism*, 1976, New York, Prodist; and V. Navarro, "The Political and Economic Determinants of Health and Health Care in Rural America", *Inquiry*, 13(2), 111-121.

emergency care for people suffering coronary illnesses. Waitzkin contends that C.C.U.s in fact generate considerable profits for corporate interests, partly through State subsidies, without demonstrating their value in alleviating the suffering associated with coronary attacks.³³ A difficulty with this approach, however, is that it dismisses or minimizes authentic contributions to health and other benefits of health care services.³⁴

Waitzkin has built on this instance of the relationship of State to Capital. Working within O'Connor's theoretical framework,³⁵ Waitzkin indicates that the development of expensive medical technology and pharmaceutical commodities becomes profitable through State auspices. As health care in the United States has become increasingly commercialized, profits for corporations have been secured. Likewise, Waitzkin points to a public-private contradiction whereby the State is encouraged to subsidize the growth of private sector health care; for example, by diverting public funds to construction costs of private hospitals.

Waitzkin is critical of the conflation of State and Civil Society as a unitary set of apparatuses. He extends Miliband's definition of the State beyond officialdom.³⁶

"..The state comprises the interconnected public institutions that act to preserve the capitalist economic system and the interests of the capitalist class. This definition includes the executive, legislative, and judicial branches of government; the military; and the criminal justice system - all of which hold varying degrees of coercive power. It also encompasses relatively noncoercive institutions within the educational, public welfare, and health-care systems. Through such noncoercive institutions, the state offers services or conveys ideologic messages that legitimate the capitalist system...."³⁷

³³ Howard Waitzkin, "A Marxian Interpretation of the Growth and Development of Coronary Care Technology", *American Journal of Public Health*, 1979, 69(12), pp. 1260-1272.

³⁴ See Nicky Hart, "Is Capitalism Bad for Your Health?", *British Journal of Sociology*, 1982, 33(3), pp. 435-443.

³⁵ John O'Connor, *The Fiscal Crisis of the State*, 1973, New York, Saint Martin's Press.

³⁶ Waitzkin, op cit., note 30, p. 52.

³⁷ Waitzkin, op cit., note 30, p. 52.

Others have developed structuralist interpretations of State involvement in health care. In Renaud's exposition,³⁸ the capitalist mode of production constrains State solutions to such health-related issues as treatment, occupational health and safety, and environmental concerns. These constraints largely supersede the "volition" of individual health care workers, public officials, and the population at large. The dominant approach of expertise and health engineering draws together healing and consumption, in other words, a commodity approach to health care. This approach mistakenly treats diseases created by industrial development as natural phenomena. Ischemic heart diseases, various cancers, and mental and nervous disorders are examples of these diseases. This point is raised in Doyal³⁹ and developed with respect to carcinogens and co-carcinogens.⁴⁰

Renaud believes that medical knowledge operates within a paradigm of the "specific etiology" of diseases, with analysis centred on the cellular and biochemical diseases of the body. This approach promotes an overemphasis on individual responsibility for health and illness and obscures structural limitations on health care that are inherent in capitalist societies.⁴¹ Foucault presented a structuralist interpretation of the "medical gaze", an epistemological and perceptual system that builds on categorization and classification of the subject.⁴² This alienation of environmental influences, of political economy, and health is promoted through the State, the legitimate problem-solver in advanced capitalist societies. Herein the State is cast in Marxian terms as the manager of crises, serving the general

³⁸ Marc Renaud, "On the Structural Constraints to State Intervention in Health" in John Ehrenreich (ed.), *The Cultural Crisis of Modern Medicine*, 1978, New York, Monthly Review Press, pp. 101-120.

³⁹ Lesley Doyal (with Imogen Pennel), *The Political Economy of Health*, 1981, Boston South End Press, pp. 24-25

⁴⁰ Samuel Epstein, *The Politics of Cancer*, 1979, Garden City, Anchor Books.

⁴¹ The importance of social factors influencing health and illness is underscored in Ronald Labonte, "Good Health: Individual or Social?", *The Canadian Forum*, 1983, 63(727), pp. 10-13.

⁴² Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, 1973, New York, Vintage.

interests of capital accumulation and maintaining social harmony, while presenting itself as a neutral agent. This dualism is a central contradiction in State intervention in health care. For Renaud, this contradiction takes form in State reluctance to address work satisfaction and safety, a reluctance that is rooted in the commodified relationships of workers to work.⁴³

"...(The State) cannot question the basic factor that makes work unhealthy: the fact that workers largely are only commodities utilized for maximum output, efficiency, and profit. It can only act on very limited, discrete, and easily identifiable working conditions."

While promoting the interest of professionals with respect to more secure income and increments in earnings, State intervention in the form of hospital and medical insurance programmes also serves as a concession to working-class struggles for improved health care.⁴⁴

The most developed critical theoretical work on the State and health care begins from the premise that an understanding of current health care policies in advanced capitalist societies requires an historical perspective. Doyal⁴⁵ documents the worsened health of the populace in Britain during the transition from feudalism to early capitalism: long hours of work, restrictions on food production due to enclosure, poor sanitation and overcrowded habitats, accidents in factories, and the ubiquitous use of women, children, and men as labourers contributed to a general drop in the standard of health. She concludes that the orthodox perspective on medicine is largely empiricist, disease-oriented, and professional; this leads to minimal emphasis on social theory, non-organic sources of disease, and non-professional action in promoting health. The possibility of substantive allocation of resources is likewise minimized, while the focus of medical research and practice is on individual pathology and curative medical treatment. Heroic medicine and high-technology

⁴³ Renaud, *op cit.*, note 35, p.115.

⁴⁴ This concession to working-class interests in turn served to consolidate electoral victories for parties other than the CCF in provincial and federal Canadian elections. See Swartz, *op cit.*, p. 335; Desmond Morton with Terry Copp, *Working People*, 1980, Ottawa, Deneau and Greenberg.

⁴⁵ Doyal, *op cit.*

approaches to illness coexist, reinforcing the medical sphere. For Doyal, high technology medicine and the dramatization of medical breakthroughs serve as "window-dressing" and support the existing system. ⁴⁶ Doyal's analysis also emphasizes two imperatives: the production of commodities in the health sector, and the securing of authority relations. Authority relations are divided along lines of race, class, and gender. The importance of gender in health care is central to this understanding, especially as gender is associated with occupational stratification. The Women's Work Project examined data from 1970 gathered from New York City hospitals. They determined that between 75 and 85 percent of Lab Technicians, Licensed Practical Nurses, and manual services Aides were women, with 80 to 90 percent of the latter occupations comprised of non-white workers. ⁴⁷ The structuring of occupations along gender lines is clear in other reports. In the professional and technical spheres in the United Kingdom only 12 percent of medical consultants in the 1970s were women. In 1982-1983, 99.8 percent of nurses in the United Kingdom and only 13.7 percent of physicians were women. ⁴⁸

In their recent analysis of sexual stratification in the Canadian work-force, Phillips and Phillips write that two features of the work-force at the turn of the century are still evident: differentials in income (whereby women earn approximately 60 percent of men's wages, averaged for full-time work); and the concentration of women's paid employment in specific groupings. ⁴⁹

The partial segregation of women into occupational groupings - in the health sector and other sectors - is thus linked with market forces. These forces in turn reinforce

⁴⁶ Ibid., p.43.

⁴⁷ Women's Work Project of the Union for Radical Political Economists, "USA - Women Health Workers", *Women and Health*, 1976, 1, (3), p. 19.

⁴⁸ John Archer and Barbara Lloyd, *Sex and Gender*, 1985, Cambridge, Cambridge University Press, p. 225.

⁴⁹ Paul Phillips and Erin Phillips, *Women and Work: Inequality in the Labour Market*, 1983, Toronto, James Lorimer.

patriarchial elements in the economy, although these relations of production in capitalist countries may also carry benefits: ⁵⁰

"...the expansion of employment opportunities for women in these industries does improve conditions for women in the labor market. In however limited a way, the availability of jobs in multinational and local export factories does allow women to leave the confines of the home, delay marriage and childbearing, increase their incomes and consumption levels, improve mobility, expand individual choice, and exercise personal independence...."

The key to Doyal's analysis, then, is the dialectical relationship between domination and exploitation on the one hand, and changing patterns of health and health services on the other. Her analysis maintains a distinctly Marxian twist in its interpretation of advances in medicine and improved medical care as either: (1) concessions to the working class, thereby ameliorating developed class struggle; or (2) a service ultimately on behalf of a dominant class whereby the need for a healthier, more reliable work-force is achieved through health care programmes and the like.

As noted earlier in this chapter, a criticism of Doyal's book — and indirectly of Marxian theories linking dialectical materialism and problems within capitalist economic systems — is that the arguments are structured to minimize or overlook health gains. Decreases in rates of infant mortality and increases in life expectancy of adults are two cases in point. ⁵¹ Moreover, many of the problems associated with capitalist economies are present in socialist countries; for instance, smoking and cancer rates, infant mortality rates, and so forth. Hence, the possibility that capitalism has ushered in substantive gains in health is either not granted or is cast in terms of the interests of Capital rather than the populace.

⁵⁰ See Linda Lim, "Capitalism, Imperialism, and Patriarchy: The Dilemma of Third-World Women Workers in Multinational Factories" in June Nash and Maria Fernandez-Kelly (eds.), *Women, Men, and the International Division of Labor*, 1983, Albany, State University of New York Press, p. 83.

⁵¹ These points are elaborated in a review of Doyal's book. See Nicky Hart, "Is Capitalism Bad for Your Health?", *British Journal of Sociology*, 1982, 33(3), 435-443.

Law and the Regulation of Health Care

The specific apparatus of law is a critical factor in promoting and discouraging initiatives in health care. Subsidization of research and formal education are forms of promotion, while restricted access to (medical insurance) billing numbers and prosecution of practitioners serve to deter some workers or to limit their practices. Legal mechanisms are a pervasive and decisive force in the restructuring of health care, including maternity and infant care.

Theoretical work on the sociology of law, as with State theory, is complex and often contradictory. Spitzer reviews the emerging theories of law that move beyond simple instrumentalism and economism.⁵² Structuralism (exemplified by Althusser) and Culturalism (exemplified by E.P. Thompson) are the major, competing theories. Both attempt to redefine the nature of relationships between human actors, external structures, and law. A structuralist tenet is that although law is in some sense relatively autonomous, along with other superstructural features of society, the vectors of legal action are ultimately traced back to the economic system. The reformulation of this structuralist approach by Poulantzas involved a recognition of the role of law as an apparatus that preserves "real rights" of dominated classes. These rights are embedded within a dominant ideology; consequently there is an overlap between justice and domination.

Thompson's emphasis on cultural factors involves an appreciation of the interplay of superstructure and economic infrastructure, as well as a more fundamental critique of the formulation of infrastructure and superstructure. Law is conceived as more than an influence on the material base of society. It is an integral part of the material base.⁵³

⁵² Steven Spitzer, "Marxist Perspectives in the Sociology of Law", *Annual Review of Sociology*, 1983, 9, pp. 103-124.

⁵³ *Ibid.*, p. 109.

The relationship between law and the state has thus undergone a contemporary reevaluation among Marxists and neo-Marxists. As Spitzer indicates, the shortcomings of legal economism and of structuralism have generated a more vital paradigm of law in which law is portrayed as created out of an "ideological pool" comprising beliefs, and assumptions from all social classes. In turn, the relatively autonomous role of the State - whereby the State is not governed by the will of a dominant class but preserves autonomous powers against direct interests of this class - reflects the contradictory nature of legal ideology and the law as practice: ⁵⁴

"...legal ideology not only reinforces, enshrines, and legitimates the victories of the capitalist order, it also registers and presages its defeats.... the contradictory nature of law threatens to destroy the symmetry and closure of a Marxism that refuses to acknowledge its mediative and transitory character."

Other radicals have also been concerned with the hidebound quality of Marxist orthodoxy. Some suggest that modern families can be a site in which progressive interactions can replace patriarchal ones, in which intimacy, cooperation, and child-rearing can exist within a feminist and socialist context. ⁵⁵

Eisenstein portrays the State as an agency containing radical alternatives, including radical feminism. ⁵⁶ The State is structured such that it cannot allow women's equality with men. The "sexual ghetto" of lower-paid occupations is one instance of sexual stratification that the State - as employer and arbiter of social conflicts - perpetuates. Through the agency of law, the State mystifies what women are and what they do. It serves to constrain people's actual options. Yet it can establish "positive rights". In keeping with the 19th century feminist strategy of Elizabeth Cady Stanton, then, Eisenstein recognizes the political power of the State over women while endorsing struggles to secure the recognition of the

⁵⁴ Ibid, p. 117.

⁵⁵ Linda Gordon and Allen Hunter, "Sex, Family and the New Right: Anti-feminism as a Political Force", 1977/78, *Radical America*, 12 (1), p. 19.

⁵⁶ Eisenstein, *ibid.*, 1981, New York, Longman.

State. Other writers appreciate the role of pressure groups which maintain a critical focus on public policies.⁵⁷

In summary, liberalism and conservatism have largely shaped the development of health care practice in Canada. The current interest in cost-containment reflects the waning of liberal programmatic expansion. As such, the State has become more of a gatekeeper, monitoring expenditures and implementing cutbacks in services and layoffs of personnel. The economic underpinnings of this have been addressed through radical perspectives on the State and economy. Here, however, significant disagreements on State theory and political practice emerge within those viewing the State critically. The extent to which alternative health care systems can emerge alongside traditional ones is a cardinal issue.⁵⁸ Some have pointed to a cultural critique of organized medicine and high technology health care. Others see cultural reactions as flowing from structural features of the economy. Structuralism cannot be equated with predetermined relations, however, for a structuralist premise is that the State remains "relatively autonomous". The State is responsive to various sectors but nevertheless uses its semi-autonomous powers to secure the interests of powerful groupings, among them the medical profession.

Theoretical and empirical studies of midwifery illustrate the nature of State intervention in restructuring health care occupations and suppressing the controversy over alternative maternity care. It will be argued that the State is not a neutral party in the controversy, but that it retains a level of relative autonomy from the contesting parties.

⁵⁷ The value of these "ginger groups" (pressure groups) is articulated in Doris Lessing, "Prisons We Choose to Live In", *The Canadian Forum*, 1986, 65(754), p. 15.

⁵⁸ See for example Donald E. Mills and Donald E. Larsen, "The Professionalization of Canadian Chiropractic" in D. Coburn et al., (eds.), *Health and Canadian Society: Sociological Perspectives*, 1986, Toronto, Fitzhenry and Whiteside, pp. 237-250.

The Midwifery Movement and the Canadian State

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

The historical depiction of midwives has been stereotypical: witch, harridan, meddling woman.⁵⁹ A closer look at contemporary midwives in B.C. indicates that they are not easily stereotyped: midwives vary in experience, professional training, and philosophies of birthing and politics.

There are however several points of agreement among midwives. First, there seems to be a general agreement that pregnancy is not synonymous with illness. Morbid situations will develop, but birth can generally be managed skillfully and safely without current levels of obstetrical intervention (often recast as obstetrical interference). Second, it is recognized that the midwife can operate more autonomously than is currently provided under provincial law (which requires the direction of a physician, or his/her delegation of responsibility where applicable). The dependent status of midwives is thus generally seen as artificial. This perception is often linked with the economic interest of physicians in attending birth and the sense of control that some physicians (especially male physicians) prefer to employ over parturient patients and the nursing staff that assist doctors in childbirth care.⁶⁰ Third, women's right to be informed and to make decisions about maternity care is vital to the midwifery debate. Fourth, a sense of iatrogenic (physician-related damage) practice is often

⁵⁹ See for example, Jean Donnison, *Midwives and Medical Men: A History of Inter-professional Rivalries and Women's Rights*, 1977, London, Heinemann; Joan Biggar, "When midwives were witches - white ones of course: A look at Maternity Care in the Middle Ages", *Nursing Mirror and Midwives' Journal*, 1972, 134(21), pp. 37-39.

⁶⁰ Suzann Buckley, "Ladies or Midwives? Efforts to Reduce Infant and Maternal Mortality" in Linda Kealey (ed.), *A Not Unreasonable Claim: Women and Reform in Canada, 1880s-1920s*, 1979, Toronto, The Women's Press, pp. 131-149.

brought forward. Reliance on such procedures as the lithotomy (prone) delivery position, drugs to induce labour and to relieve pain, lack of continuity of care (throughout the prenatal period, labour, delivery, and postpartum), and the overarching ideology that birth is a *medical* event, are seen as contributing to substandard maternity care.

Differences within the movement occur at various points. First, there is an ongoing debate over the importance of nursing training as prerequisite to midwifery training. Others favour direct entry into midwifery that incorporates some aspects of orthodox nursing curricula, while others maintain that formal criteria are not a necessary condition for midwifery practice. Second, there has been a movement toward establishing guidelines (or standards) for practice. Most midwives' associations have developed guidelines for practice. These guidelines may require that members do not manage breech presentations or twins at home, that women are to be transferred to hospital if their amniotic fluid is discoloured (this may be a sign of fetal distress) or if the fetal heart rate falls or rises sharply, and so forth. A few midwives believe that such contraindications to midwifery management are unnecessary controls on the midwife's judgement. Another point of disagreement involves the necessity of midwives working with physicians and the delegation of ultimate responsibility for maternal and infant welfare to physicians. The traditional division of responsibility between nurses and physicians involves delegation of primary responsibility to the physician.⁶¹ A counter-position is that midwives can work independently of physicians, at least in cases of uncomplicated deliveries.⁶²

The author's fieldwork on midwifery in British Columbia allows a few impressions on the sources of support for community midwives. First, community midwives are able to avail

⁶¹ For an example of this with respect to domiciliary births, see College of Nurses of Ontario, "Guidelines for Registered Nurses Providing Care to Individuals and Families Seeking Alternatives to Childbirth in a Hospital Setting", 1983, Toronto, College of Nurses of Ontario, (Typescript mimeo).

⁶² Vicki van Wagner, "The Current Politics of Midwifery in Ontario", Paper Presented at the 20th Annual Meetings of the Canadian Sociology and Anthropology Association, University of Guelph, 1984.

themselves of a variety of resources in conducting their work. There are legal resources available to them through legal advice, sometimes connected with litigation, and sometimes not. Likewise, there are legal defences available to midwife-defendants. As demonstrated by recent criminal prosecutions of the Halifax midwives and the birth attendant in Victoria (see below), these defences have been successfully employed against criminal charges. The various court-situated contests over midwifery and birth-related issues have been accompanied by some political support from opposition parties. In Ontario and British Columbia, for example, the provincial New Democratic Parties - through caucus or private member's bills - have supported the legalization of midwifery in their provinces.⁶³ The National Action Status on the Committee of Women also passed a resolution in 1984 in support of midwifery legalization in Canada.⁶⁴ Second, many practicing midwives are aided by the material and emotional support of "significant others" - spouses, other midwives, neighbours, family members - which allows them to practice midwifery alongside other responsibilities of income, child care, and the like. Third, resources can be mobilized if a midwife is threatened with legal action. In one instance recounted to the author by a Lower Mainland midwife, the threat of prosecution for the unlawful practice of midwifery under the *Medical Practitioners Act* was not followed through, ostensibly because as a politicized midwife she was prepared to muster considerable support in defence of community midwifery.⁶⁵

Fourth, midwives do work in conjunction with sympathetic physicians and other personnel with respect to back-up and transfers of women into hospital. Fifth, midwives do utilize various forms of medical technology (oxygen for resuscitation, sutures for tears) and a variety of communications devices (the ordinary telephone, message recorders, "beepers") to

⁶³ Dave Cooke, "Government Should Recognize Midwifery", *N.D.P. News*, December 4, 1984, p. 30; Robert Stephens, "Ontario midwives merit legal status, NDPer says", *The Globe and Mail*, March 16, 1984, p. 4.

⁶⁴ Lois Sweet, "Midwives are Battling for their Freedom", *The Toronto Star*, April 8, 1985, p. C1.

⁶⁵ This episode is outlined in Chapter Five. See also Brian Burtch, "Community Midwifery and State Measures", *Contemporary Crises*, 1987 (in press).

contact other midwives, clients, and so forth.

Community midwives have also developed the resource of media exposure, through letter-writing campaigns to newspapers and contributions to such periodicals as *The Maternal Health News*. Increased income is another resource. Fee increases for birth attendance are especially important in light of the relatively low incomes generated by community midwifery and the economic strain on family earnings. Apparently, the "service" orientation of the mid-1970s has been succeeded by higher fees (approximately \$600 for prenatal, labour and delivery, and postnatal care).

These resources must be placed in a larger context of midwifery containment. Community midwives are liable to quasi-criminal prosecution for the unlawful practice of midwifery, they are occasionally faced with the real possibility of criminal prosecution, their personal incomes are far below that of physicians and below that of obstetrical nurses working full-time. Nurse-midwives face constraints in existing law and the policy position of their College and the College of Physicians and Surgeons. Recent initiatives to practice midwifery on a more autonomous footing required the unpaid involvement of nursing professionals on the Low Risk Clinic in Vancouver. There has also been a reluctance to recognize midwives as midwives (since midwifery is seen as a physician's monopoly under current legislation); at one point recently there was an unsuccessful attempt to define trained midwives as "primary care perinatal nurses".

The practice of midwifery is, for the most part, both constrained and facilitated through its legal status. A key element in the involvement of the State - through its legal powers - in what was previously a localized, neighbourhood event in North America, has been the assumption that midwifery practice is intrinsically more hazardous than physicians' attendance. A related assumption is that midwives require supervision by physicians, although legislation such as the 1902 *Midwives' Act* in England has established a basis for self-regulation by midwives to a considerable degree. A second assumption is that legal constraints on midwives

emerge from a public consensus on the appropriateness of restricted birth practices. ⁶⁶

Unlawful Practice of Medicine: Quasi-Criminal Law

The customary assistance of women in childbirth has generally been replaced by a professional monopoly on birth attendance. In 19th century Ontario, for instance, the right to practice midwifery (independently of physic or surgery) was eventually restricted to medical practitioners. ⁶⁷ Enforcement was problematic at this time due to the limited number of doctors and the lack of doctors in what was then a predominantly rural region. Nevertheless, section 49 of the Ontario *Medical Act* held that: ⁶⁸

"It shall not be lawful for any person not registered to practise medicine, surgery or midwifery for hire, gain, or hope of reward, and if any person not registered pursuant to this Act, for hire, gain or hope of reward practices or professes to practice medicine, surgery or midwifery, or advertises to give advice in medicine, surgery, or midwifery, he shall, upon summary conviction thereof before any Justice of the Peace, for every such offence, pay a penalty not exceeding \$100 nor less than \$25."

An important qualification at this point in legal regulation was that the alleged illegal practices must encroach on medical practice, and that isolated episodes would not sustain a conviction. As Garrow, J.A. indicated: ⁶⁹

"The thing practised must, to be illegal, be an invasion of similar things taught and practised by the regular practitioner, otherwise it does not affect the monopoly, and is outside the statute. And it must be practised as the regular practitioner would do it - that is, for gain, and after diagnosis and advice. And it must be more than a mere isolated instance, which is sufficient to prove a 'practise'".

⁶⁶ There is little evidence that women are largely favourable to the elimination of midwifery services or great limitations on midwifery practice. See for example Peter Howitz and Jytte Ussing, "(Delivery at Home or at an Institution? An Analysis of the preferences of 5,240 Danish women concerning the place of delivery)", *Ugeskrift For Laeger*, 1978, 140(26), pp. 1569-1573.

⁶⁷ The takeover of birth attendance was not so one-dimensional. The *right* of women to practice midwifery without a license was recognized in the first legislation passed in Upper Canada. See Biggs, op cit.

⁶⁸ Biggs, op cit.

⁶⁹ Re Ontario Medical Act, 1906, p. 513.

The obligation to prove more than a single act had been upheld in a number of precedents. The conviction of a Toronto midwife under section 49 of the *Ontario Medical Act* was reversed on appeal. The Appeal Court found that the Crown had not established that the midwife had practised medicine on more than one occasion, and further that she had not always received financial gain through her actions.⁷⁰ The necessity to prove that financial gain was received and that the illegal practice of medicine occurred repeatedly was crucial in the acquittal of another accused person.⁷¹ The judge held:

"Before an accused person can be convicted of falsely pretending to heal the sick, it is necessary that it be shown that the accused was in the habit of so pretending, or at least that there had been continuous treatment, the principle being the same as practising medicine for gain or hope of reward. An isolated case is not sufficient to secure a conviction".

A subsequent decision by Justice Simmons confirmed that a single act does not constitute the practise of medicine or a trade.⁷²

Nonetheless, as the State has deliberated over birth-related law, this criterion for an offence has been broadened. In Ontario, the common law rule that "practice" implied repetition of the offending act was altered. A single act was deemed sufficient to establish the practice of medicine. Nevertheless, the prosecution of midwives was not always successful. One criminal conviction of a midwife in the Northwest Territories was quashed on appeal. The Court held that section 60 of the *Medical Profession Ordinance* did not include "midwifery" as a form of practice to be covered along with "medicine" and "surgery". Since section 60 had been composed with reference to the earlier Ontario Medical Act – which prohibited midwifery, medical, and surgical practice by unregistered persons – the Court reversed the conviction.⁷³

⁷⁰ Regina v. Whelan, (1900) 4 *Canadian Criminal Cases*, p. 277 [Ontario].

⁷¹ Regina v. Armstrong, (1911) 18 *Canadian Criminal Cases*, p. 72 [Saskatchewan].

⁷² Regina v. Cruickshanks 6 *Western Weekly Reports*, 1914, p. 524; *Alberta Law Reports*, 92; 23 *Canadian Criminal Cases* p. 23; 16 *Dominion Law Reports*, 536 [Court of Appeal].

⁷³ Regina v. Rondeau, 5 *Territories Law Reports*, pp. 478–483.

Legal prohibitions on the practice of medicine thus serve to protect unregistered practitioners to a degree. In another case, an orderly accused of practising midwifery and with practising medicine, both for "hope of reward", was acquitted on both counts. The court held that the accused orderly had assisted a woman following delivery when no doctor was available to her; that is, he acted under emergency circumstances and did not attempt to charge for his attendance. On the second count, although the accused had on two occasions filled in blank prescription forms, taken patients' temperatures, and given instructions as to treatment, there was no proof of payment or a request for payment by the orderly. ⁷⁴

The corollary is also true: persons practising medicine on more than one occasion and seeking payment for their advice could be convicted. ⁷⁵ About two decades later, in a case heard in Saskatchewan, Justice Trant declared that the rights of unregistered practitioners are limited and sharply defined. They must not offer diagnosis, give advice, or prescribe medicines. ⁷⁶

The practice of midwifery in British Columbia is legally protected as the bailiwick of medical practitioners. Section 72 of the British Columbia *Medical Practitioners Act* stipulates that:

- "(1) A person who practices or offers to practice medicine while not registered or while suspended from practice under this Act commits an offence.
(2) For the purposes of and without restricting the generality of subsection (1), a person practices medicine who... (d) prescribes or administers a treatment or performs surgery, midwifery or an operation or manipulation, or supplies or applies an apparatus or appliance for the cure, treatment or prevention of a human disease, ailment, deformity, defect or injury.... [emphasis added]".

⁷⁴ Regina v. Ornavowski 1, *Western Weekly Reports*, (1941), p. 103 (Saskatchewan).

⁷⁵ Provincial Medical Board v. Bond (1890), 22 N.S.R. 153 (C.A.). The County Court decided in favour of the defendant following a charge under the *Medicine and Surgery Act* of 1884. The defendant had treated people with plaster and given advice on the use of poultices for people suffering from tumours and cancer. On appeal, however, the initial judgement was reversed: a penalty of \$20 for one day's practicing and court costs were imposed on the defendant.

⁷⁶ Regina v. Raffenberg 12 *Western Law Reports* (1909), p. 419.

Again, it is important to note that alternative practitioners may be acquitted on charges of unregistered practice of medicine. In *Wong* the court held that the art of acupuncture was not recognized as a branch of *medicine* by the Alberta College of Physicians and Surgeons. Moreover, acupuncture was not taught in North American *medical* education.⁷⁷ A later conviction of an acupuncturist in B.C. occurred despite the reasoning in *Wong*. It was held that the defendant had violated the B.C. *Medical Practitioners Act*.

Under section 83 of the *Medical Practitioners Act*, the minimum penalty for a first offence of practicing medicine or midwifery is \$100 or imprisonment (section 87). It is set at \$300 or imprisonment for a second conviction, and imprisonment for a third or subsequent conviction. It must be kept in mind that the court has the power to dismiss charges against defendants when the information is insufficient. In one instance where a defendant was charged under the British Columbia Medical Act the information alleging the unlawful practice of medicine was quashed since it failed to set forth the act or acts constituting the alleged offences and failed to name the persons with whom the defendant was alleged to have unlawfully practised medicine⁷⁸

Under section 73 there are several exceptions to the broad ambit of medical practice set out under section 72. The following practitioners do not practice unlawfully while registered under their respective Acts: chiropractors, dentists, naturopaths, optometrists, pharmacists, podiatrists, psychologists, nurses, and dental technicians. Orthoptic technicians, physiotherapists, and dieticians may also be exempt from section 72. The legal standing of these practitioners, and their self-regulation through professional associations reinforces, qualifies the purely instrumentalist approach to medicine as an elite profession that is able to monopolize health services. Emergency procedures are permitted under the *Health Emergency Act*. Domestic administration of family remedies is permitted, and religious practitioners "...who

⁷⁷ Regina v. Wong (1979) 6 *Western Weekly Reports* (Provincial Court), p. 163.

⁷⁸ See Regina v. Kripps (1977) 4 *British Columbia, Law Reports*, (Provincial Court) 364.

practise the religious tenets of their church without pretending a knowledge of medicine or surgery" are exempted under section 74 of the Act.

Liabilities associated with childbirth become even more complex when one considers the liabilities of parents. In the United States the parents' duty of care has traditionally begun with the birth of the child: there has been no obligation on the part of the mother, for instance, to seek medical assistance prior to the birth of a child. Nevertheless, there appears to be a shift in legal opinion whereby "parental" failure to obtain medical care in circumstances where such care is clearly warranted ought to be culpable.⁷⁹ Parental liability is also at issue with respect to responsibility surrounding midwifery attendance in jurisdictions where it is illegal. One midwife stated that the choice of a birth setting - and, by extension, the choice of birth attendants - is the responsibility of the expectant mother.⁸⁰ A number of prenatal documents examined by the researcher also contained a waiver, signed by the mother (and father, where applicable), which did not hold the midwife legally responsible. Members of the Fremont Birth Clinic linked their philosophy of parental responsibility and decision-making with a non-hierarchical approach to birth management:⁸¹

"Working as a team throughout pregnancy and labor, prospective parents and workers all share in the responsibility for the situation. The woman who is pregnant or in labor, and her support people, are the ones who ultimately make the decisions about what to do, how to proceed. Especially because we're not certified in any way, we're concerned that people analyze their level of comfort working with us. We encourage people to educate themselves as much as possible, consult the statistics we have kept, ask us lots of questions, talk to others who have experienced obstetrical care in other settings, and to make conscious decisions to really think about what they want and to make intelligent judgements".

⁷⁹ For a review of American litigation on this point see George Annas, "Legal Aspects of Homebirths and Other Childbirth Alternatives", in David Stewart and Lee Stewart (eds.), *Safe Alternatives in Childbirth*, 1977, Chapel Hill, NAPSAC, p. 180.

⁸⁰ Sandra Klein, *A Childbirth Manual*, 1980, Victoria, British Columbia (Typescript mimeo).

⁸¹ Fremont Birth Collective, "Lay Midwifery - Still an 'Illegal' Profession", *Women and Health*, 1977, 2 (3), pp. 19-27.

On another level, legal actions are conventionally brought against the birth attendant, not the expectant mother. This locus of responsibility avoids a direct confrontation with parental rights, at the same time locating the legal conflict as essentially a property dispute pertaining to occupational licensure. Legal protections for unborn children have also been strengthened. In Canada and in other industrialized countries the unborn child has been vested with certain rights. As mentioned below, the *Marsh* case in British Columbia included a decision that a child at term — but not expelled from the mother — was a person and entitled to protection. As the "human status" of the infant has been secured,⁸² there appears to be a rise in litigation in the event of injury or death to fetuses or infants.

The conjuncture of medical knowledge and legal protection of medical practice is best suited to the structural motif of power. The mechanics of touch, palpation, measuring, and viewing of the pregnant woman or fetus have become centred in hospital-based obstetrics, and other forms of practice have been largely excluded. Professional interests are thus protected, even as there has been some erosion of the monopoly status of physicians under quasi-criminal statutes.

Criminal Prosecution of Birth Attendants

The *Canadian Criminal Code* stipulates that criminal negligence occurs when a person, either through commission or omission, shows wanton or reckless disregard for the lives or safety of other persons. The omission or commission must be associated with something that is his or her duty to do. Section 203, "Causing Death By Criminal Negligence", states:⁸³

"Every one who by criminal negligence causes death to another person is guilty of an indictable offence and is liable to imprisonment for life."

⁸² See Dana Raphael, "Matresence, Becoming a Mother, a 'New/Old' Rite de Passage" in D. Raphael (ed.), *Being Female*, op cit., p. 67.

⁸³ *Martin's Annual Criminal Code*, Toronto, Carswell, 1984, p. 212.

The criminal prosecution of midwives, while less prevalent than civil actions launched against midwives, is nonetheless crucial to an understanding of legal encumbrances on midwives: criminal prosecution carries the possibility of severe dispositions, including life imprisonment in Canada in cases involving criminal negligence causing death.⁸⁴ Criminal actions against midwives have increased as home birth has become more prominent since the mid-1970s. The three recent cases outlined below involve an ex-physician and two midwives. No other reported cases of criminal prosecution of non-physician birth attendants were found in the search of legal cases or cases cited by the trial lawyers.

Regina versus Marsh (1979)

A major trial concerning home birth attendance in British Columbia is the prosecution and acquittal of a spiritual healer (and former doctor) on a charge of criminal negligence causing death. In *Marsh* an infant death was attributed to cerebral haemorrhage due to a tear in the tentorium of the skull. This tear was in turn associated with malpresentation of the fetus at term.⁸⁵ The legal actions which followed this infant death were two-fold. First, a charge of criminal negligence causing death was laid against the birth attendant, a former physician who had been dropped from the rolls of the College of Physicians and Surgeons of British Columbia. Second, following her acquittal of the above charge, a quasi-criminal charge of *Practicing Medicine Without a License* – a contravention of the British Columbia *Medical Practitioners Act* was successfully brought against the defendant.⁸⁶

In his "Reasons for Judgement" Judge Millward concluded:⁸⁷

⁸⁴ The three main classifications of criminal negligence in Canada are criminal negligence causing death (section 203), bodily harm (section 204), and in the operation of a motor vehicle (section 206). See Paul Bourque, "Proof of the Cause of Death in a Prosecution for Criminal Negligence Causing Death", *The Criminal Law Quarterly*, 1980, 22 (3), pp. 334-343.

⁸⁵ Regina v. Marsh (1979)

⁸⁶ Greg McIntyre, "Midwives Ask for Sanction of Law", *The Province*, February 18, 1983.

⁸⁷ Peter Millward, "Reasons for Judgement", Regina v. Marsh 1980, Victoria, County Court of British Columbia.

"...Mrs. Marsh first became aware of the unusual and dangerous position of the child when the first foot appeared. By then, the evidence clearly shows it was too late to save the child from the injury that it suffered, or at least on the evidence, it is most unlikely, given the situation, that is a lack of skilled personnel present, the distance in time and space from the hospital, and the lack of any previous arrangements having been made ...On that finding, and with reference to the acts or omissions of Mrs. Marsh from the point in time when the foot first emerged, there cannot be a finding of criminal negligence causing death arising out of those acts or omissions, and accordingly, if any criminal liability is to be attached, it must be found in her acts or omissions prior to that point in time.... a most important point, in my view, is that there is no evidence whatever of any doubt, in the mind of Mrs. Marsh as to the position of the child at that point.

Accordingly, while Mrs. Marsh may have been incompetent, yet I am faced with the evidence of eminent authorities called both by the Crown and by the Defence, to the effect that even the most expert and experienced practitioners do make mistakes from time to time in detecting the position of fetuses in circumstances similar to those which were obtained here.

I am faced with that clear evidence and a total lack of any positive evidence of a wanton or willful disregard. I am unable to conclude that any act or omission of Mrs. Marsh, prior to the emergence of the foot was indeed negligent, and certainly I am unable to conclude that it was criminally negligent."

A key decision in the *Marsh* trial involved whether an infant at term, but not yet expelled from the mother, could be deemed a "person" for purposes of the *Criminal Code*. In an earlier case,⁸⁸ an award for the loss of a child not born alive was denied. In the judgement, a human being was described as an entity which has proceeded completely out of the mother's body.⁸⁹ In *Marsh*, Judge Millward held that a fetus at term, but not yet expelled, could be considered as a person for purposes of the *Criminal Code*.⁹⁰

"The essential nature of the organism, that is the fetus, is not changed by the fact of birth, and to hold that prebirth criminal negligence causing death of a fetus immediately after birth is an indictable offence, while similar negligence causing death immediately before delivery is not criminal, is not a conclusion that accords well with the concept that the State has a duty to protect unborn children and to preserve their

⁸⁸ *Lavoie v. Cite de Riviere-du-Loup et Autre* (1955) C.S. 452 (1955) (Quebec S.C.).

⁸⁹ Glanville Williams also spoke of the "conditional legal personality" of the unborn child, and that claims of defendants for negligence injuring unborn children crystallize after the child-plaintiff is born alive. See Alec Samuels, "Injuries to Unborn Children", *Alberta Law Review*, 1974, 12, p. 266.

⁹⁰ Reasons for Judgement of His Honour Judge Millward, *Regina v. Margaret Lillian Marsh*, County Court of Vancouver Island, November 7, 1979, pp. 14-15 (trial transcript).

opportunities to be born and to enjoy the rights and obligations normally incident to the status of human kind."

Regina versus Carpenter et al. (1983)

Since the 1980 decision in *Marsh*, three midwives faced criminal prosecution in Halifax. The three defendants were charged with criminal negligence causing bodily harm on January 27, 1983 following the transfer of an infant to hospital. This charge was later raised to criminal negligence causing death in the summer of 1983, a few weeks after the infant's life support system was disconnected.

At the preliminary inquiry to determine whether the defendants would be brought to trial, Judge Gunn decided that the women would not be brought to trial due to lack of evidence. Witnesses at the preliminary inquiry made three key observations: first, that the infant suffered a hemorrhage to the portion of her brain that governed breathing; second, that this injury was not attributable to the midwives' care; and third, that similar injuries have been noted among babies delivered in hospital settings under medical care. ⁹¹

Regina versus Lemay and Sullivan (1986)

Two Vancouver midwives were charged with criminal negligence causing death, assault, and other charges following the death of a baby girl on May 3, 1985 in Vancouver. These charges followed the transfer of a mother and unborn child to hospital following an attempted delivery of a shoulder dystocia. This situation in which the oblique diameter of the pelvic inlet is smaller than the bisacromial diameter - is regarded as an "obstetric emergency" along with other forms of dystocia. ⁹²

⁹¹ Alternative Birth Crisis Coalition, "News Analysis - Canada: Midwives on Trial", *ABCC News*, 1984, 111 (3), pp. 3-4.

⁹² See Jensen et al., op cit., pp. 492 and 505.

As expected, the parents were reported to be supportive of the attending midwives.⁹³ In contrast to other cases, however, the two midwife-defendants were found guilty on the charge of criminal negligence causing death. The midwives were ordered to perform community service, to refrain from attending births, and to be on probation for two years. Expert witnesses called by the Crown were critical of their management of the birth, and the trial judge encouraged greater regulation of midwifery practice in British Columbia.

Inquests into Infant Deaths

The McLaughlin-Harris Inquest (1984)

The death of Daniel McLaughlin-Harris in October 1984 in Toronto, Ontario was followed by a provincial inquest into the infant's death. Two midwives had attended the mother in labour at a Toronto Island residence. The baby was born asphyxiated and transported to The Hospital for Sick Children by one of the midwives. The inquest dealt with the viability of midwifery as an independent profession, along with the causes of the infant's death.

The Coroner's jury made several recommendations to alter the status of midwifery in Ontario. First, it was recommended that the Ontario Health Disciplines Act be rewritten to specify what constitutes midwifery practice and strict penalties for illegal practice be provided for practice outside the Act. Second, that midwifery should be undertaken as a specialty practice under the College of Nurses of Ontario; after five years, an independent College of midwives should be established. Third, that midwifery training should be set at international standards and taught at accredited post-secondary institutions. It would require at least two years' midwifery training and a year of general nursing. Fourth, that licenced midwives should be given hospital privileges in maternity wards. Fifth, that the Ontario Health Insurance Plan

⁹³ Sullivan-LeMay Legal Action Fund, "Bulletin and Trial Update", Vancouver, B.C., September 1986.

coverage should be available for midwives and that malpractice insurance should be compulsory. Sixth, that birthing centres should be established in hospitals. Seventh, that the option of home birth attendance should be available within the Ontario health care system. Finally, that the College of Physicians and Surgeons should establish safety standards for home births. Doctors should be free from censure by their colleagues if they attend home births. ⁹⁴

Criminal Negligence and Physicians

Canadian case law reveals few instances in which charges of criminal negligence causing death have been brought against doctors attending births. There are cases involving illegal abortions, for example, but a search of Canadian legal periodical indexes, and discussion with trial lawyers, did not yield many instances of physicians tried for birth-related criminal matters.

In *Simard* the conviction of a physician for criminal negligence was quashed on appeal to the Quebec Court of Queen's Bench. The newborn child died of a cerebral haemorrhage a few days following delivery by forceps. Nevertheless, the Appeal Judges clearly felt that the facts of the case did not warrant the jury finding of guilt. These facts included the wish of the mother to not be delivered in a hospital but rather at a clinic, her failure to follow Dr. Simard's suggestion of an X-ray for suspected cephalo-pelvic disproportion, and the mother's departure from the birth setting against the doctor's advice. The Court also accepted expert testimony vindicating the use of chloroform and forceps and rejected contrary opinion on this point. ⁹⁵

⁹⁴ Anne Besharaw, "Jury recommends legalization, recognition of midwifery in Ontario", *The Canadian Nurse*, September 1985, p. 11.

⁹⁵ *Simard v. The Queen* 43 *Criminal Reports* (Canada), 1964, pp. 70-82. It seems that deaths of infants in hospital or clinic settings with attendance by medical or nursing personnel are generally followed by internal hospital reviews. In some instances physicians may lose their hospital privileges or be struck from the College rolls. In few cases, however, are physicians

A subsequent case in which a physician was convicted of criminal negligence causing death arose out of the death of a child. The young boy had been put on a very low protein diet for treatment of a skin condition. The boy lost weight and died in hospital due to gross malnutrition. In dismissing an Appeal by the accused, the principle of competency required by law was reaffirmed: ⁹⁶

"In enacting s. 187, Parliament has imposed a legal duty upon every one who undertakes to administer medical treatment. Included in that legal duty is to have 'reasonable knowledge' in doing so. The essence of that 'reasonable knowledge' was that a physician (which Rogers was) should have foreseen the harmful consequences of depriving the child of proteins and calories in the circumstances. Regardless of his personal theories, Rogers was under a duty to have that foresight. It was, therefore, irrelevant for the jury to consider Rogers' own belief that his diet was a beneficial treatment."

Civil Suits against Birth Attendants

Malpractice suits against physicians are proportionately smaller (on a *per capita* basis) in Canada than in the United States. While 20,000 malpractice suits were launched in the United States in one year, only 200 to 300 were initiated in Canada. ⁹⁷ Another author, using data from the Canadian Medical Protective Association, reported that between 1966 and 1970 the number of monetary settlements against its members averaged 18 per year; in 1971, only 22 monetary settlements resulted from 131 writs against its members. ⁹⁸

In a 1981 case following hypoxia of an infant in a Vancouver hospital, a provincial Supreme Court Justice ordered payment of unspecified damages to the family. The nursing

⁹⁵(cont'd) faced with criminal charges.

⁹⁶ Regina v. Rogers, (1968) 4 *Canadian Criminal Cases*, p. 299.

⁹⁷ David Coburn, "Patients' Rights: A New Deal in Health Care", *The Canadian Forum*, 1980, 60 (699), p. 14.

⁹⁸ Ronald MacIsaac, "Negligence Actions Against Medical Doctors", *Chitty's Law Journal*, 1976, 24 (6), p. 204.

care afforded the mother was deemed below the expected standard of care and the attending physician failed to establish the progress of labour before prescribing pain killers. Lack of suctioning equipment in the emergency bundle and the absence of attending staff for a 30-minute period while the woman plaintiff was in labour were other factors in the decision.

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Coburn suggests that judges in Canada are generally sympathetic to physicians because of a common status.¹⁰⁰ This notion of class affinity is developed further with respect to the British judiciary and the Canadian judiciary.¹⁰¹ At the same time, there is little evidence of civil suits launched against community midwives by their "clients". It is noteworthy, however, that as American nurse-midwives have become established as professionals in institutional (hospital and clinic) settings, they are now increasingly subject to malpractice actions.¹⁰²

Conclusion

There is ample evidence that dominant groups invoke their powers to exclude competing groups. The State is central to these exclusory attempts. It has the power to criminalize behaviour, to adjudicate civil matters, and to direct its financial resources to specific groups.

¹⁰³ Hospital-based birth attendance is either directed by physicians or, less commonly, responsibility may be delegated to nursing personnel. Physicians' incomes (on average) remain well above average incomes for North Americans, while as a rule midwives' incomes are

⁹⁹ "Grace Hospital, doctor faulted in baby's birth", *The Vancouver Sun*, April 7, 1981, pp. A1-A2.

¹⁰⁰ Coburn, op cit.

¹⁰¹ See Miliband, op cit.; and Dennis Olsen, *The State Elite*, 1980, Toronto, McClelland and Stewart.

¹⁰² Gail Sinquefield, "A Malpractice Dilemma: Defining Standards of Care for Certified Nurse-Midwives", *Journal of Nurse-Midwifery*, 1983, 28 (4), pp. 1-2.

¹⁰³ For a critique of Parkin's theories of exclusory tactics see Anthony Giddens, *Profiles and Critiques in Social Theory*, 1982, Berkeley, University of California Press.

markedly lower, especially with respect to community midwifery. Concern has also been expressed over patriarchy in law,¹⁰⁴ not only in the struggle for the legalization of midwifery, but also in the regulation of other conflicts surrounding human reproduction.¹⁰⁵

Community midwifery in British Columbia and other regions is a concrete instance of resistance to medical dominance in managing childbirth and providing prenatal and postnatal care. As noted above, attempts to use the courts to prosecute midwives under the *Criminal Code* have not always been successful. Even quasi-judicial hearings such as Coroners' inquests do not automatically reinforce the authority of medical control over birth: two recent coroners' inquiries in Ontario recommended legal recognition of midwives and the establishment of a provincial School of Midwifery.¹⁰⁶

Legal struggles and the continuing dominance of physician authority in Canadian maternity care touch directly on the criticism of Western legal ideology for the adherence to formal, abstract equality of citizens despite substantive inequalities before the law.¹⁰⁷ Some socialist writers, while acknowledging the role of law in perpetuating inequality, have favoured the *use* of law as a form of political struggle.¹⁰⁸ In the health sector, some have favoured

¹⁰⁴ Patriarchy has been defined as "...a specific organization of the family and society, in which heads of families controlled not only the reproductive labor, but also the production of all family members". See Gordon and Hunter, *op cit.*, p. 12.

¹⁰⁵ See Shelley A.M. Gavigan, "The Criminal Sanction as it relates to human reproduction", *Journal of Legal History*, 1984, 5(1), pp. 20-43.

¹⁰⁶ Ontario Association of Midwives and the Nurse Midwives Association of Ontario, Brief on Midwifery Care in Ontario, 1983, Toronto, Ontario; Brief submitted to the Health Disciplines Review Committee [Typescript mimeo]. As indicated above, these constraints have been challenged by more autonomous midwifery projects in hospital and domiciliary settings, and there are contradictory decisions in criminal and quasi-criminal actions against birth attendants.

¹⁰⁷ Isaac Balbus, "Commodity Form and Legal Form: An Essay on the 'Relative Autonomy' of Law", *Law and Society Review*, 1978, 2, pp. 571-588.

¹⁰⁸ If midwifery is taken as one instance of a "rights struggle", then struggles for such rights as the right to abortion, prisoners' rights, redress of racial and sexual discrimination, and so forth are to be encouraged. The importance of such "rights struggles" and the democratization of the State have been articulated in maternity care, by many socialist writers. See for example: Colin Sumner, "The Rule of Law and Civil Rights in Contemporary Marxist Theory", *Kapitalistate*, #9, pp. 63-91; Piers Beirne and Robert Sharlet (eds.),

"democratic relativism" as a means of protecting unorthodox forms of medicine and healing, thereby permitting comparisons of the various forms of health care.¹⁰⁹ These struggles in maternity care should not overshadow the continuing protection of professional attendance and medical dominance in the Canadian context and elsewhere.

A key consideration is to determine when midwifery practice is demonstrably as safe as (or safer than) conventional physician-managed, deliveries and when it may be more hazardous. This issue is addressed directly in Chapter Five. A related point concerns the role of the State in promoting or containing midwifery initiatives. Laws that largely buttress the professional dominance of obstetricians and general practitioners are one case in point. By vesting policing powers with the Medical Colleges, and through the occasional prosecution of alternative practitioners, the implementation of safe, pluralistic maternity care services remains greatly constrained.

The constraints on midwifery practice should not however overshadow the role of the midwifery and nursing professions in various countries in lobbying for recognition and resources. As set out in the discussion of nurse-midwifery and community midwifery, support has emerged from within the state and within the professions for implementation of midwifery services. Reconceptualizing midwifery as governed by the State also requires greater attention to the resources provided through the State. One of the difficulties with the oppositional ideology that appears among some community midwives is the bold line drawn between natural childbirth and obstetrical intervention, between spiritualism and science, and between home and hospital. The machinery of the State can be seen as emerging from popular concerns over safety and welfare, not simply from the logic of capital or the interests of specific professions.

¹⁰⁸(cont'd) *Pashukanis: Selected Writings on Marxism and Law*, 1980, London, Academic Press.

¹⁰⁹ Paul Feyerabend, "Democracy, Elitism, and Scientific Method", *Inquiry*, 1980, 23 (1), pp. 3-18. *Implementation* of pluralism has not been secured in Western public policy. See Kenneth McRae, "The Plural Society and the Western Political Tradition", *Canadian Journal of Political Science*, 1979, 12 (4), pp. 675-689.

The instrumentalist portrait of the State is further qualified by the requirements of due process and procedural rules. A variety of enactments including the Charter of Rights and Freedoms can and have been used to offset the potentially absolute powers of the State. Relevant to an understanding midwifery practice, the law of evidence and judicial rulings have generally not been helpful in prosecuting community midwives for criminal negligence causing death. Also, despite the hegemonic powers exercised by the State and the professions, the midwifery movement continues a tradition of collective self-help and opposition to professional control in health care. The State may attempt to "colonize all forms of existence" ¹¹⁰ but this attempt is not wholly successful.

Chapter Three provides additional information on diversity of childbirth practices, including the status of midwives in global perspective. An important dimension that connects State theory with cross-cultural and historical materials is the need for *specificity*. Within liberal democracies there are countries such as Canada which have promoted an outlaw status for midwives, while other democracies have supported direct entry training of midwives and a broader sphere of practice for trained midwives active in Canadian hospitals. The theme of the relative autonomy of the State, evident in clashes within the Canadian courts and within legislatures, and also evident in this global perspective, captures the structuralists' premise that the State is used to contain initiatives from relatively powerless groups. This containment objective is nonetheless subject to change, and the sources of change emerge not only in Civil Society but within the very framework of the State. This is an apt theme in the Canadian context: whereas the monopoly status of medicine in childbirth reflects an instrumentalist perspective, there is evidence that the medical thrall is diminishing in North America as other health professions demand legal status. ¹¹¹

¹¹⁰ Stuart Ewan, "Charlie Manson and the Family: Authoritarianism and the Bourgeois Conception of 'Utopia': Some Thoughts on Charlie Manson and the Fantasy of the *Id*", *Working Paper in Cultural Studies*, Centre for Contemporary Cultural Studies, Birmingham, 1972, Volume 3, pp. 33-45.

¹¹¹ David Starr, "Medicine and the Waning of Professional Sovereignty", *Daedalus*, 1978, 107(1), 175-193; David Coburn et al., "Medical Dominance in Canada in Historical

These modern conflicts surrounding monopolistic professional powers, safety of infants and mothers, and women's right to choose the place of birth and birth attendants, become understandable when two dimensions are considered: first, the historical dimension of control over childbirth; and second, cross-cultural variations in birthing practices, particularly in the role played by midwives. Chapter Three elaborates on these points, and the pivotal role of the State in shaping the directions of midwifery practice.

¹¹¹(cont'd) Perspective: The Rise and Fall of Medicine?", *International Journal of Health Services*, 1983, 13(3), 407-432.

CHAPTER III

HISTORICAL AND CROSSCULTURAL PERSPECTIVES

"Then the king of Egypt said to the Hebrew midwives, one of whom was named Shiph'rah and the other Pu'ah, 'When you serve as midwife to the Hebrew women, and see them upon the birthstool, if it is a son you shall kill him; but if it is a daughter, she shall live.' But the midwives feared God, and did not do as the king of Egypt commanded them, but let the male children live." *Exodus*, Chapter 1:15-16

"...And if there is a single piece of wisdom that has more humanity in it than any other it is this: befriend the womb." ¹

Introduction

Thousands of years have elapsed between the biblical account of the midwives' defiance of Herod and current conflicts over the State and midwifery. This chapter provides an overview of major developments in the evolution of midwifery worldwide. Two broad sections are included: first, the historical development of formalized midwifery practice in England, Continental Europe, the United States, and Canada; and second, crosscultural variations in midwifery and birthing customs. In virtually all cultures women have been responsible for assisting births, and birth attendance has involved the presence of kin and neighbours. Birth was thus a localized event, a community event in a sense. The advent of professionalized midwifery – in the wider framework of technological advances, centralization of maternity services, and formal bureaucratic structures – is a relatively recent transformation of the context of birth.

¹ Hugh Hood, *Reservoir Ravine*, 1985, Toronto, General Publishing, p. 195.

Historical Perspectives on Midwifery

"...there is an underside to every age about which history does not often speak, because history is written from the records left by the privileged. We learn about politics from the political leaders, about economics from the entrepreneurs, about slavery from the plantation owners, about the thinking of an age from its intellectual elite." ²

Midwifery in Europe

The evolution of midwifery in Europe reflects technological advances in the medical sciences and the changing patterns of control through the professions and the influence of the State. These structural changes have contributed to the eclipsing of the traditional midwife by physicians, and their replacement by the nursing and nurse-midwife professions. As feminist writers have documented, this inclusion into what was, historically, a women's sphere, has produced the incorporation of women into maternity care. This incorporation means that reproduction is usually mediated and controlled by an elite of primarily male physicians. ³

Bohme traces four phases in the social history of European midwives. ⁴ The first phase, **solidary aid**, is traced to the very early days of mankind. Knowledge of childbirth was gained through personal experience of childbirth: giving birth was a necessary aspect of becoming a midwife. The concept of solidary aid underlines the communal involvement of women assisting other women during labour, delivery, and the post-partum period. The second phase is that of **office**. The ecclesiastical administration of life in the Middle Ages was extended to childbirth. Midwives were appointed and licensed by the Church so as to ensure

² Howard Zinn, *The Politics of History*, 1970, Boston, Beacon Press, p. 102.

³ Ann Oakley, *Women Confined: Towards a Sociology of Childbirth*, 1980, New York, Schocken, pp. 8-10.

⁴ Gernot Bohme, "Midwifery as Science: An Essay on the Relation between Scientific and Everyday Knowledge," in Nico Stehr and Volker Meja (eds.), *Society and Knowledge: Contemporary Perspectives in the Sociology of Knowledge*, 1984, New Brunswick, Transaction Books, pp. 365-385.

that the moral character of birth attendants befitted the office. Attempts to thwart abortions, substitutions (i.e., changelings), and infanticide were made, paternity was established by midwives, and newborns were baptised by midwives. Midwives could not profit by their work. As Bohme puts it, the office of midwife sought "poor but honest" practitioners. ⁵

The third phase, **traditional profession** marked the transition from an assigned office to a clearer conflict between midwives and male physicians at the beginning of the eighteenth century. Surgeons and barber-surgeons, once restricted to performing Caesarean sections or extracting stillborn babies (or babies who could be removed otherwise), asserted their superiority via innovations such as the forceps and anaesthesia. The exclusion of women from the Universities and the development of Gynecology and Surgery further reduced the province of the appointed midwife. ⁶ The status of midwifery as a **modern profession**, self-regulating and licensed, now predominates in Europe. Specialized training of midwives, local and international Associations, and the conjuncture of theoretical and practical midwifery characterize this contemporary phase of midwifery.

There has been a considerable literature on the historical development of midwifery in Britain. This section relies substantially on Donnison's comprehensive review of lay midwifery and the rivalries that ensued with the growth of professionalized medicine and nursing. ⁷ Midwives in the Middle Ages were likely to be middle aged, married women who had given birth. Personal experience was seen as an important qualification.

The customary practice of lay midwifery was altered dramatically with the advent of surgeon's guilds in the thirteenth century. Surgeons were designated as the appropriate birth attendants for births in which natural delivery was not possible. Fifteenth century English

⁵ Ibid., p. 375.

⁶ Ibid., pp. 375-377.

⁷ Jean Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*, 1977, New York, Schocken.

midwives were vilified as agents of the Devil but were not subjected to the Inquisitorial punishments to the same degree as midwives in Continental Europe. ⁸

Episcopal licensing was a form of midwifery regulation that influenced birth attendance. As noted earlier, midwives were to be of good moral character and they were obliged to see that babies were christened in accordance with Church doctrine. The licensing of physicians was vested in Church authorities in England in 1511, while the informal regulation of midwives by the Church was legalized in 1512. Power over birth attendants, particularly midwives, was thus transferred from the community and the parish and centralized at the Bishops' level in the Church hierarchy. ⁹ The combined weight of traditional community customs and of Church regulation was eventually offset by the growing power of the nation-State in England. This expansion can be linked with European political philosophy, and especially Liberalism, in which the mediating role of the State in human affairs was acknowledged.

In Germany concerns were expressed about illiteracy and superstition among midwives, along with damages to infants and mothers by such practices as manually removing the placenta and incorrect cutting of the infant's frenum, the small ligament controlling the movement of the tongue. ¹⁰ These concerns led to formal regulations specifying the responsibilities of midwives and physicians in Germany. One of the ironies of late 15th century and early 16th century urban ordinances in Germany was that midwives were

⁸ Donnison, op cit., p. 4. See Nacham Ben-Yehuda, "The European Witch-Craze of the 14th to 17th Centuries: A Sociologist's Perspective", *American Journal of Sociology*, 86, 1-31.

⁹ See William Ray Arney, *Power and the Profession of Obstetrics*, 1982, Chicago, University of Chicago Press, p. 22. Midwives were hindered by Church proscriptions on their conduct and by the lack of an internationally recognized knowledge base. This limited knowledge base contributed to the limited powers of community midwives in resisting the growth of scientific obstetrics developed in France and adapted in Britain. See *ibid.*, pp. 21-29.

¹⁰ For a general critique of the motif of European lay midwives as respectful of the natural course of childbirth see Edward Shorter, *A History of Women's Bodies*, Toronto, University of Toronto Press, 1982(?).

required to summon physicians for advice or direct assistance in complicated deliveries.¹¹ Control of German midwives was often more direct. Witch-hunting resulted in the executions of thousands of midwives, and it appears that those without an affiliation with a male were especially vulnerable to witch hunts.¹²

The critique of lay midwives was also present in France. As Theophile Roussel indicated in 1874, many birth practices of the day were seen as unenlightened, and the menace of untrained midwives was decried:¹³

"Notwithstanding the disinterested counsel of physicians and enlightened persons, the force of habit, the brutish stubbornness of the peasants, and the foolish advice of the midwives maintain practices that are fatal to children whose health needs are poorly attended to...."

In France the government also established midwifery instruction at the Hotel Dieu Hospital in Paris. Donnison concludes that government intervention was to the benefit of French and German midwives. Government-subsidized instruction was however lacking in England in the eighteenth century and charitable institutions were not greatly involved in promoting improved midwifery practice.¹⁴ The growth of State authority served to mediate the growing rivalry between traditional, female midwives and the men-midwives who aspired

¹¹ It is noteworthy that earlier regulations required midwives to consult with *other midwives* when complications arose. Nevertheless, by the beginning of the 17th century midwifery had become an inferior occupation while the status of physicians had increased. Control was not simply by men over women: at this time, male physicians and surgeons were forbidden to examine female genitalia. See Thomas G. Benedek, "The Changing Relationship Between Midwives and Physicians During the Renaissance", *Bulletin of the History of Medicine*, 1977, 51(4), pp. 550-564.

¹² See H.C. Erik Midelfort, *Witch Hunting in South Western Germany: The Social and Intellectual Foundations*, 1972, Stanford, Stanford University Press; and the discussion of his work in Mary Daly, *Gyn/Ecology: The Metaethics of Radical Feminism*, 1978, Boston, The Beacon Press, pp. 184-185.

¹³ Cited in Jacques Donzelot, *The Policing of Families*, 1979, New York, Pantheon, pp. 30-31.

¹⁴ Donnison, *op cit.*, pp. 18, 40-41. She notes on p. 21 that by the 1720s men-midwives were becoming more prominent in uncomplicated deliveries as well as abnormal deliveries.

to attend a greater proportion of births. Midwives and medical practitioners were vilified and satirized, and appeals were made to government for recognition of the superior skills of either profession. Midwives in Europe were denounced as witches and thousands of midwives and female healers were executed.¹⁵ Yet this vilification campaign was not without its critics. Some opposed the encroachment of men-midwives in birth on grounds of modesty as well as the unnatural methodologies and inferior skills of male attendants. In *A Treatise on the Art of Midwifery (1760)*, Elizabeth Nihell also criticized the lower pay available to women attendants relative to men.¹⁶

The *Midwives Act* of 1902 followed the efforts of the Midwives' Institute and its supporters to gain legal recognition and a protected status in law. This was not, however, an autonomous status. This Act subjected the midwives to local authorities. It also provided broader grounds for de-registration on grounds of professional misconduct. The private lives of midwives were open to scrutiny. Essentially, midwives were not self-regulating since the role of the medical profession was dominant in midwife-related matters.¹⁷ The *Midwives Act* of 1936 reflected concerns over the falling birth rate in England and the likelihood of war. Local authorities were to secure salaried, full-time midwifery services adequate to the citizenry. This Act also promoted the development of professional midwifery: unqualified midwives were banned from attending birth in any capacity.¹⁸ The amended *Midwives Act* of 1951 continued the stipulation that the Board could strike off midwives for conduct unrelated to their work that brought the profession into disrepute.¹⁹

¹⁵ Doreen Nagy, "Obstetrical Forceps: Symbols of Power and Professionalism in Victorian Britain", *Nexus*, 1983-1984, 3(1-2), 98-103. Obstetrical forceps were refined and by the 1860s were used more frequently by doctors. Nagy concludes that forceps served not only a beneficial clinical purpose, but also had a symbolic value in establishing midwifery as a branch of medicine.

¹⁶ See Arney, op cit., pp. 30-31.

¹⁷ See Donnison, op cit., pp. 174-175.

¹⁸ Donnison, *ibid.*, p. 191.

¹⁹ Donnison, *ibid.*, p. 183.

Midwifery in Canada

The historical study of midwifery in Canada suffers from the elitist view outlined by Zinn. In Canada, historical approaches have favoured a Whig version of history written "from above" and not from a working-class perspective. Biographical accounts of eminent physicians and chronicling of dramatic medical advances are featured in this Antiquarian approach, while accounts by working-class people are absent or minimal.²¹ For Nellie McClung, those who did "the work of the world" were not written about by historians.²² There is however a renewed interest in Marxist historiography and critical interpretations in Canadian history.²³ This stems from the interest of several prominent social historians in writing history "from below"; that is, from the viewpoint of working people who have for the most part been neglected in historical accounts.²⁴ Women's accounts have also been "hidden from history" in

²⁰ Some have indicated that the greater institutionalization of midwifery in Britain – relative to the United States – hinges in part on the *lack* of regulation of midwifery in colonial America, and the failure to establish midwifery as a centrally-controlled institution in the face of opposition by organized medicine. See P. Anisef and P. Basson, "Institutionalization of a Profession – Comparison of British and American Midwifery", *Sociology of Work and Occupations*, 1979, 6(3), 353–372.

²¹ The Antiquarian approach tends to avoid or minimize contributions of non-medical practitioners as well as external factors influencing health care. S.E.D. Shortt, "Antiquarians and Amateurs: Reflections on the Writing of Medical History in Canada", in S.E.D. Shortt (ed.), *Medicine in Canadian Society: Historical Perspectives*, 1981, Montreal, McGill-Queen's Press, pp. 1–17. Shortt notes that compensatory historical work on working class history has been limited.

²² See Nellie McClung, *Clearing in the West*, Toronto, Thomas Allen, 1935.

²³ For instance, the tradition of paternalistic authority relations in Upper Canada between 1800 and 1850 was influenced by working-class resistance and negotiations between dominant group members and subordinates. Bryan Palmer, *Working Class Experience: The Rise and Reconstitution of Canadian Labour, 1800–1980*, 1983, Toronto, Butterworth, p. 18. See also Desmond Morton with Terry Copp, *Working People: An Illustrated History of Canadian Labour*, 1980, Ottawa, Deneau and Greenberg.

²⁴ Peter Burke, in Raphael Samuel (ed.), *People's History and Socialist Theory*, 1981, London, Routledge and Kegan Paul, pp. 370–373. See also E.P. Thompson's social historical approach

many respects. ²⁵

The historical assessment of Canadian midwives is alternately hindered and developed through these Antiquarian and radical approaches. It is hindered by the palpable lack of records and documents of lay midwifery in frontier and post-frontier eras. Lay midwives in Canada rarely kept systematic records. Moreover, available records from Ukrainian, Scandinavian, Acadian, and Quebecoise midwives do not appear to have been translated into English. The lack of written records has also been observed in historical accounts of lay midwifery in the United States. ²⁶ As with other scholars who have delved into hospital practices in 19th century Canada, for instance, historical records of lay midwives are often incomplete or absent. ²⁷ Historical writing on Canadian midwives has thus been limited, although there is a renewed interest in excavating documentary materials related to lay midwives and the nurse-midwives who succeeded them.

It is clear that lay midwives were the primary birth attendants in colonial Canada. Lay midwives in pre-Confederation Canada were often affiliated with specific immigrant groups. ²⁸ Cameron provides a fictional account of native Indians attending a white woman in labour, ²⁹ Historical accounts have confirmed that native midwives assisted settlers in the colony of

²⁴(cont'd) in *The Making of the English Working Class*, 1968, Harmondsworth, Penguin.

²⁵ Sheila Rowbotham, *Hidden From History*, 1973, London, Pluto Press.

²⁶ Jane Donegan, *op cit.*, pp. 3-4, 20.

²⁷ S.E.D. Shortt, "The Hospital in the Nineteenth Century", *Journal of Canadian Studies*, 1983, 18(4), 3-14. A 19th century Nova Scotia midwife's records were restricted to the date of birth and the name of the mother. See Jane Hamilton Sorley, "'Five Islands, N.S., midwife'" (Records of births attended in the Five Islands-Economy Area, 1851-1893), Sackville, New Brunswick, Mount Allison University Archives. As noted below, oral histories have served to retrieve some information on community midwifery in more recent years. For a statement on the possibilities of incorporating oral history into general historical understanding see Paul Thompson, *The Voice of the Past: Oral History*, 1978, Oxford, Oxford University Press.

²⁸ David Cayley, "Midwifery in Canada: Part IV," *CBC Morningside*, Canadian Broadcasting Corporation, 1981.

²⁹ Anne Cameron, *The Journey*, 1982, New York, Avon Books, pp. 243-249.

"In the earliest days there were no trained nurses such as we know in 1945, and there were no hospitals. It was not considered necessary for a mother to go to a hospital for the birth of a child, and, further, it was not considered a matter for hospital attention. Children, in those days, were born in their homes—not in hospitals....In Moodyville, a neighbour acted, assisted by an Indian woman, and at the Hastings Sawmill, and in Granville it was much the same...Indian women never had mid-wives other than another Indian woman."

A history of Pemberton, B.C. also indicates that native midwives assisted settlers. ³¹ At the turn of the 20th century, maternity cases in British Columbia were increasingly directed to two general hospitals, four or five maternity homes, and "dozens" of midwives attended women in labour at home. ³² There are oral histories on frontier midwives and nurses in Western Canada, including Icelandic midwives and other, ethnically-affiliated midwives. In some places women trained in nursing and midwifery worked with country doctors; sometimes neighbourhood women were the sole birth attendants. ³³ Coburn concludes that community midwifery was essential since few doctors practiced in the colony.

³⁰ J.S. Matthews, "Mid-wives", Typescript mimeo, file folder #175, Vancouver Public Archives, Vancouver, B.C.

³¹ "Babies were delivered by Indian mid-wives trained in their own traditional herb medicines, or by neighbours such as Mrs. Neill. The more prosperous or more nervous (women) preferred to travel to Vancouver several weeks ahead of time...." It was also noted that some settlers were anxious to have trained nurse-midwives in the Pemberton area. The arrival of Lorraine Carruthers, a nurse with the Squamish Public Health Service, had been long awaited according to this account. See Francis Decker, Margaret Fougberg, and Mary Ronayne, *Pemberton: The History of a Settlement*, Pemberton, Pemberton Pioneer Women, 1978 (second edition, revised), pp. 241 and 258.

³² J.S. Matthews, "Letter re: Fred H. Goodrich's 'Victorian Order Born in Vancouver', *The Daily Province*, November 10, 1947," dated November 17, 1947, File Folder #17, "Victorian Order of Nurses," Vancouver City Archives.

³³ Linda Rasmussen et al., *A Harvest Yet To Reap*, 1976, Toronto, The Women's Press. Others have noted the work of ethnic, lay midwives in the Red River Colony. See also Judi Coburn, "I See and am Silent: A Short History of Nursing in Ontario," in Linda Kealey (ed.), *Women at Work: Ontario, 1850-1930*, Toronto, Canadian Women's Educational Press, p. 132; and Alvine Cyr Gahagan, *Yes, Father: Pioneer Nursing in Alberta*, 1979, Manchester, N.H., Hammer Publications, p. 1.

Benoit's oral histories of empirical midwives in 20th century outports in Newfoundland preserves a sense of the tradition of community self-help and folkways before the establishment of formal medicine and nursing in that province. ³⁴ These midwives tended to be older than contemporary community midwives in Canada. The Newfoundland midwives were customarily 40 years of age, or older. Local midwives were generally well-respected. Their practice was diversified, ranging from midwifery to bone-setting and tending to animals. In contrast to the fee-for-service practice of the professions, payment to community midwives was often made through bartering. The world of the outport midwife in Newfoundland was not entirely self-contained. Threats to mothers and infants remained, and it was not uncommon for local midwives to accompany women to hospitals or nursing stations staffed by doctors or nurses. Some midwives also took formal training in Boston or other urban centres.

Coburn explains the displacement of lay healers and midwives in early Canada by nurses as one instance in which patriarchal ideology aided the relegation of women to the domestic sphere, while professional ideology attracted trained nurses as allies with medical personnel against folk healing and birth attendants. ³⁵ Historical accounts confirm the displacement and replacement of lay midwives by pioneer doctors and nurses. Increasingly, doctors were involved in home deliveries and practice in early hospitals, occasionally assisting by telephone when travel was impossible. ³⁶

The exclusion of female birth attendants in the 18th and 19th centuries included bars to women applicants to medical schools in the United States and in Canada. ³⁷ Likewise, a

³⁴ Cecilia Benoit, "Midwives and Healers: the Newfoundland Experience," *Healthsharing*, 1983, pp. 22-26.

³⁵ Coburn, op cit.

³⁶ See for example H.L. Burris, *Medical Saga: The Burris Clinic and Early Pioneers*, 1967, Kamloops, Mitchell, pp. 223-224.

³⁷ See Donegan, op cit., Ch. 8, and Veronica Strong-Boag, "Canada's Women Doctors: Feminism Constrained", in Linda Kealey (ed.), *A Not Unreasonable Claim: Women and Reform in Canada, 1880s-1920s*, 1979, Toronto, The Women's Press, pp. 109-129. A woman who graduated from Queen's Medical School in Kingston, Ontario mentioned the hostility of

woman applying for admission to the Royal College of Surgeons in Edinburgh in 1869 was ridiculed by medical students.³⁸ The exclusion of women from medical education can be linked with broader restrictions on women in 19th century Canada. There was concern among some physicians that anatomy and physiology should not be taught to girls for fear of hypochondria. The belief that women were *by their nature* ill-suited for competition and higher education also reflected the patriarchal differentiation of women and men.³⁹

The professionalization of childbirth attendance in Canada has thus been placed in a critical framework of patriarchy and gender. Coburn maintains that the general ideology of women's inferiority promoted work structures in which women's labour was auxilliary (to men's work), either voluntary (charitable) or poorly-paid, and in which the material concerns of doctors and legislators were joined. The displacement of the lay midwife in Canada was not connected with the *intrinsically* superior power of medical and nursing attendants. Coburn adds that the intertwining of professionalism, sexism, and exclusion of women healers from lay practice and the barring of women from medical schools facilitated capital accumulation and industrialism, while the movement from the home to the hospital promoted structural, disciplinary environments more conducive to industrialism.⁴⁰

In her comprehensive essay, Buckley maintains that the liason between nurses and doctors in Canada, far from reflecting public opinion and preferences for professional

³⁷(cont'd) male classmates toward female medical students. See Elizabeth Smith, *A Woman with a Purpose*, 198(?), Toronto, University of Toronto Press.

³⁸ Recent examples of dismissiveness and hostility directed toward female students in physics, psychology, and other disciplines are mentioned in Jo Ann Ashley, "Power in Structured Misogyny: Implications for the Politics of Care", *Annals of Nursing Science*, 1980, 2(3), pp. 16-17.

³⁹ Wendy Mitchison, "Historical Attitudes Toward Women and Childbirth", *Atlantis*, 4 (2), Part II, pp. 19-20.

⁴⁰ Coburn, op cit. Others have made the general point that the gradual achievement of improved medical and health conditions not only benefits the population at large, but also owners and managers of capital since the work-force is healthier and hence more productive. See for example, Ian Gough, *The Political Economy of the Welfare State*, London, MacMillan, 1979.

attendance, stemmed from professional interests in securing a monopoly over health-related services as well as middle-class preferences for higher-ranking attendants. The securing of childbirth attendance further served to establish family practices for general practitioners. ⁴¹

Cayley adds that doctors obstructed attempts to establish midwifery certification and practice in Canada, launching a "campaign of vilification" against lay midwives as ignorant, dirty, and dangerous. ⁴²

Law and the Containment of Midwifery

Legal prohibitions on midwifery practice also offered a deterrent to midwives practicing without the protection of law. As Ward indicates, the movement of the State in regulating birth has varied considerably. In New France, in the 1720s and 1730s, the Crown subsidized midwives trained in France. By 1788 the British required midwives practicing in the larger cities of Montreal and Quebec (and adjacent areas) to have a certificate. In 1879 the Quebec College of Physicians and Surgeons extended their control: in fact, about 95% of midwifery licenses were issued to *male* physicians and surgeons. In 1872, midwives in the City of Halifax were certified through a Medical Board, while country midwives remained unregulated. In 1881, licensed physicians were legally empowered to practice midwifery. ⁴³

Biggs interprets the legislation governing midwives in Upper Canada and 18th century Ontario as a device enabling the exclusion of lay midwives: the 1795 *Medical Act* prohibited

⁴¹ Suzann Buckley, "Ladies or Midwives? Efforts to Reduce Infant and Maternal Mortality", in Linda Kealey (ed.), *A Not Unreasonable Claim*, 1979, Toronto, The Women's Press, pp. 131-149.

⁴² Cayley, op cit.

⁴³ W. Peter Ward (ed.), *The Mysteries of Montreal: Memoirs of a Midwife*, Vancouver, University of British Columbia Press, 1984, p. 7. He notes (p. 10) that: "Even educated, well-qualified licensed midwives found themselves largely superseded, while those without training were confined to the countryside".

the practice of physic and surgery. This prohibition was reversed, however, through new legislation in 1806. This legislation expressly protected midwifery practice: ⁴⁴

"...nothing in this Act contained shall extend or be construed to extend to prevent any female from practising midwifery in any part of the Province, or to require such female to take out such license as aforesaid."

Three bills to regulate or exclude domestic midwifery practice were defeated between 1845 and 1851. Nevertheless, medical influence was extended through establishment of licensing powers, a system of registration, and medical education. With the increasing objections to midwifery – for undercutting doctors' fees, and for allegedly dangerous practices – midwifery attendance declined as doctors established practices in urban areas and as new legislation removed the protective status of female birth attendants set out in the 1806 legislation. ⁴⁵

There was thus substantial opposition to suggestions that lay midwives could be trained and used in (remote) district nursing in 19th century Canada. Attempts to import trained midwives were also resisted by some 19th and 20th century Canadian physicians: in 1917 the chief superintendant of the Victorian Order of Nurses in Canada, a foreign midwife, was criticized for her foreign status. ⁴⁶ These initiatives followed much earlier attempts to restrict the practice of medicine in Upper Canada in 1795 to graduates from universities in the British Empire ⁴⁷

Opposition to lay midwives was generally tempered by the geographical distribution of the population in Canada. Until the early part of this century the population was primarily rural. The substantial distances that often separated inhabitants, compounded by inclement weather and rudimentary transportation, meant that birth attendance was often left to

⁴⁴ C. Lesley Biggs, "The Case of the Missing Midwives: A History of Midwifery in Ontario from 1795 to 1900", *Ontario History*, 75(1), p. 22.

⁴⁵ Biggs, *passim*.

⁴⁶ See Buckley, *op cit.*, p.143.

⁴⁷ See Coburn, *op cit.*, pp. 133–134).

neighbouring women. Even where a clear preference for physician-attended births was stated, such limitations were recognized: One Commissioner reporting to the Saskatchewan Health Services Survey Commission allowed that: ⁴⁸

"While it is desirable to have women delivered by physicians, if possible in a maternity home, there are still numerous sections of the province that have no physician at all, and that, during the winter, are completely cut off from hospitals. In such regions, a nurse-midwife, that is a nurse trained in midwifery, could render invaluable services, *without encroaching upon the field of the physician*. A course would have to be devised for which the system practiced in Alberta, England and other countries, would have to be consulted."

It is also clear that opposition to midwives was not characteristic of all doctors in pioneer Canada. There is evidence that relations between some doctors and midwives were amicable.

⁴⁹

A controversial point, developed in the next section, is whether the monopoly status of Canadian doctors and nurses contributed to direct improvements in maternal and infant well-being. ⁵⁰ It is farfetched to attribute declines in the rates of infant and maternal mortality to medicine *per se* when larger factors influence these rates. Besides improvements in sanitation, diet, and so forth, childrearing customs affected the neonatal mortality rate. In 18th century France, the custom of child care by "wet" and "dry" nurses not uncommonly resulted in infant deaths through neglect. ⁵¹

The transition from home births to hospital births involved an interstitial period in which domiciliary midwifery was practiced extensively by public health nurses. Coburn notes

⁴⁸ See Henry Sigerist, *Saskatchewan Health Services Survey Commission: Report of the Commissioner*, 1944, Regina, King's Printer [emphasis added].

⁴⁹ See Ward, *op cit.*, p. 13.

⁵⁰ Buckley, *op cit.*, p. 132, notes that maternal and infant mortality *increased* during this period of urbanization and replacement of the midwife in late 19th century Canada. Shortt, *op cit.*, also mentions that early hospitals of the day were not uncommonly regarded as "gateways to death" (although he believes this allegation is exaggerated) and avoided by wealthier inhabitants who could afford home attendance and general practice of physicians.

⁵¹ Elisabeth Badinter, *The Myth of the Maternal Instinct*. See also Colette, "The Patriarch", in *The Rainy Moon and Other Stories*, 1979, Harmondsworth, Penguin, p. 128.

that in 1925, 38,634 births occurred in V.O.N. hospitals or Red Cross Outpost Hospitals, whereas the V.O.N. attended 14,700 obstetrical cases at home. ⁵² Thus, approximately 27 percent of births managed by the the Victoria Order of Nurses at this time were home births.

Domiciliary midwifery in Vancouver was praised for its safety. Nationwide, approximately 24,000 maternity cases were assisted by members of the V.O.N., of which 5,000 were home births. Apparently, however, only a small minority at this time were managed by the nurse without the doctor present. ⁵³ Notwithstanding the work of public health nurses in attending home deliveries, the shift to hospital delivery was quite dramatic. It has been estimated that only 40 percent of Canadian mothers delivered in hospital in 1939, but 93 percent delivered in hospital by 1959. ⁵⁴ The reasons underlying this shift from home to hospital deliveries include greater accessibility to hospitals and professional attendance, provision of services through provincial and federal funding of hospital construction, the development of Medicare plans, and a cultural shift which promoted the superior skills of physicians and surgeons over the midwives' skills.

Midwifery in the United States

The hegemonic status of doctors in the management of childbirth also characterized developments in the United States. ⁵⁵ The shift from lay practitioners –many of whom were women – in colonial America was gradual. Midwifery in 18th century America was not

⁵² Coburn, op cit, p. 150.

⁵³ Charlotte Whitton, "V.O.N. Stands for Victorious Over Need", *Saturday Night*, June 2, 1945, pp. 5 and 27.

⁵⁴ W.G. Cosbie, *The History of the Society of Obstetricians and Gynaecologists of Canada, 1944- 1966*, 1969(?)

⁵⁵ Paul Starr, *The Social Transformation of American Medicine*, 1982, New York, Basic Books.

subject to substantial formal regulation. Midwives were not regulated until the middle of the sixteenth century when episcopal licensure ensured, among other things, that babies were baptized. ⁵⁶ After Independence in 1776, many legislatures extended licensing powers to medical societies. These licensing powers usually exempted apothecaries, botanists, and midwives. In the Jacksonian period, however, women were no longer so dominant in healing. Doctors mobilized against lay midwives, an ideology of protection of women from "unfeminine" work gained currency, and urban, middle-class women in the United States began to gravitate to physician attendance in childbirth between the mid-1700s and the Civil War. ⁵⁷ Later in the century the campaign against granny midwives continued in the Southern U.S.A. In W. Eugene Smith's photographs of the work of a black nurse-midwife, the accompanying essay clearly favours nurse-midwives over traditional birth attendants. The former maintains aseptic conditions and has proper supplies: a blood pressure gauge, cord ties, a stethoscope, and sterilized gloves. ⁵⁸ In the early 19th century, accounts of fatalities attributed to unlicensed midwives enjoyed newspaper coverage, for example. Concerns over high rates of childbirth-related deaths culminated in 1933 in a major report on maternal mortality in New York City. The recommendation that proper training of midwives should be encouraged was largely disregarded. ⁵⁹

Starr states that the lay midwife was seen as a competitor for physicians, while nurse-midwives were valued by obstetricians for their assistance in childbirth. ⁶⁰ Even if

⁵⁶ Jane Donegan, *Women and Men Midwives: Medicine, Morality, and Misogyny in Early America*, 1978, Westport, Greenwood Press.

⁵⁷ Starr, *op cit.*, p. 49; Donegan, *op cit.*, pp. 4-5.

⁵⁸ See W. Eugene Smith, "Maude Callen Eases Pain of Birth, Life and Death," *Life*, December 3, 1951, 31(23), pp. 134-145. On page 135 the distrust of lay midwives is clearly set out: "The new midwife had succeeded where the fast-disappearing 'granny' midwife of the South, armed with superstition and a pair of rusty scissors, might have killed both mother and child."

⁵⁹ See New York Academy of Medicine, *Maternal Mortality in New York City: A Study of All Puerperal Deaths in 1930-1932*, 1933, New York, Commonwealth Fund.

⁶⁰ Starr, *op cit.*, p. 223.

midwives could circumvent licensing restrictions, they discovered that they could not collect from Blue Shield plans, and their patients could not collect under indemnity insurance plans.

⁶¹ As with their European counterparts, American physicians were successful in establishing clinical instruction in which medical students viewed the birth of babies. This innovation of "demonstrative midwifery" by Dr. James White in Buffalo in 1850 was widely debated but eventually became established. ⁶²

CROSS-CULTURAL PERSPECTIVES ON MIDWIFERY

Cross-cultural variation in midwifery practice and birth practices generally have long been recorded. Midwives are variously called *sage-femme* in France, *dukun bagi* in Java, *nana* in Jamaica, and *partera* in Spanish-speaking countries. Other names include *comadrona*, *bidan*, and *dai*. ⁶³ Traditional midwives are almost always women, although there are cultures in which male midwives have practiced. ⁶⁴

Several themes become evident in examining historical and cross-cultural materials on midwifery and childbirth. First, anthropological studies have captured the *diversity* of childbirth practices in various cultures. In many non-industrialized cultures a variety of beliefs and

⁶¹ Ibid., p. 333.

⁶² Judy Barrett Litoff, *American Midwives: 1860 to the Present*, 1978, Westport, Greenwood Press, p. 20. For a more detailed review of the incident see Virginia Drachman, "The Loomis Trial: Social Mores and Obstetrics in the mid-Nineteenth Century", in Susan Reverby and David Rosner (eds.), *Health Care in America: Essays in Social History*, 1979, Philadelphia, Temple University Press, pp. 67-83. Manual examinations of women by male physicians were permitted in mid-19th century but visual examination of a woman's genitals was forbidden. See Ward, op cit., p. 14.

⁶³ See S. Cosminsky, "Cross-cultural Perspectives in Midwifery", *World Anthropology*, 1976, pp. 229-248.

⁶⁴ Laderman, op cit., describes a male *bidan* in a Malaysian hamlet as "a great rarity". His practice ceased when a female village midwife relocated in his hamlet. Another writer notes that males began practicing midwifery in the rural Philippines after 1963. Male midwives were referred to as *sibulan*. See Donn Hart, "From Pregnancy Through Birth in a Bisayan Filipino Village", in Donn Hart et al., (eds.) *Southeast Asian Birth Customs: Three Studies in Human Reproduction*, New Haven, Human Relations Area Files Press, 1965, pp. 22-23.

practices have been recorded. These include dietary restrictions and proscriptions on who may attend births. In some cultures, husbands are expected to be absent during the birth; in others the absence of the father is seen as a portent of misfortune for the newborn child. Birthing positions likewise vary from the standard lithotomy position (on one's back) in Western medical practice to a variety of birthing positions, including squatting, delivery on all fours, use of birthing stools, ropes or poles for support, and so forth. The complexity of this subject is not only evident *between* cultures but also *within* some cultures. Research on the Rogai in South Vietnam, for instance, suggested that women deliver their babies using a variety of gravitational aids: birthing stools, ropes, vines, and a pole for support. ⁶⁵

One issue in the modern debate over obstetrics and midwifery is the use of technology for control purposes. Critics of the unnecessary use of obstetrical technology claim that a variety of surgical measures such as episiotomy and Caesarean section serve more than medical purposes; they also help to consolidate medical power during childbirth. There have been shifts in this debate, however. Women's associations lobbied for scopolamine (a narcotic and analgesic, also known as "twilight sleep") in 1914 and 1915, whereas some modern feminists lobby for the right to unmedicated births. ⁶⁶

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

A number of writers have thus linked the growth of technological approaches to childbearing with alienation of mothers. Recourse to routine induction (without a clear demonstration of

⁶⁵ See Lois Lee, "Pregnancy and Childbirth Practices of the Northern Roglai", *Southeast Asia*, 2(1), p. 40.

⁶⁶ Judith Walzer Leavitt, "Birthing and Anesthesia: The Debate over Twilight Sleep", *Signs: Journal of Women in Culture and Society*, 1980, 6(1), p. 164.

the benefits of induction) has been associated with professional convenience, to some extent.⁶⁷ For some, the act of accepting pain relief in labour alters the essential quality of birth, reducing the women receiving medication to "a passive thing".⁶⁸

Variations in Infant Mortality Rates

High life expectancy in many countries is a dramatic change from earlier periods:⁶⁹

"...'It is not uncommon, I have frequently been told,' Adam Smith soberly noted, 'in the Highlands of Scotland for a mother who has borne twenty children not to have two alive'. The poor died freely, in unrecorded numbers, but even men of means thought long life a stroke of unexpected luck."

"Some progress has already been made in reducing infant mortality, but the differential in maternal mortality between rich and poor countries is among the highest observed in public health, reports WHO (World Health Organization). Eighty-five per cent of the world's births take place in developing countries but these same countries suffer 95% of the world's *infant deaths*, and a terrible 99% of all *maternal deaths*. WHO figures also show that more women die in India in 1 month than die in all of North America, Europe and Australia in 1 year."

⁷⁰

There is substantial disagreement over the part played by medical science in reducing infant and maternal mortality, and the influence of improved hygiene, sanitation, and diet.⁷¹

Regardless, in Europe and other industrialized countries there has been a great reduction since

⁶⁷ Ann Cartwright, *The Dignity of Labour? A Study of Childbearing and Induction*, London, Tavistock, 1979. Between 1965 and 1974 the percentage of births using induction rose from 15% to 41% in England and Wales.

⁶⁸ Carol McMillan, *Women, Reason and Nature*, Princeton, Princeton University Press, 1982, p. 133. Setting aside this sweeping point, McMillan does establish the importance of reconsidering how women's consciousness is shaped and ordered in the course of pregnancy and childbirth.

⁶⁹ See Peter Gay, *The Enlightenment: An Interpretation (Volume II: The Science of Freedom)*, London, Weidenfeld and Nicholson, 1970, p. 21.

⁷⁰ "International News", *Midwifery*, 1986, 2(1), p. 53.

⁷¹ See J. McKinlay and S. McKinlay, "The Questionable Contribution of Medical Measures to the Decline of Mortality in the United States in the Twentieth Century", *Millbank Memorial Fund Quarterly*, 55(3), 405-428.

the 18th century in the proportion of children who die in childbirth or in the first few years of childhood. Historical research on parishes in Finland, for example, indicated that the infant mortality rate was 970 per 1,000 births (during a typhoid epidemic) and subsequently in 1881, the rate remained at 375 per 1,000 births. Many infants who died between one and six months of age suffered from gastric illnesses or contagious diseases, and breast-feeding provided greater protection against these illnesses. ⁷² Higher rates of infant mortality *within* Western societies have been noted for black infants in the United States ⁷³ and for Native infants in Canada. ⁷⁴ And even while it appears that the decline in the birth rate in some Western countries has halted, ⁷⁵ there is a substantial difference in birth rates in comparison with Third World countries. Studies early in this century recorded what are today regarded as high rates of infant mortality. Two studies noted by Kitzinger address miscarriages in a South African tribe between 1929 and 1935, while the second study found that one-eighth of pregnancies in another African village resulted in miscarriage, while 28% of newborns did not survive to maturity. ⁷⁶ Even in modern times comparatively high rates of infant mortality have been documented in non-industrialized areas. The authors of a UNICEF report in 1973 estimated that 17.6% of babies born in an Arabian community died in their first year. By

⁷² See Ulla-Britt Lithell, "Breast-Feeding Habits and their Relation to Infant Mortality and Marital Fertility", *Journal of Family History*, 1981, 6(2), 182-194. A comprehensive review of the politics of breastfeeding is provided by Maureen Minchin, *Breastfeeding Matters: What we need to know about infant feeding*, 1985, Alfredton, Alma Publications and George Allen & Unwin.

⁷³ Alfred Yankauer, "Infant Mortality and Morbidity in the International Year of the Child", *American Journal of Public Health*, 1979, 69(9), p. 852.

⁷⁴ A greater incidence of low birth weight (LBW) and of infant mortality in the Northwest Territories in 1972 was noted by Marcia C. Smith, "Changing Health Hazards in Infancy and Childhood in northern Canada" in Roy J. Shepard and S. Itoh (eds.), *Circumpolar Health*, Toronto, University of Toronto Press, 1976, pp. 448-449. Mortality rates among reserve Indians in Ontario in 1898 were three times higher than the provincial rate. See Sally M. Weaver, *Medicine and Politics among the Grand River Iroquois: A Study of Neo-Conservatives*, Ottawa, National Museums of Man, p. 43.

⁷⁵ John Archer and Barbara Lloyd, *Sex and Gender*, 1985, New York, Cambridge University Press, p. 296.

⁷⁶ Sheila Kitzinger, *Women as Mothers*, Glasgow, Fontana, 1978, pp. 75 and 107.

age two, this statistic exceeded 23 percent. ⁷⁷

Dangers to the mother during labour, delivery, and postpartum were also evident. In the Yucatan, birth attendants are vigilant in watching for placental retention which can cause maternal deaths. ⁷⁸ Again, in many cultures maternal deaths are attributed to supernatural powers, including witchcraft. Smith-Bowen wrote a poignant account of the death of her friend Amara, a woman in a bush tribe in Africa. The exchange between Smith and Yabo reflects the contest between reliance on Western medicine as a lifesaving measure and the tribe's cultural belief in the powers of magic that are beyond the powers of doctors. ⁷⁹ Others have noted the belief in spirits as causes of death in childbirth. In Malaysia, the *badi mayat* - an evil spirit or principle believed to exist in a human corpse - was associated with the wasting away of an infant. Interestingly, the author also attributes the infant death to a misdiagnosis at a medical clinic. ⁸⁰ One respondent in this study had assisted Bedoin women in Saudi Arabia in the late 1950s and early 1960s. She recounted one incident in which Western medicine was well-received by the Tribe.

"I suppose it was about eight o'clock in the morning and I went out to this infant that had been born between four and five a.m. The doctor had delivered it. It was a Friday, a religious holiday, and since it was a day of rest he had gone off to Kwaittown; as far as he was concerned it was a fairly standard delivery. It was the first time I've taken a pulse that I couldn't count quickly enough: the pulse rate was so high. The infant's temperature went off the thermometer, over 108 degrees. I had never seen anything like this, and what I did in panic (not through skill), was to move the mother and the family into the jeep and we drove across the desert to a medical clinic which happened to be air-conditioned. I sponged the infant down and his temperature came down nicely. I was scared to take him out again...I waited until

⁷⁷ Women in Hamra (an oasis in Oman) attribute the death of a child to Allah; it is God's will. See Christine Eickelman, *Women and Community in Oman*, 1984, New York, New York University Press, pp. 126 and 181.

⁷⁸ Brigitte Jordan, "Studying Childbirth: The Experience and Methods of a Woman Anthropologist" in Shelly Romalis (ed.), *Childbirth: Alternatives to Medical Control*, 1981, Austin, University of Texas Press, pp.

⁷⁹ Elenore Smith Bowen, *Return to Laughter: An Anthropological Novel*, 1964, New York, Doubleday, Chapter 14.

⁸⁰ Carol Laderman, op cit., pp. 95-102.

the sun went down to take him to a doctor at a neighbouring oil company. (What we found was that) this was the seventh baby this women had birthed, and every one had died on the first day of birth. Their metabolic rate followed the sun's temperature... and of course they would die once the sun was out...We kept this seventh child in the air-conditioned room and gradually exposed it to the outside. Eventually this infant's system just corrected itself and it grew, it coped. This made an incredible impact on the local people....(Former nurse, A3, January 1985).

A common theme in reconstructing childbirth ritual in Third World countries is the control women usually exerted in birth attendance. This control extended to reproduction generally, including contraception and abortion. Some conclude that men were excluded from these matters or involved only marginally.⁸¹ In some Phillipine villages fathers were expected to be present, while in other locales in Northern India fathers were excluded from childbirth.⁸² This theme has also been qualified by other accounts pointing to the mythology of women as dangerous in a number of folk cultures.⁸³ Childbirth ritual has been specifically interpreted as reinforcing such devaluation of women.

Traditional Practices and Medicalization of Birth

The medicalization of childbirth is evident in Third World countries and elsewhere. Increasingly, traditional midwives, many of whom had apprenticed with other lay midwives and have practiced in their villages for decades, are being displaced in favour of nurses trained in obstetrical nursing or midwifery, or by physicians. The traditional reliance on touch,

⁸¹ For a detailed discussion of the takeover of reproductive care see Ann Oakley, "Wisewoman and Medicine Man: Changes in the Management of Childbirth", in Juliet Mitchell and Ann Oakley (eds.), *The Rights and Wrongs of Women*, 1976, London, Penguin, pp. 19-23 *et seq.*

⁸² See Beatrice Whiting and John Whiting, *Children of Six Cultures: A Psycho-Cultural Analysis*, Cambridge, Harvard University Press, 1979 (4th printing), p. 112 (??). Indian fathers in Guatemala were expected to assist their wives in childbirth, holding them from behind in a supported squat delivery position. See Eileen Maynard, "Guatemalan Women: Life Under Two Types of Patriarchy" in Carolyn Matthiasson (ed.), *Many Sisters: Women in Cross-Cultural Perspective*, New York, The Free Press, p. 90.

⁸³ Nancy Chodorow, "Being and Doing: A Cross-Cultural Examination of the Socialization of Males and Females" in Vivian Gornick and Barbara K. Goran (eds.), *Women in Sexist Society: Studies in Power and Powerlessness*, New York, Mentor, p. 274.

on amulets, and so forth has likewise been overshadowed by technological machinery and the role of technicians in medicalized antenatal, postnatal, and labour and delivery stages. Record-keeping is emphasized, registration of births and deaths is required by law, and control over licensure and training is formally vested in such government bodies as Departments of Health.

Traditional midwives in Malaysia - *bidan kampung* - have been trained in principles of hygiene, sterile techniques, and family planning. Home deliveries have however tended to shift to formally trained nurse-midwives. There has been some adaptation of government-trained midwives to local customs; nevertheless, the legislation requiring midwives to be registered (and the lack of registration procedures for *new* village midwives) means that the tradition of village midwifery is likely to disappear as the current *bidans* age.⁸⁴ The *bidan kampung* thus are responsible for instruction in breast-feeding (or proper preparation of formula) and family planning, but not for assistance in labour and delivery.⁸⁵ Western influences on traditional birth practices are not entirely irresistible. Opposition to Western medical practices has been noted of rural women in Guatemala, Malaysia, Papua New Guinea, and the Yucatan.⁸⁶ Despite such resistance, there has been a clear movement away from home delivery and toward hospital or clinic deliveries in many Third World countries. As set out below, this shift toward medical management of births has benefits for infants and mothers in terms of life-saving interventions through modern equipment and improved

⁸⁴ Laderman, *op cit.*, Ch. 5.

⁸⁵ See P.C.Y. Chen, "Incorporating the Traditional Birth Attendant into the Health Team: The Malaysian Example", *Tropical and Geographical Medicine*, 1977, 29(2), 192-196. Laderman *op cit.*, p. 91 indicates that village midwives may be trained in recognizing symptoms of hypertension, placental retention, and postpartum haemorrhage.

⁸⁶ See respectively Cosminsky, *op cit.*; P.C. Chen, "Reasons Underlying the Maternal Choice of Midwives in Rural Malaysia", *Medical Journal of Malaysia*, 1978, 32(3), pp. 200-205; Naomi Scaletta, "Not Just Something Females Do: The Birthing Process in West New Britain, Papua New Guinea", Paper presented at the Annual Meeting of the Canadian Sociology and Anthropology Association, University of Guelph, Ontario, June 1984; Brigitte Jordan, *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden and the United States*, 1980, Montreal, Eden Press.

training of birth attendants regarding nutrition, sepsis, and careful management of labour, delivery, and post-partum complications.

A detailed account of this shift was provided by McClain. Her fieldwork in Ajijic – 40 kilometers from Guadalajara, Mexico – revealed a variegated system of maternity care: women delivered at home with traditional birth attendants or with an attending physician, although increasingly women in Ajijic were being delivered in hospitals. Accompanying this trend away from home deliveries was a decline in the number of practicing *parteras* coupled with the aging of two of the three practicing midwives (who were over 65 at the time of McClain's more recent fieldwork).

There are numerous instances of resistance to the Western model or incorporation of valuable aspects of Western medicine (asepsis, more nourishing diets, encouragement of earlier breastfeeding to provide colostrum to newborns) with traditional rituals.⁸⁷ A detailed biography of Jesuita Aragon, a senior midwife in Los Vegas, a small community in northern New Mexico, captures the incorporation of traditional healing practices with modern principles of hygiene and professional attendance. At the time of writing, folk beliefs in supernatural elements coexisted to some degree with sterilized equipment, procedures for emergency transfers to hospital, instruction by nurses, and so forth.⁸⁸ Traditional Hispanic midwives have nevertheless fallen in numbers and it seems more appropriate to speak of the replacement or displacement of folk healers and midwives by professional healers.⁸⁹ One point of commonality between latter-day and modern lay midwifery is a spiritual dimension in maternity care.⁹⁰ Source materials on the retention of African practices by Southern black

⁸⁷ McClain (1975), cited in Cosminsky, op cit.

⁸⁸ See Fran Leeper Buss, *La Partera: Story of a Midwife*, Ann Arbor, University of Michigan Press, 1980.

⁸⁹ Datha Brack, "Displaced: The Midwife by the Male Physician", *Women and Health*, 1976, 1(6), 18-24.

⁹⁰ Black, granny midwives in the southern United States sang spirituals during meetings with nurses. Campbell adds that the advent of formal midwifery instruction was not always

midwives include documentation of practices in folk midwifery. The authors add (without elaboration) that many of these folk practices have been adopted by modern obstetricians to improve birth outcomes for mothers and infants. ⁹¹ Hull found that midwives in rural Java believed that colostrum was contaminated, used septic bamboo blades to sever the umbilical cord, and used manual removal of the placenta, sometimes causing serious infections. ⁹² Observations by a Western-trained midwife of four village midwives in India included harmful practices such as vaginal examinations after touching cow dung (thus producing tetanus and other infections), rupture of women's membranes with fingernails, manual pressure on the fundus, ⁹³ and a cultural prohibition on "cold" foods and substances that led to labouring women becoming dehydrated and to ketosis poisoning. ⁹⁴

Some researchers have disagreed with favourable assessments of the work of traditional midwives in Third World countries. Traditional midwives in rural Vietnam were described as lacking precise knowledge of management of complicated deliveries. Their ineptitude could lead to "disaster" for mothers or their infants. ⁹⁵ Traditional midwives in Mexico, for instance, were perceived as not being knowledgeable about diagnosis of pregnancy, midwifery techniques in uncomplicated deliveries, and appropriate responses for complicated deliveries when a doctor

⁹⁰(cont'd) opposed by the granny midwives, and in some instances it was welcomed. Op cit,m pp. 23-24.

⁹¹ Nancy Faires Conklin, Brenda McCallum, and Marcia Wade, *The Culture of Southern Black Women: Approaches and Materials*, University of Alabama, Archive of American Minority Cultures and Women Studies Program, 1983, p. 79.

⁹² V.J. Hull, "Women, Doctors and Family Health Care: Some Lessons from Rural Java", *Studies in Family Planning*, 10(11/12), p. 316.

⁹³ Peruvian midwives were also observed applying pressure to women's abdomens to assist in delivery. See Gertrude E. Dole, "The Marriages of Pacho: A Woman's Life Among the Amahuaca" in Carolyn J. Mattiasson (ed.), *Many Sisters: Women in Cross-Cultural Perspective*, New York, The Free Press, 1974, p. 24.

⁹⁴ Holiday Tyson, "Village Midwifery in Northern India: The Role of the Dai", *Issue*, #5(5), 5-6.

⁹⁵ Richard J. Coughlin, "Pregnancy and Birth in Vietnam" in Donn Hart et al. (eds.), *Southeast Asian Birth Customs: Three Studies in Human Reproduction*, New Haven, Human Relations Area Files Press, 1965, p. 213.

was unavailable to them. Moreover, criticisms of indigenous midwives have emerged from their home countries, for example, in the Philippines. ⁹⁶

Other beliefs in traditional cultures clash with medical science. McClain's study of birth in a small Mexican community touched on the folk belief that a father's blood-drop created female embryos, while a mother's created male embryos. Congenital deformities, spontaneous abortions, and stillbirths were attributed to factors external to the mother, not to genetically-determined abnormalities. ⁹⁷

It has been generally reported that septic procedures by traditional midwives in Tropical countries contributed to serious infections. ⁹⁸ One programme in rural Bangladesh was designed to incorporate some traditional practices with principles of hygiene and adequate diet. The attendance of the traditional midwife, the *dai*, was supervised by paramedical staff and complemented by a local clinic consisting of a physician and other paramedics. The custom of withholding breastfeeding for three to five days after birth did not allow the newborn to receive colostrum (which aids the developing immune response system). Education regarding appropriate supplementary feeding when breastfeeding continues into the sixth month was also carried out, as was instruction in sanitation and hygiene to reduce the substantial numbers of children dying of postpartum tetanus and sepsis during infancy. ⁹⁹

High rates of infant mortality have thus been linked with inferior skills of traditional birth attendants. It has not however been established that decreases in infant and maternal mortality are attributable primarily to advances in the medical and nursing sciences. As one

⁹⁶ See Helga Velimirovic and Boris Velimirovic, "The Role of Traditional Birth Attendants in Health Services," *Medical Anthropology*, 1981 (Winter), pp. 91-92.

⁹⁷ McClain, 1975, op cit., pp. 40-41.

⁹⁸ V. da Cruz, *Bailliere's Midwives' Dictionary*, London, Bailliere Tindall and Cassell, 1969 (fifth edition), p. 354.

⁹⁹ Shushum Bhatia, "Traditional Childbirth Practices: Implications for a Rural MCH (Maternal and Child Health) Program", *Studies in Family Planning*, 1981, 12(2), pp. 70-71.

researcher concluded regarding birthing practices and infant mortality on a Guatemalan *finca* (plantation): ¹⁰⁰

"...the main causes of this problem (high death rates) do not lie in the birth practices themselves, but in the poor nutritional and health state of the mothers, the poverty and the larger socioeconomic problems of the *finca* population".

Research in American cities has likewise documented a positive correlation between poverty (and race) and infant mortality. It is generally accepted that many deaths of neonates (babies under 28 days old) are caused by congenital factors whereas postneonatal mortality is more likely associated with low income of mothers. ¹⁰¹

Birth Practices in Western Countries

The diversity of birth ritual and belief systems in the countries mentioned above is not absent in wealthier countries. While there is no question that there has been an entrenchment of obstetrics and technological monitoring and management of childbirth, ¹⁰² there are variations within cultures that are predominantly, but not wholly dependent on professional maternity care. Hazell found that many of the women giving birth at home in California used a variety of birthing positions including supported squatting and delivery on all fours. She noted that in many non-European countries the upright birthing position and the side-lying position was commonly used, while the lithotomy position remains standard practice in Western obstetrics. ¹⁰³

¹⁰⁰ Sheila Cosminsky, "Childbirth and Midwifery on a Guatemalan Finca", *Medical Anthropology*, 3(1), p. 101.

¹⁰¹ For a detailed discussion see Charles Brooks, "Social, Economic, and Biologic Correlates of Infant Mortality in City Neighbourhoods", *Journal of Health and Social Behaviour*, 21(1), pp. 2-11.

¹⁰² For a discussion of the extension of "obstetrical space" see the structuralist analysis by William Ray Arney, *Power and the Profession of Obstetrics, 1983*, Chicago, University of Chicago Press, p. 9

¹⁰³ Lester Dessez Hazell, *Birth Comes Home*, 1978 (2nd edition), Marble Arch, NAPSAC, pp.

Jordan's study of childbirth practices in four countries pointed to significant differences in childbirth management between Western nations: specifically, the Dutch approach retained domiciliary deliveries and discouraged routine medication, whereas Swedish practitioners relied on painkillers and hospital-based obstetrics. ¹⁰⁴ Home birth is not only a feature of contemporary Third World countries. In Holland, for example, approximately one-third of births occur at home. ¹⁰⁵ Nevertheless, the list of contraindications to home birth in Holland has increased over time while the percentage of births at home has slowly, but steadily decreased in recent years ¹⁰⁶ A hallmark of Dutch birthing policy is the reliance on midwifery assistance in birth, whether at home or in hospitals or clinics.

Midwifery in Japan and China

The majority of published works on cross-cultural midwifery practices pertain to Europe, North America, and Third World Countries. A sense of midwifery practice and of kinship practices surrounding birth in the Orient is provided by some recent studies. For example, Kitahara reported that midwives in contemporary Japan must be licensed and, as in Denmark, must practice in hospital settings. ¹⁰⁷ A contemporary observer depicted birth in Japan as hospital-oriented, technological, and medically-dominated, with some counter-trends in terms of

¹⁰³(cont'd) 40-42. Nevertheless, there have been alternative approaches to childbirth in European and North American settings, including the LeBoyer method and more recently Michael Odent's reliance on supported squat techniques in France. Of 898 births there in 1980, the episiotomy rate was only 8% and the rate of Caesarean section was five percent. See Michael Odent, "The Evolution of Obstetrics at Pithiviers", *Birth and the Family Journal*, 1981, 8(1), 7-15.

¹⁰⁴ Jordan, *op cit.*

¹⁰⁵ Paula Brook, "Midwives and Medicine", *The Magazine (The Vancouver Province)*, May 18, 1980, p. 7.

¹⁰⁶ See Gerald Kloosterman, "Organization of Obstetric Care in the Netherlands", *Midwifery is a Labour of Love*, 1981, pp. 9-24.

¹⁰⁷ Ryuju Kitahara, "Health Care and Medicine in Japan", Presentation, Department of Anthropology and Sociology, University of British Columbia, March 11, 1982.

domiciliary and clinic midwifery practice.¹⁰⁸ In her detailed observations of health care customs in Japan, another writer drew attention to the incorporation of scientific medicine with established kinship relations. Specifically, the practice of *satogaeri* – returning to the natal home for delivery of a woman's first child – is fairly common and stands in some contrast to the usual practice in Canada of women delivering in their locality.¹⁰⁹ The blend of modernity and tradition is also evident in the frequent use of the pregnancy sash (*iwata-obi*) which is thought to promote easier delivery by restricting the size of the fetus, and in the reliance on obstetricians, hospitals, and clinics.¹¹⁰

The global movement toward professionalized attendance in childbirth is apparent in China and Japan. This movement appears most pronounced in urban centres. In the early 1970s, it was reported that Chinese babies born in cities were usually delivered in hospitals, with doctors supervising these births. On the other hand, babies born in the countryside were delivered at home with the assistance of midwives. Anaesthesia was not used routinely for uncomplicated deliveries.¹¹¹

Conclusion

Cross-cultural birthing practices reflect considerable variation in birthing customs and the role of the midwife. Crucial to an evaluation of midwifery development in Canada, however, is the finding that only nine of 210 nations studied by the World Health Organization made

¹⁰⁸ Anna Jean Bradley-Low, "Observations on Midwifery and Maternity Care in Japan, *Issue*, #5, pp. 13-14.

¹⁰⁹ The custom in some other cultures is for the child to be born in the father's house. Misfortune was believed to befall children born elsewhere. See Doranne Jacobson, "The Women of North and Central India: Goddesses and Wives" in Carolyn Mathiasson, *op cit.*, p. 108.

¹¹⁰ See Emiko Ohnuki-Tierney, *Illness and Culture in Contemporary Japan*, 1984, Cambridge, Cambridge University Press, pp. 181-188.

¹¹¹ Ruth Sidel, *Women and Child Care in China*, 1973, Baltimore, Penguin, pp. 59-61.

no provision for midwifery service. Canada was one of these nine nations, and the only major industrialized nation without established midwifery services in the infrastructure of national birth attendance. The history of midwives in Europe reveals important variations: the promotion of scientific midwifery in France and Germany, for instance, contrasts with the general lack of publicly-sponsored midwifery instruction and government regulation in England.

The conflict over midwifery in British North America reflected many of these European concerns. Much of the literature on midwifery in Canada is critical of the takeover of birth by physicians and the displacement of midwifery. Nevertheless, serious consideration must be given to benefits that have accrued from medical research, nursing and medical training. These benefits include a stronger knowledge base on pregnancy, birth, and child development, and the translation of this knowledge into improved clinical care.

The point remains, however, that these benefits are not clearly predicated on medical dominance in childbirth. Substantial research and clinical programmes have been established in many countries worldwide in conjunction with developed midwifery programmes. Further work in understanding Canada's anomalous policy on midwifery could be connected with Lipset's interpretation of greater deference to elites in Canada and the identification of deference as a trait in Canadian political culture.¹¹² Despite the renaissance of community midwifery and demands for direct entry midwifery training (autonomous midwifery), less than one percent of deliveries are planned, home births in North America.

The midwifery conflict remains complex, however. Not all jurisdictions in Canada or the United States expressly prohibit the practice of community midwifery (or nurse-midwifery).¹¹³

¹¹² Seymour Martin Lipset, "Historical Traditions and National Characteristics: A Comparative Analysis of Canada and the United States", *Canadian Journal of Sociology*, 1986, 11(2), p. 138. According to Lipset, this diffuse respect for elitism is interpreted as greater encouragement of State powers in economic and social affairs. Edgar Z. Friedenberg, *Deference to Authority: The Case of Canada*, 1980, New York, Sharpe.

¹¹³ See Eleanor Barrington, *Midwifery is Catching*, 1985, Toronto, NC Press, pp. 140-141. State legislation of midwives is reviewed by Pacia Sallomi, Angie Pallow, and Peggy O'Mara McMahon, "Midwifery and the Law", *Healthsharing*, 1981, #21, pp. 63-83.

The regulation of midwives in British North America also varied from province to province. The variations in provincial statutes lend support to the historically specific nature of States as opposed to a monolithic view of State regulation of midwives. Federal, provincial, and state levels are not uniform in their statutes and may vary in their enforcement of these statutes.

Historical accounts of midwifery in Canada have generally highlighted the struggle between men and women: the exclusion of women from the universities, and the ideology of a "proper sphere" of reproduction and domesticity.¹¹⁴ The fault-finding remarks by some physicians toward midwifery practice are misplaced, especially concerning the competency of *trained* midwives practicing as an autonomous or semi-autonomous profession. As this Chapter has indicated, the general rejection of independent midwifery practice in North America stands in contrast to its acceptance in many other countries. The review of midwifery practice in Canada in the next Chapter provides additional support for the viability of *regulated* midwifery practice in home and hospital settings.

¹¹⁴ Ramsay Cook and Wendy Mitchinson (eds.), *The Proper Sphere: Women's Place in Canadian Society*, 1976, Toronto, Oxford University Press.

CHAPTER IV

RESEARCH METHODS

Introduction: Studying Childbirth

This study attempts to overcome several methodological difficulties with previous research on midwifery in Canada. The first difficulty is that women's voices are often absent in accounts of childbirth and in other forms of research. ¹ Notwithstanding the proliferation of specialized journals and organizations devoted to midwifery, it is still unusual to find detailed studies of midwifery, especially community midwifery, from the viewpoint of midwives. There are of course exceptions. The articulation of spiritual midwifery in the United States is one case-in-point. ² Recent interviews with community midwives in Canada also reflect the consolidation of knowledge about modern practicing midwives. ³

The second difficulty is that the study of birth is dominated by medical and scientific evaluations of childbirth. Birth outcome data, socio-demographic or medical descriptions of clients or patients, and continuing debates over the appropriateness of maternity care provisions in the health sector tend to be appraised within a paradigm of scientific measures.

The study of childbirth has been predominantly associated with medical research. Childbirth has been transformed into a medical phenomenon, flanked by legislation prohibiting non-medical attendance, and accompanied by a cultural expectation of medically-attended, hospital-situated births. ⁴ The obstetrical literature includes the central concern with reducing

¹ See for example Margrit Eichler and Jeanne LaPointe, *On the Treatment of the Sexes in Research*, 1985, Ottawa, Social Sciences and Humanities Research Council of Canada; Helga E. Jacobson, "Women's Perspectives in Research", *Atlantis*, (1979), 4(2), 98-107.

² Ina May Gaskin, *Spiritual Midwifery*, 1978 [revised edition], Summertown, The Book Publishing Company.

³ Eleanor Barrington, *Midwifery is Catching*, 1984, Toronto, NC Press.

⁴ Ann Oakley, "Wisewoman and Medicine Man: Changes in the Management of Childbirth"

rates of maternal and infant mortality and morbidity, the appropriateness of caesarean section operations, and other interventions alongside vaginal deliveries, the influence of diet and lifestyle on birth outcomes, and so forth. The corresponding model of pregnancy thus retains the traditional medical concern with disease and pathology. While childbirth is not identified as a disease akin to cancer, polio, or other diseases, it is seen as a process that can produce morbid conditions for mothers or fetuses. Some medical advances have in fact made major contributions in the management of pregnancies. Amniocentesis (analysis of amniotic fluid to check for congenital abnormalities of the fetus), ultrasound, and fetal heart monitoring are but a few of the technological approaches that can be utilized in the management of pregnancy and childbirth.

The midwifery debate is thus not usually pitched as midwifery versus technology. Instead, serious concerns have been voiced about routine and unnecessary medical interventions in childbirth and how the excessive use of valuable interventions has dramatically altered women's experience of birth. The medical paradigm emphasizes the specific etiology of disease, the treatment of diseases and illnesses by a professional health care team, and the development of health care policy by professional consultants, researchers, and administrators. An overarching theme in health care is the rationalization of resources, including the centralization of health care resources. This paradigm of health care now represents the dominant way of perceiving health and illness and of organizing material and human resources. The upper level of the health care research hierarchy, as in scientific research generally, is predominantly male.⁵

⁴(cont'd) in Juliet Mitchell and Ann Oakley (eds.), *The Rights and Wrongs of Women*, 1976, Harmondsworth, Penguin, 17-58. See also Diana Scully, *Men Who Control Women's Bodies*.

⁵ Specifically, research on reproductive technology tends to be carried out by male researchers. See the discussion by Angus McLaren and Arlene McLaren, *The Bedroom and the State: The Changing Practices and Politics of Contraception and Abortion in Canada, 1880-1980*, Toronto, McClelland and Stewart, 1986, pp. 144-145.

The hegemony of the medical paradigm has however been challenged by a folk model of health care. This model has roots in the Popular Health Movement and in a centuries-old tradition of community healing. ⁶ This folk paradigm is opposed to several tenets of the medical paradigm. Specifically, prevention of illnesses and disease is often sought through diet, stress reduction, visualization, and spiritual healing. Non-medical practitioners such as massage therapists, chiropractors, acupuncturists, herbalists, and naturopaths may also be involved in health care. Many forms of illness are seen as treatable by nonprofessionals or by self-help. Certainly the organization of health care administration and research and development has been criticized for the overrepresentation of men at the apex and for the dehumanizing treatment of women as patients and health care workers. ⁷ Finally, attempts to further centralize health care delivery are countered by local health care services, including maternity care centres and health collectives. ⁸

Alternatives to the medical perspective on birth have also been broadened through social research, including participant-observation studies. ⁹ These interpretive studies provide a greater appreciation of mothers' subjective experiences of birth. This complements the more tangible, "hard" measures of such variables as length of labour, parity (number of live births), and rates of infant or maternal mortality. There has also been a renewed interest in controlled studies of birth outcomes that compare midwife-attended home births (and transfers)

⁶ Barbara Ehrenreich and Deirdre English, *Witches, Midwives and Nurses*, 1977(?), Old Westbury, New York, The Feminist Press.

⁷ Lesley Doyal with Imogen Pennel, *The Political Economy of Health Care*, 1980, Boston, Beacon Press.

⁸ For a discussion of feminism and collectivity in health care see Linda Light, *Feminism and Collectivity: The Integrative Function*, September 1981, M.A. Thesis, Unpublished, Department of Anthropology and Sociology, University of British Columbia.

⁹ For critical accounts of childbirth management in hospitals see: Sandra Danzinger, "Treatment of Women in Childbirth: Implications for Family Beginnings", *American Journal of Public Health*, 69(9), 895-902; and Michelle Harrison, *A Woman in Residence*, 1983, Harmondsworth, Penguin. A comparative view of birth in various settings is developed by Brigitte Jordan, *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*, 1980, Montreal, Eden Press.

with physician and nurse-managed births in hospitals.¹⁰ These studies are frequently used to bolster the claim that midwife assisted deliveries at home – with proper screening of mothers and fetuses and with skilled attendants present – do not pose a greater risk of maternal or infant mortality or morbidity. There are however opposing studies and viewpoints on the desirability of out-of-hospital births. This research project on Canadian midwifery was therefore designed to explore the safety of midwifery practices in Canada, and to link the findings with international studies of midwifery practice and development.

Research Design

The medical and folk approaches to childbirth have influenced the design of my study. The medical-scientific influence on community midwives is reflected in improving documentation of their practices, more sophisticated equipment in their kits, examinations in clinical practice and theory, and the important liason with medical practitioners (e.g., screening out high-risk patients, and transfers to hospital during labour or post-partum). The influence of the folk model on *hospital* births is perhaps less dramatic: interventions in childbirth continue to be the norm, although there has been greater awareness of humanism and the role of family members in the management of childbirth.

My study design began with standard medical variables, including obstetrical and gynecological histories of patients, kinds of medications and monitoring devices during labour, and Apgar scores (a composite score of the newborn's heart rate, respiratory effort, muscle tone, reflex irritability, and colouration). While it was possible to document many of these variables, limits of time and human resources required a selective approach. I broadened the study methods to suit the practices of midwives operating outside of hospital settings. These included a description of the number of births attended by nurse-midwives and community

¹⁰ Two widely cited American studies are: Lester Hazell, *Birth Goes Home*, 1978, Marble Arch, NAPSAC and Lewis Mehl, "Outcomes of elective home births: a series of 1,146 cases", *Journal of Reproductive Medicine*, 19(5), 281-290.

midwives, the location of these births, the kinds of management and interventions utilized, along with standard birth outcome data. This descriptive approach was supplemented by interviews of practicing midwives and by my examination of memoranda pertinent to midwifery in British Columbia.

Another difficulty I faced was the time required to collect and analyze birth data gathered by community midwives. Midwives are notoriously busy with their practices, with a great deal of time devoted to prenatal care, consultations, postpartum checks, and attendance during labour and delivery. In addition, I was not personally acquainted with many practicing midwives, especially those who lived outside the lower Mainland region. Over a year was spent contacting these midwives by letter, using follow-up telephone calls or letters, and arranging meetings to discuss my study. There was an understandable reluctance to part with their documents, especially since very personal matters such as gynecological histories and marital relationships were often noted in prenatal visits. Some midwives were able to arrange drop-off of records personally or via friends, and out-of-province midwives usually enriched Courier services with their packaged birth records. From the initial 19 records handed to me by a B.C. midwife, the number of home birth records was gradually increased to over 1,000 cases of attempted home births.

There were some irresolvable differences. Some midwives did not have copies of their records and were only willing to have me code the records in their homes. Since some B.C. midwives lived a day's travel from my residence, and since the coding could require four or five days' work, this arrangement was untenable and their records are not included in my analysis. Other midwives had records stolen from their vehicles and in at least one instance records were destroyed out of fear that they could be used as evidence in a court prosecution.

The study methods are especially appropriate for the central problem of the research. The current status of midwifery in the context of State control becomes understandable

through a close examination of birthing practices, of the system of maternity care and its financial considerations, and through recent examples of prosecution of midwives through criminal law or quasi-criminal proceedings. The combination of documentary analysis, reference to case law and to the recommendations of Coroner's juries in Ontario and British Columbia, semi-structured interviews, and the available literature thus provides a backdrop against which the complex, containing function of the State is intelligible. The following sections elaborate on methodological procedures for the literature review, in-depth interviews, and my statistical analysis of midwifery practice in British Columbia.

Literature Review

The primary data gathered in interviews and through documentary analyses were set in context through a literature review. The review was initially used to determine issues surrounding midwifery practice. These included the controversy surrounding alternative (out of hospital) birthing centres, the viability of domiciliary midwifery, professional regulation and the organization of midwifery practice, and details of State regulation in various jurisdictions.

The literature review began with a search of social science citations on midwifery between 1975 and 1984, using the *Social Science Citation Index*. The available literature on nurse-midwifery was traced through a "Medline" computer search of references in *Index Medicus* between 1977 and 1984. A supplementary Medline search was completed on references to birth outcomes between 1977 and 1984. These references centred on current issues in obstetrics: rates of episiotomy, forceps extraction, and Caesarean section; reduction of maternal and infant mortality; induction and augmentation of labour, among others. In addition, a search of legal periodical literature was undertaken to identify case law and legal commentaries pertinent to childbirth-related law.

These core searches were followed by reference to *Current Contents*, specialized journals such as *The Practicing Midwife*, *The Journal of Nurse-Midwifery*, and *Mothering*. Two Canadian-based periodicals - *The Maternal Health News* and *Healthsharing* were also consulted. Various newsletters from midwifery and consumer associations added to these sources of information. Articles from larger-circulation magazines served to round out the available literature on contemporary midwifery; and reference was made to historical accounts of midwifery in England, France, the United States, and Canada. Materials from the Public Archives of Canada and the Vancouver Public Archives were also used in the literature search.

The theoretical dimension of the thesis was developed with reference to the growing literature on State theories and social control. The hegemonic status of liberal-democratic pluralism required attention to its precepts, particularly the notion that groups compete for political recognition within a general social consensus. Critical readings on the State have been integrated with the primary data and the available literature.

Thus, the methodology has been to employ the primary data as a means of testing several assumptions about the manner of State intervention into health services, the interests served by this intervention, and the nature of resistance to State-defined social relations. The specific apparatus of legal authority is considered with respect to the special (monopolistic) status of the health professions.¹¹ This focus is then linked with the intricate connections between legal enactments, legal enforcement, and midwifery practice.¹² These considerations are inseparable from the cultural critique of contemporary medicine as profit-oriented, male-dominated, and undercutting the public interest in favour of professional self-protection

¹¹ Eliot Freidson, *Profession of Medicine*, 1970, New York, Dodd, Mead and Company; Pierre Issalys, "The Professions Tribunal and the Control of Ethical Conduct among Professionals", *McGill Law Journal*, 1978, 24, 588-626.

¹² Much of this material arises from litigation in the United States. See Mary Forrest, "Natural Childbirth: Rights and Liabilities of the Parties", *Journal of Family Law*, 1978/79, 17, 309-322; and Raymond DeVries, *Regulating Birth*, Philadelphia, Temple University Press, 1985.

and remuneration.¹³ These considerations are also connected with sexual stratification in the health care sector. Women workers tend to be lower paid than males, and this appears true for midwives when compared with other obstetrical personnel.¹⁴ This research project thus required the integration of two often disparate research traditions – state theory and professional influence – with feminist work on gender, health, and law.

Sampling Procedures

As the researcher became more familiar with a number of midwifery projects that had been attempted or were ongoing, it became clear that a fairly complete sample of practicing community midwives could be obtained. Since nurse-midwives tend to be employed as obstetrical nurses, there was a fairly small number of nurse-midwives who had contributed to the birthing clinic proposal for Vancouver in 1980, to the Low-Risk Clinic Project between 1981 to 1984, or to the recent Midwives' Programme at the new Grace Hospital. Some midwifery initiatives required an overlap of community midwife and nurse-midwife involvement. These included media presentations (radio, television), lobbying government officials to establish Midwifery legislation outside of the British Columbia *Medical Practitioners Act*, plus the inauguration of a *sub rosa* Midwifery School in 1985 in Vancouver.

The identification of these initiatives and the creation of a roster of people involved in them were facilitated through "snowball" – or chain referral sampling. A chain referral sample involves a number of referrals established through a network of people who know

¹³ The major work from a cultural viewpoint is Ivan Illich, *Limits to Medicine*, 1977, Harmondsworth, Penguin.

¹⁴ One writer mentions that the low salaries of nurse-midwives in Britain have contributed to a shortage of trained midwives. See Robert MacDonald, "Midwives in Britain handle 76% of the births", *The Toronto Star*, July 18, p. A16. Community midwives in British Columbia currently require between \$600 and \$700 for prenatal, postnatal, and labour and delivery services. As will be demonstrated, this does not provide a high standard of living, especially if travel costs, equipment, time, and risk of legal prosecution are considered.

each other.¹⁵ It differs from random, representative sampling techniques in that the researcher does not have access to a standard information source such as a mailing list or a telephone directory; rather, direct references to other people is the central method for proceeding. The snowball approach has been widely used in sociological research, especially with populations who are difficult to contact through more conventional means such as telephone directories. It is an appropriate method for contacting individuals engaging in activities that are illegal.¹⁶ Snowball sampling has been employed in earlier studies of midwifery and obstetrics. An anthropological study of the West African Bariba used the chain referral method to correct deficiencies in lists of officially-known indigenous midwives.¹⁷

Snowball sampling was crucial in contacting community midwives in British Columbia and other provinces. Some community midwives had appeared on television and radio programmes addressing midwifery, others had advertised their practices, and some had published monographs or made other contributions in print. But only a small number of community midwives were thus visible, so six community midwives known to the researcher were interviewed as a point of departure. These midwives had practiced in various regions of British Columbia - in Vancouver, in the Fraser Valley, on the Gulf Islands, and in the Kootenays - and had diverse backgrounds. Some had completed nursing training; others had apprenticed as community midwives. They also differed in their affiliations: some were active in a Midwives' Collective, others were members of the Midwifery Task Force or the Midwives' Association of B.C., and some had contacts with other Associations in North America and Europe. These midwives knew one another personally but did not socialize together on a weekly basis. These midwives provided names of other midwives known to

¹⁵ Biernacki and Waldorf, "Snowball Sampling: Problems and Techniques of Chain Referral Sampling", *Sociological Methods and Research*, 10(2), 151. See also Nan Lin, *Foundations of Social Research*, 1976, New York, McGraw-Hill, pp. 162-163.

¹⁶ For example, see John L. McMullan, " 'Maudits voleurs': Racketeering and Debt Collection in Montreal", *Canadian Journal of Sociology*, 1980, 5(2), 121-143.

¹⁷ Carolyn Sargent, *The Cultural Context of Therapeutic Care: Obstetrical Care Among the Bariba of Bebin*, 1982, Dordrecht (Holland), D. Reidel.

them in order that they might be contacted by the researcher, and the growing list of active midwives was increased further by contacts with people active in the Midwives' Association of British Columbia. The 1986 Conference - *Midwifery in the Americas: Woman to Woman* - attracted many other midwives to Vancouver. The author met several midwives from B.C., Saskatchewan, Manitoba, and Saskatchewan. After considerable discussion of my study and the problems of sending documents to me, all agreed to send material or to discuss this research project with other practicing midwives known to them. In some cases several weeks elapsed between this meeting and receipt of records. Approximately five community midwives from British Columbia and Manitoba did not provide records. Most of these midwives offered no explanation for their decision. One midwife was reluctant to release her records but expressed support for the study. Her suggestion that I travel to her home to examine the records was not feasible due to the distance and time required.

Table Two outlines the representation of birth records by province.

Table 2: Home Birth Records by Province

	n	%
British Columbia	613	61.9
Ontario	346	35.0
Saskatchewan	20	2.0
Other	11	1.1
Total	990	100.0

Source: B.C. Home Birth Records

Community midwives are unregistered practitioners under current provincial legislation. In light of their outlaw status, few community midwives openly advertise their services. Most prefer to act less publicly, finding clients through word of mouth, self-referral, or through referrals from other midwives or organizations sympathetic to community midwifery. For sampling purposes, then, the most appropriate method of interviewing community midwives was

through the chain referral method. The pre-test interviews with midwifery lobbyists, lawyers, community midwives, and nurse-midwives provided a roster of currently practicing community midwives. This roster was then checked against the membership list of the Midwives' Association of British Columbia.

The sample of nurse-midwives was also drawn through a chain referral method. Unlike the community midwife sample, this was not necessary for legal reasons. Nurse-midwives are able to practice obstetrical nursing under the provincial *Nurses Act* and they are not on the same precarious legal footing as community midwives. Rather, the difficulty is that the majority of certified nurse-midwives and obstetrical nurses in Canada are restricted in using their skills. In theory, if not always in practice, doctors are primarily responsible for the management of childbirth, including "catching" the baby. Since the focus of the research was on more autonomous midwifery practices it was not helpful to draw a random, representative sample of nurse-midwives currently registered in British Columbia. Instead, interviews were conducted with midwives who had contributed to the Low-Risk Clinic, to the new Grace Midwives' Project, to the grant proposal for an out-of-hospital Birthing Clinic, and to other attempts at innovative midwifery practices. For this sample and the community midwife sample, an attempt was made to interview each midwife to address the problem of skewed samples sometimes associated with the snowball sampling technique. ¹⁸

The scope of interviews and birth record data followed the contours of midwifery practice. For community midwives, most respondents were active in the lower mainland of British Columbia, the Kootenays, and to a lesser extent, on Vancouver Island and in the Okanagan Valley. Nurse-midwife initiatives tended to emerge from the more urbanized regions, especially Greater Vancouver. For the community midwives and the nurse-midwives, the researcher sought to gain as complete a sample as possible. Since the number of eligible respondents was fairly small this strategy was feasible; in a larger pool of eligible

¹⁸ David Downes and Paul Rock, *Understanding Deviance*, 1982, London, Martin Robertson.

respondents a randomized sampling approach might have been necessary.

There were few refusals. Most midwives were quite agreeable to the interview, supplying their birth records and other documentation upon request, and all respondents were generous with their time. The face-to-face contact likely resulted in fewer non-responses than might have been expected with mailed questionnaires, particularly those requiring detailed responses.¹⁹

Interview Frame

The core interview frame for the study (see Appendix D) was adapted to the midwife respondents. Since training for nurse-midwives and community midwives was rarely identical – all nurse-midwives were trained in formal nursing or midwifery programmes while most community midwives had not completed these programmes but had learned through apprenticeship and their own empiric – the basic interview frame was designed to record such dissimilarities and also points of commonality, including opinions on specific issues in maternity and infant care.

Semi-structured interviews with community midwives and nurse-midwives were used to complement the other sources of evidence. The interviews enabled the researcher to probe behaviours that were not usually available from the other sources: involvement with other health care professionals; contact with legal authorities and threatened legal action against midwives; training in midwifery and experience in maternity and infant care.

The initial interview frame was developed from current literature on midwifery. The researcher provided the Consent Form (see Appendix C) to the respondent prior to the interview. Once the Consent Form had been signed by the respondent and the researcher, and dated, several general topics were covered in the interview. The initial questions were

¹⁹ Daniel Koenig, Gary Martin, and Lauren Seiler, "Response Rates and Quality of Data: A Re-Examination of the Mail Questionnaire", *Canadian Review of Sociology and Anthropology*, 1977, 14(4), 432-438.

very open-ended, dealing with why the respondent became a midwife, and how she justified midwifery. This open question occasionally had a chilling effect, but most midwives articulated their attachment to midwifery at some length. This enabled the respondents to sketch the elements of midwifery they perceive as most important in their decision to enter midwifery. Specific data on training - e.g., state-certified midwifery [Britain], certified nurse-midwifery [United States], empirical training, and so forth - were often elicited; when they were not, the researcher probed for details of training.

Subsequent questions dealt with the capacity in which the respondent attended births. Most began as apprentice midwives, later moving into primary caregiving and, in many cases, into partnerships with another midwife. The years in which births were attended, the number of births for each year, and reasons why the respondent might have undertaken fewer births in a given period were also determined. Additional information on the number of prenatal visits, timing of visits, and philosophy concerning prenatal care were noted.

The management of labour, delivery, and the postpartum period is central to the work of midwifery. Questions about screening of clients were asked in a structured fashion to begin with. This included asking the respondents if they would screen out (i.e., refer them elsewhere or simply decline to see the client in future) clients for such reasons as breech presentation at term, previous caesarean section, epilepsy, gestational diabetes, smoking during pregnancy, home birth. Respondents were then asked if they referred to a written set of guidelines or standards regarding contraindications to attendance. Additional information included their "transfer rate" to other settings. For community midwives, this involved transfer of women in labour or after delivery to hospital; for nurse-midwives, transfer usually involved the movement of women to another setting within the hospital or the involvement of other specialists when complications arose. These verbal reports were combined, where possible, with documentation of birth attendance. These documents dealt explicitly with birth outcomes, including rates of forceps delivery, caesarean section, induction, episiotomy, and the like. This

information was crucial with respect to the continuing debate over unnecessary interventions and the contention that midwives can lower intervention rates without jeopardizing the safety of mothers or infants.

The section on optimal structures for birthing in British Columbia augmented the above information. This allowed the respondents to reflect on what could be (or what ought to be) in place. This was a useful point of departure for the companion questions on the role of the State in encouraging or impeding optimal maternity and infant care. The specific role of the legal sector in regulating birthing – through the monopoly status of doctors and nurses, and through criminal sanctions that can be brought against birth attendants – helped to illuminate the relationship of State intervention to occupational practices. This was especially useful in probing the controversial issue of whether the State should be involved in establishing standards of care, and if so, what considerations should be foremost.

The final part of the Interview Frame consisted of specific social and demographic information on each respondent. Marital status, age, educational level completed, personal income and family income (where appropriate), religious or spiritual affiliation, associations and memberships, nationality, and the like were queried. This helped to round out the profile of respondents and to provide valuable detail on how midwives are able to practice (what resources are available to them), and the general nature of contemporary midwifery.

The interview frame developed through the pre-test and subsequent interviews thus allowed a good deal of construct validity. Since, as a researcher, I was not involved as a practitioner, the midwives were able to reflect on the questions set out and to suggest other significant aspects for midwifery practice in particular regions of British Columbia. The interview frame was used, where applicable, in the four interviews with non-midwives. Two lawyers, a nursing educator, and a lobbyist for midwives were interviewed to determine their views on the midwifery debate in British Columbia.

The researcher decided against interviewing physicians during the course of data collection. In part, this reflected the illegal status of community midwives. Since the researcher could not be guaranteed that the documents in his possession or his knowledge of particular midwives' practices would not be used in a police investigation or trial, it was best to restrict interviews to the midwifery community at this point. Moreover, given the effort required to gather and code the midwives' documents, there was little time during the study when the author could have scheduled several interviews with non-midwives. Reference is made in Chapter Six to some critical reflections by physicians on unregulated midwifery practice. Physicians' and nurses' views on optimal maternity and infant care are needed to complement the materials gathered in this project.

Interviewing Techniques

Interviews were designed to allow the researcher and the respondent to cover a variety of issues in a relaxed manner. Two to three hours were allotted for the interview. In some cases this allotment was exceeded; in others the interview took place in two or three installments if the respondent was unable to meet for a lengthy time-bloc. The pre-test interviews confirmed that the complexities of midwifery practice and of the political context in which it occurs could not be covered in depth in less than the three hours. A few midwives, who had practiced for several years and attended a few hundred births as a primary caregiver, were interviewed for several hours.

The interviewing strategy required a sensitivity to possible sources of distortion in respondents' accounts. Probes were used to clarify what the respondent mentioned.²⁰ "Triangulation" techniques – reference to other sources of information – was employed to supplement or cross-check the interview data. Birth records were one source of verification; records and recollections of other midwives involved with the particular respondent were other

²⁰ Seymour Sudman and Norman Bradburn, *Asking Questions: A Practical Guide to Questionnaire Design*, 1983, San Francisco, Jossey-Bass.

sources.²¹ The semi-structured format also avoided some of the difficulties associated with pre-figured, closed interview formats.²² At the same time, the interview strategy and frame allowed for comparability of data. This offset the possibility that a completely open format might result in fairly idiosyncratic material that could not be comparatively assessed.

Documentary Evidence

Birth records are a valuable source of descriptive information about the management of birth, the number of prenatal and postnatal visits recorded by the midwives, birth outcome, and aspects of the woman giving birth. In this study, the documentary analysis began with records of attempted home deliveries with midwife assistance. This sample of records includes planned attempts to deliver at home, whether the delivery was completed there or not, regardless of the birth outcome.

A preliminary sample of 440 home birth records was gathered from midwives primarily active in Vancouver, the Fraser Valley, and the Kootenays. These records were examined and numerous variables were coded on Fortran sheets using a preliminary codebook.²³ The codebook served to quantify numerous variables associated with the management of labour and delivery. For example, the three stages of labour indicated on the home birth records were noted. The first stage is conventionally recorded from the onset of regular contractions to full dilation (10 centimetres) of the cervix. This stage is usually far longer than the other two stages, averaging 12 hours for primigravidas and about six hours for multigravidas.

²¹ Biernacki and Waldorf, *op cit.*, p. 150.

²² For a demonstration of the differences in responses associated with different formats see Howard Schuman and Stanley Presser, "The Open and Closed Question", *American Sociological Review*, 1979, 44, pp. 697-712.

²³ Earl Babbie, *The Practice of Social Research*, 1979, [second edition], Belmont, Wadsworth, pp. 367-369.

The second stage of labour lasts from full dilation to delivery of the fetus. For primigravidas its duration is about one hour; for multigravidas this stage averages 20 minutes. The third stage begins from the time of delivery of the baby until the placenta is delivered. Usually the placenta is delivered spontaneously, although it may also require manual assistance or oxytocin for its expulsion.²⁴ Normally, labour is expected to be completed within 24 hours of onset of regular contractions. A fourth stage of labour may also be denoted. This stage lasts until about two hours after the placenta is delivered. Birth attendants are watchful of post partum complications, including haemorrhage or other kinds of excessive bleeding. Other variables recorded included the duration of active labour and specific information on the mother giving birth.

Data on the woman (or couple) electing home deliveries were quite limited. Nevertheless, age of the mother, her parity (number of previous pregnancies), and gravida (number of live births), along with information on previous births where applicable were frequently indicated on the records. Reasons for electing a home delivery were quite instructive. In most cases this involved a feeling that hospital deliveries were inappropriate with respect to interventions during labour and delivery, separation of mothers from newborn babies, and a general sentiment that giving birth in the presence of people one knows well can foster a healthier birth for mothers and infants.

A central issue in the midwifery debate is whether midwives can reduce such interventions as episiotomy, caesarean section, forceps delivery, induction and augmentation of labour while maintaining safety of the mother and child. These two dimensions were quantified for the home birth records and then compared with similar statistics from hospital-situated deliveries. The records also traced the rate of transfer from an attempted home delivery to hospital as well as calls to paramedics for resuscitation or transfer to hospital.

²⁴ For a thorough coverage of the duration of these stages of labour see Margaret Jensen et al., *Maternity Care: The Nurse and the Family*, 1979, St. Louis, C.V. Mosby, p. 423.

Once the preliminary coding of 206 births was completed by the researcher, the preliminary codebook was taken to two senior community midwives for their comments. A physician and a nurse-midwife were also consulted and suggested changes to the codebook. These suggestions included more precise notations of delivery positions, inclusion of diverse measures of perinatal and neonatal mortality, and recording the time elapsing between rupture of the membranes and birth (to establish if serious infections resulted from prolonged rupture of the membranes before birth). A nurse-midwife also made several suggestions for revising the codebook, especially with respect to possible statistical comparisons between births at home and births in hospital. With her suggestions in mind, the preliminary codebook was tentatively revised. The revised codebook (Appendix B) and the Fortran sheets on which the 206 births were coded were then taken to three practicing midwives who were involved in most of these births. Their reflections on the codebook and on the Fortran data were helpful in correcting mistakes, in filling in missing data, and in providing construct validity due to their familiarity with the situations documented in the birth records.

At this point the remaining home birth cases were coded, either by the researcher or by research assistants under his supervision. A central guideline during the coding was that missing data would be inserted only if adequate documentation could be secured or if the primary care midwife was certain about missing data. Guesswork was strongly discouraged. The midwives were urged to not guess at information or speculate as to what might have happened. Missing data were thus left blank on the coding sheet. Where they could be determined, they were entered subsequently into the data file; where they were not recoverable, they were coded as "not available" for data analysis purposes.

All files were then checked by the researcher for accuracy, missing data, and possible recoding. The coding sheets were then submitted to the Data Entry Services department at the University of British Columbia Computing Centre. Each case was entered as machine-readable data, and analyzed using S.P.S.S. (Statistical Package for the Social Sciences).

Care was taken to insure that it would be impossible to identify any individuals through the use of the data.

Documentary evidence from nurse-midwife assisted births was comparatively small. The birth records from the Low-Risk Clinic ²⁵ and from the Grace Hospital Midwifery Programme were gathered to provide an initial point of comparison. Where possible, these statistics were compared against hospital-wide statistics within these hospitals, and with province-wide intervention statistics and birth outcomes. ²⁶ Each birth record in this study was treated as a single case. The statistical analysis began with the birth of each child, indicating how many birth attendants were involved, the date of delivery, and so forth. As set out in Appendix B (Codebook), other variables included the city or region in which the birth occurred, mother's age, gravida (number of pregnancies during the woman's lifetime), and parity of the mother, previous home births by the mother, diet, number of prenatal and postnatal visits by the midwives, time of each stage of labour, birth outcomes and interventions, transfers to hospital and calls for paramedics (where applicable), baby's weight and sex, information on the delivery of the placenta and suctioning or resuscitation procedures.

Summary

This study explores several dimensions of community and nurse-midwifery practice. Through interviews and documentary analysis a profile of midwifery as an occupation is developed and linked with the literature on medical dominance and occupational resistance to

²⁵ The report of the Project Team included numerous measures of the clientele, surgical interventions, and birth outcomes. See Elaine Carty et al., *The Low-Risk Clinic: Family Care Based on the Midwifery Model, 1981-1984*, 1984, Vancouver, Shaughnessy Hospital and University of British Columbia, School of Nursing.

²⁶ Roger Tonkin, *Child Health Profile: Birth Events and Infant Outcomes*, 1981, Vancouver, Hemlock Printers. Dr. Tonkin's study was largely concentrated on the period between 1971 and 1979. Additional data were obtained from Statistics Canada, *Births and Deaths*, and *Surgical Interventions and Treatments*.

monopolies such as the medical profession. A central dimension is the manner of State intervention in birthing. This is tapped through the available literature on the State (see Chapter Two), case law pertaining to criminal and quasi-criminal prosecution of birth attendants, instances in which B.C. midwives have been subject to legal threats or investigation, and the wider structuring of patterns of health care practice under the aegis of the State. The State is conceptualized within a structuralist framework for contemporary purposes. This reflects the limits of instrumentalist approaches to the State and the professions. Instrumentalism fails to consider the benefits offered through State intervention and professional service, does not account for fractions *within* the State and the professions, and fails to recognize that State officials can be held accountable for policy decisions and that affect the public interest.

Several methodological approaches are combined in this project. The available literature was used to isolate significant issues in the midwifery debate and to complement the primary data analysis. The primary data were gathered through qualitative and quantitative sources. Qualitative data were obtained via semi-structured, in-depth interviews with practicing community midwives and practicing nurse-midwives and through interviews with other people who were active in obstetrics and gynecology, teaching, or lobbying for more autonomous midwifery training, licensure, and practice. The interviews were conducted with samples of midwives drawn through a chain referral technique, accompanied by a cross-check of membership lists where possible. This sampling technique was necessary since a roster of independently practicing midwives is not readily available for nurse-midwives or community midwives. The interview data were transcribed in point form, numerous details were coded and statistically analyzed, and selected passages pertinent to the study are reproduced verbatim throughout this report. Quantitative data were secured through an examination of birth records. The final set of birth records involved over 1,000 cases of attempted home births in British Columbia, Ontario, and Saskatchewan between 1972 and 1986. Information on women seeking to birth at home, the nature of prenatal and postnatal care, and labour and delivery,

were coded and analyzed using S.P.S.S.. These records were then compared, where possible, with province-wide statistics on hospital-based births, complemented by statistics from particular hospitals and specific programmes, especially demonstration projects in which midwives were the designated primary caregivers.

The home birth records were cross-checked through other sources to obtain missing information and to check the accuracy of data initially gathered. It was thus customary to probe respondents' answers during the in-depth interviews. Moreover, coding of birth records was cross-checked with the primary care midwives to identify discrepancies between reportage and recall, and also to obtain information that was not set out in the birth records. Validity checks were also made by comparing multiple records (of the same birth) provided by midwives.

The pre-test phase of research involved interviews with five nurse-midwives, eight community midwives, and four persons who were either lobbyists for midwifery, nursing educators, or lawyers who had been involved either in midwifery litigation or in providing advice to midwives. Following the pre-test phase, the interview frame for practicing community midwives and nurse-midwives was refined. This involved the addition of more specific questions on their experiences with State regulation (actual or threatened prosecution, containment of their scope of practice). The interview frame was also altered in the interest of clarifying obstetrical procedures and terminology. The interview frame for the sample of non-midwives was semi-structured, including several standard questions about the viability of midwifery practice and the appropriate role of trained midwives.

Some problems were not resolvable in the course of research. Some midwives indicated that they were too busy to participate in the augmentation of data phase, while others no longer had pre-natal records (the records had been passed on to the client, had been destroyed by the midwife, or had been stolen). Again, the face-to-face contact or being vouched for by a midwife known to prospective contributors seemed to be vital in securing

these documents.

Extensive attempts have been made by the researcher and research assistants to record as much information as possible from the available records. Documents were examined carefully, and the augmentation phase of research provided either new information or correction of earlier codes. Nevertheless, where Apgar scores were not recorded, family income, and so forth, guesswork was not encouraged, and these blanks in the data set remain. This said, the data gathered here represent the largest number of attempted births managed by community midwives and they are interpreted in greater detail than in any previous accounts.

CHAPTER V

COMMUNITY MIDWIFERY AND NURSE-MIDWIFERY

"Pessimists may comment that one should not aspire to natural childbirth in case complications develop. This is like saying one shouldn't bond with the baby in case it dies, or one shouldn't fall in love in case one gets hurt. Such timidity and antilife sentiments lead to self-fulfilling prophecies and deny the human potential to respond to the unexpected." ¹

"The autonomous midwife - frequently self-trained - is a major anomaly in Canadian health care...Over 200 midwives ...have provided care for thousands of women in their homes over the past 15 years in Canada. This is a situation that organized medicine, nursing and properly trained midwives should not contemplate with satisfaction." ²

Introduction

The above excerpts illustrate the diversity of opinion surrounding the proper sphere of midwifery. The growth of the "New Midwifery", a form of community midwifery rooted in home birth and intensive prenatal and postnatal care, has attracted great controversy since its appearance in B.C. in the early 1970s. This chapter presents a detailed examination of midwifery practice and birth outcomes, primarily using B.C. data in combination with documentation from Ontario and Saskatchewan and, where possible, national statistics.

This form of community midwifery has endured despite legal prohibition. Community midwives in Canada derive incomes from their practices, obtain necessary supplies and equipment, and are active in lobbying for recognition through the State. For example, the

¹ Elizabeth Noble, *Childbirth with Insight*, 1983, Boston, Houghton Mifflin, p. 15.

² Robert A.H. Kinch, "Midwifery and Home Births", *Canadian Medical Association Journal*, 1986, 135(4), p. 280. Dr. Kinch favours the accreditation of Canadian midwives and the elimination of the self-taught midwife.

Midwives' Association of B.C. (M.A.B.C.) lobbies for legalized, autonomous midwifery and to develop guidelines for midwifery practice. They consult with sympathetic medical and nursing practitioners, and only a few births out of thousands assisted by community midwives in Canada have resulted in criminal prosecution or prosecutions for violation of the B.C.

Medical Practitioners Act.

However, community midwifery is marginalized and illegal. Out-of-hospital births comprise less than one percent of births in British Columbia (and nationwide). Community midwives are unable to bill for their services through the provincial Medical Services Plan and they do not have established hospital privileges. Community midwives are also more likely than medical personnel to be prosecuted for criminal negligence causing death. They are also subject to the quasi-criminal charge under the *Medical Practitioners Act* of practicing medicine without a license.

Community midwifery in Canada illustrates the structural limits placed on female birth attendants working outside the norm of professionally accredited, hospital situated childbirth. In spite of these limitations, for the past 15 years a debate over childbirth attendance has been evident in Canada and other industrialized countries. This debate addresses several issues: maternal and infant wellbeing throughout pregnancy, delivery, and the postnatal stage; women's control over pregnancy and childbirth; personal liberty and the overreaching powers of the State (including the institution of the hospital and powers allotted to the professions). There is concern over the increased use of childbirth technology in labour and delivery, and what some regard as the alienation of health care practitioners from their direct work with women.

3

In recent years, several midwives attending home deliveries have abandoned the term "lay midwife". The connotation is one of the laity, of hierarchy, and has long been

³ William Ray Arney, *Power and the Profession of Obstetrics*, 1982, Chicago, University of Chicago Press, p. 9. See also Stewart Wolf and Beatrice Bishop, *The Technological Imperative in Medicine*, 1981, New York, Plenum Press.

connected with *unprofessional* standards. Community midwifery emphasizes the decentralized nature of childbirth attendance along with the more personal emphasis between the community midwife and her constituency.

The sphere of practice is a continuing issue among midwives. The International Definition of the Midwife adopted by the International Confederation of Midwives clearly sets out a broad range of activities that can comprise midwifery. The midwife can be active during pregnancy, labour, delivery, and the postpartum period. She is also able to detect abnormal conditions (although a doctor should be summoned) and to work in domiciliary settings as well as hospitals, clinics, and the like. The sphere of practice also stipulates that midwives should be sensitive to the client's right to make decisions about the place of birth and general care. ⁴

COMMUNITY MIDWIFERY PRACTICE IN CANADA

The community midwife network in British Columbia is complex. Most midwives have learned their skills through a mixture of apprenticeship with senior midwives, their own empiric, reading, and some have moved into community midwifery after completing formal nursing requirements. The dichotomy between the traditional midwife and the professional midwife seems more appropriate for non-Westernized societies in which there may be substantial gaps in literacy, formal education, knowledge of hygiene and birth management between the two groupings.

⁴ International Federation of Gynaecology and Obstetrics (F.I.G.O.) and the International Confederation of Midwives (I.C.M.), "International Definition of Midwifery", *Maternity Care in the World*, (second edition), 1976, pp. x-xi.

Empirical Training and the Midwifery School

One development in the community midwifery movement has been the extension of formal instruction into the movement. A full year of academic training was recently completed *sub rosa* by 17 students through a Midwifery School established in Vancouver by local community midwives and some of their supporters.⁵ The academic phase, paid for by the students, staffed by trained nurse-midwives, and examined by midwives with International training is followed by a clinical phase of perceptorship. While many of the new community midwives have not completed formal nursing requirements, a number of British Columbia midwives are either registered as (or are eligible to join) the Registered Nurses' Association of B.C. One practicing community midwife expressed her ambivalence toward formal nursing training in childbirth:

"The nursing (training) was a mixed blessing. Nursing gave me a lot of the skills. I was comfortable giving injections, comfortable with catheterizations, with taking blood pressure and pulse, just those basic nursing skills that a midwife apprentice has to learn. And it can be difficult learning those skills. The thing that was really difficult for me was that even though I basically knew that women could birth babies, and birth them graciously and have them at home, it took me a long time to understand that on a gut level, and to really believe, yes, that women could give birth."
(Community midwife #3, February 1985).

Thus, the complex relationships between State and community initiatives are again evident. Against the norm of professionalized nursing — situated in the hospital and supervised by physicians — some nurses have opted for community midwifery practice. Others have contributed to an unlicensed, unrecognized Midwifery School. One irony here is that accreditation for this School is currently being sought through Washington State, even as efforts continue to lobby for legalized midwifery in British Columbia.

Some out of province midwives report attending workshops as a form of instruction. A

⁵ See Cheryl Anderson, "Midwifery and the Family Physician", *Canadian Family Physician*, 1986, 32, p. 11.

Manitoba community midwife noted:⁶

"After those first four births I went and took a very good workshop in Vancouver. I invested money and bought books and equipment and felt a little more like I knew what I was doing...."

Teamwork

A general principle is that community midwives prefer to assist in labour and delivery with at least one other midwife present. It is rare for birth attendants to attend births by themselves, with the possible exception of emergency situations when another midwife or birth attendant cannot be present. The philosophy of the Freemont Birth Collective is clear on this point: two midwives are ordinarily present for births, sometimes a third, but never one.⁷ There are instances where a midwife may assist at a precipitous labour and delivery by herself but these are not planned. A senior midwife (CM #2) explained that of over 200 primary care births only one or two were conducted without another midwife present.

There is a commonsense basis to this. Midwives are likely to encounter situations which require the skills of two attendants.

"Probably the highest stress of any year in my practice was handling all the responsibility at births for about a year...it's a huge disadvantage, there is no advantage as far as I am concerned. It's really high stress. And it's really important to have a second opinion, especially if you are emotionally involved and often you have an attachment to the woman. It is helpful to have someone present who doesn't have that rapport and who can look at it more objectively.

The turning point for me was when I did a birth alone (in an area where a hospital was not at hand). The woman had a precipitant labour, one hour start to finish for her first birth, which runs a lot of risk for the mother and the baby. The baby didn't breathe and the mother had a massive post-partum haemorrhage. There was a real sense of having only two hands...the father completely flipped out and left the room. It was managed by giving the mother an injection to stop the bleeding with one

⁶ See Ya'qub ibn Yusuf, "Learning from Birth - an interview with midwife Darlene Birch," *Chautauqua Review*, Summer 1984, #2, pp. 13-23.

⁷ Freemont Birth Collective, "Lay Midwifery - Still an 'Illegal' Profession", *Women and Health*, 1977, 2 (3), p. 20.

hand, and using the other hand to stimulate the baby... That was the last time I did a birth alone" (Community midwife #4, March 18, 1985)

Community midwives also maintain contacts with general practitioners. This may involve referrals of the midwife's clients to a physician for a check-up; in other cases the contacts are more direct.

"The back-up physician for one birth had been at the home, as a friend only, and had been completely informed about the care of this client. The physician knew an hour before we arrived that (this client) would be transferred from home to hospital. S/he called in a specialist that we knew would not be hostile: this specialist likes women and is cooperative with us...I knew there would be no repercussions against any of us because the whole team had been in on it." (Community midwife #4, March 18, 1985)

Collaboration between general practitioners and obstetricians and the community midwives indicates that midwifery is not entirely an oppositional movement, and that there are some medical personnel are sympathetic to the midwives' efforts to reestablish more autonomous midwifery services.

Caseload

The available literature on lay midwives indicates that caseloads are not particularly high, perhaps because of the organization of lay midwifery practice relative to more formalized practices of obstetricians and general practitioners. A midwifery practice shared by two midwives in a rural area of Montana ranged between 20 to 30 women.⁸ Community midwives in British Columbia generally report that they have more demand for their services than they can provide. It is now fairly common for a community midwife to attend between two to four births monthly. This caseload allows a sufficient monthly income for midwives. It also is a manageable number since the midwives' time must be allocated to prenatal visits, postnatal check-ups, time with the midwives' own family (most community midwives have

⁸ Joyce Sutley, "Montana Midwife", *Mothering*, 1982, #24, pp. 80-81.

children). This varies considerably but is usually constrained by the time midwives devote to prenatal and postnatal visits with clients, time with their own children, and meetings and formal instruction. Barrington found that contemporary community midwives in Canada play many roles: ⁹

"She is a domestic helper, a community worker, and a feminist health activist. Chances are, she is also someone's mother and someone's sweetheart. A midwife doesn't get much sleep!"

Community midwives interviewed by the author also reported that their work was very demanding. They were usually "on call" for their clients, care for their children was not always at hand if they were called to a birth, and financial pressures added to their stress. It is noteworthy, however, that a number of these midwives have since restricted their caseloads and made arrangements for childcare and some additional time for themselves.

Fees and Payment: "Eggs for a Year"

The term "fees" may be inappropriate since lay midwives have not always stipulated a fee, and there is evidence of lay midwives accepting payment "in kind" in lieu of cash payment. ¹⁰ In a discussion with a senior community midwife in 1987 she mentioned that she had been given "eggs for a year" after attending a birth in the Kootenay region of B.C. An important change has been a clear trend toward more standardized cash payments. The early days of the New Midwifery, where spiritual inclination was emphasized, has shifted toward a more businesslike stance. The days when a midwife took the bus to a birth or hitch-hiked (because she could not afford a car) have passed. Fees also have a professional connotation, something that lay midwives may wish to avoid since hypothetically it could bolster allegations that they are practicing medicine without a license. One lay midwife in British Columbia charged \$400 in 1983 for prenatal and postnatal care, labour, and delivery. ¹¹ Currently, midwives interviewed by the author charge approximately \$600 for this package.

⁹ Eleanor Barrington, *Midwifery is Catching*, 1985, Toronto, NC Press, p. 14.

¹⁰ Campbell, op cit., pp. 45-47. See also Sandra Klein, *A Childbirth Manual*, 1980 (revised) Victoria, B.C., Typescript Mimeo.

Community midwives enjoy tax advantages since they are self-employed. Supplies, transportation costs, costs of electricity, telephone, and office space can be calculated and deducted as employment expenses when midwives report their self-employed income to tax authorities.

Supplies

Another difference between lay midwives historically and their contemporary, North American counterparts is the latter's access to medical supplies and equipment. These could include oxygen, intravenous equipment, drugs, and so forth. The establishment of professional medical and nursing schools and practice has been accompanied by a degree of control over birthing supplies as well as technical knowledge and practice. Community midwives in B.C. have access to surgical gloves and scissors, oxygen, pitocin. It has been observed that practicing midwives in British Columbia have fewer difficulties obtaining such supplies than midwives in the United States, as a rule.¹² One lay midwife relied on oxygen supplies, a fetal monitor, and (unspecified) drugs in her practice.¹³ A variety of technological aids including telephone answering machines, pagers, and answering services are also commonly used by community midwives.

A number of community midwives have completed nursing training, while others have empirical training and the option of study within the Midwifery School. The question remains: to what extent is this control partial, how accessible are supplies to non-professional birth attendants in various locales?

Home Births by Province and Year

¹¹(cont'd)

¹¹ Tim Padmore, "Vancouver Hospital Tries Midwifery Program", *The (Montreal) Gazette*, February 21, 1983, p. A7.

¹² Paula Brook, "Midwives and Medicine", *The Magazine*, May 18, 1980, p. 6.

¹³ Tim Padmore, op cit.

The records used for the documentary analysis were drawn primarily from community midwives who were active in British Columbia, Ontario, and Saskatchewan.¹⁴ A few records from Manitoba, New Brunswick, California, and Washington State are also included. The entire sample of records spans the period between 1972 and 1986, with most records concentrated in the 1980s.

The difficulty in obtaining records from 1972 to 1977 is apparent in this Table. A number of the midwives who were active with a Birthing Centre in Vancouver and in attending births have since moved out of province. Moreover, record-keeping for many midwife-assisted births in this period was not extensive. This stands in some contrast to the current emphasis on careful charting of prenatal and postnatal developments, as well as labour and delivery. Nevertheless, the bulk of births analyzed in this chapter occurred between 1978 and 1986, and primarily in British Columbia and Ontario.

Clients

The clients of community midwives vary considerably within British Columbia. There has certainly been a stronghold of New Age philosophy in the Kootenays, where alternative lifestyles have taken root including adaptation of Navajo rituals, traditional healing, and the like.¹⁵ There is clearly an expectation by community midwives that their clients should take precautions against poor nutrition and other factors that might pose problems for the fetus or mother. The following outline of the "Parents' Role and Responsibility" is part of an *Informed Choice Agreement* prepared by two senior community midwives in B.C.

¹⁴ There appears to be a lower proportion of home births in Saskatchewan compared with British Columbia. One source indicated that there were approximately four births per month in Saskatoon. See Cindy Devine, "Childbirth Surrounded by Myths, lack of medical information", *Network of Saskatchewan Women*, 1981, 1(3), p. 6.

¹⁵ The most extensive work on community midwives in Canada, including the Kootenay midwives, is Eleanor Barrington's *Midwifery is Catching*, Toronto, NC Press, 1985.

Table 3: Home Births by Year and Province

YEAR	B.C.	Ont.	Sask.	Other	Total
1972	1	0	0	1	2
1973	6	0	0	1	7
1974	1	0	0	0	1
1975	0	0	0	0	0
1976	2	0	0	0	2
1977	22	0	1	0	23
1978	51	1	0	2	54
1979	40	16	4	0	60
1980	32	10	2	0	44
1981	57	54	2	3	116
1982	57	74	4	1	136
1983	59	39	1	3	102
1984	63	58	2	3	125
1985	81	59	3	3	146
1986	23	33	1	0	57
Total	495	344	20	17	875

Source: Home Birth Records.

"We request that the mothers we are involved with be responsible about the health of themselves and their babies, follow a balanced diet, receive good prenatal care and get adequate sleep and exercise. We also request that the couple acquire knowledge and skills necessary for labour and birth and relaxation, either through completion of prenatal classes, or a sufficient programme of self education. A midwife's care is individualized according to the clients she serves. It is important for you to make her aware of your expectations. In order for us to be effective as caregivers, we require that parents keep us well-informed as to problems or situations which may affect their care."

The natural childbirth style is often captured in the mother's intention to breastfeed. Of all the women attempting to deliver at home, 99.5% intended to initiate breastfeeding. This percentage even exceeds the 93% figure of breastfeeding among members of a Parents' Choice sample; i.e., women inclined to breastfeed their infants, on discharge from hospital. ¹⁶

The ages of women attempting home births ranges between 17 and 42 years. Two age-groupings that are at greater statistical risk of birth complications were underrepresented in this sample. Only a few teenagers attempted a home birth, and there were few women over 35 years of age in the home birth sample. ¹⁷ Other midwives practicing in Alberta report a similar profile of clients' ages. Their ages ranged from 20 to 42 years old, with an average age of 28.3 years. ¹⁸

Table 4: Ages of Home Birth Clients and Women Giving Birth in Canada

Ages	Home Birth		B.C.		Canada	
	N	%	N	%	N	%
15-19	9	1.1	2,348	5.4	22,090	6.0
20-24	154	18.4	11,212	26.0	98,272	26.8
25-29	317	37.9	16,349	37.9	143,386	39.1
30-34	268	31.9	9,990	23.2	79,121	21.5
35-39	84	10.0	2,914	6.8	21,048	5.7
40-44	6	0.7	287	0.7	2,400	0.6
Total	838	100.0	43,100	100.0	366,317	99.7

¹⁶ Other comparison groups in a Vancouver-based study did not rely so extensively on breastfeeding. Specifically, the percentage of women who initiated breastfeeding, by ethnicity, was as follows: English-Canadian (79%), East Indian (59%), Italian (50%), Greek (47%), and Chinese (31%). See C.F. Bradley et al., *Perinatal Health for the City*, Vancouver, Vancouver Perinatal Health Project, 1978, pp. 18-19. A study of 123 Malaysian women found that 75% breastfed their babies, 22% combined breastfeeding with bottlefeeding, and only three percent used formula milk exclusively. See Carol Laderman, *Wives and Midwives: Childbirth and Nutrition in Rural Malaysia*, 1983, Berkeley, University of California Press, p. 84.

¹⁷ The median age of 28 years is squarely in the middle of the childbearing years. The average age for women (having live births) in Canada in 1985 was 27.3 years, and the median age was 27.1 years. Statistics Canada, *Births and Deaths: Vital Statistics 1985*, November 1986, Ottawa, Supply and Services Canada, p. 17.

¹⁸ Noreen Walker, Sandy Pullen, and Marilyn, "Domiciliary Midwifery Report: 1980-1985", *Safe Alternatives in Childbirth*, Edmonton, 1986 (March/April), 3(2).

Sources: (1) Home Birth Records; and (2) Statistics Canada, *Births and Deaths: Vital Statistics 1985*, November 1986, Ottawa, Supply and Services Canada, pp. 6-7.

Gravida and Parity (Pregnancies and Births) of Clients

The number of pregnancies and previous births are two significant variables in establishing a client profile for community midwifery. **Gravida** refers to the number of times a woman has been pregnant, including her pregnancy at the time she is seen by the midwife. **Parity** indicates the number of times she has given birth.

Table 5: Gravida and Parity of Home Birth Clients

	Gravida		Parity	
	N	%	N	%
None	N.A.*	N.A.*	411	40.9
One	220	22.1	369	36.7
Two	318	31.9	162	16.1
Three	247	24.8	42	4.1
Four	123	12.4	16	1.6
Five	50	5.0	3	0.3
Six	25	2.5	2	0.2
Seven	7	0.7	0	0.0
Eight	1	0.1	0	0.0
Nine	2	0.2	0	0.0
10+	3	0.3	1	0.1
Total	996	100.0	1,006	100.0

Source: Home Birth Records.

* The minimum gravida is one. This measure includes the current pregnancy at the time of contact with the midwife.

A minority of the sample (22.2%) had previously given birth at home. Most of these women had just one previous home birth (n =156), twenty-one had two previous home births, and one Mennonite woman had seven previous home births. ¹⁹ Approximately one-third of these attempted home births were made by women who had not given birth previously, and about one-third of the sample had one previous birth.

Income and Occupation of Clients

The variables of income and occupation have been linked with birth outcomes in previous studies of health care. As noted in Chapter Three, there seems to be a positive correlation between greater income and higher status occupation, and lowered rates of infant mortality.

Community midwives did not usually indicate income of their clients and spouses, although one Ontario midwife tended to record these incomes, along with occupation. What is presented below, then, is a partial profile of couples attempting home birth. It serves, however, as an indicator of the *diversity* of occupations held by these people. The author's impression is that fewer lower-income people are evident in the home birth sample in recent years. Community midwives did not usually indicate income of their clients and spouses, although one Ontario midwife tended to record these incomes, along with occupation.

There is considerable variation in occupations of the home birth clients and their spouses. The entire range of occupations is reproduced in Appendix F. There were 54 homemakers listed among the women attempting home birth. Sixteen women were listed as "unemployed", and there were 10 nurses in the sample. The majority of women (29 of 182 listed) were working in clerical or secretarial positions. There was also a great range in occupations among the spouses of the women attempting home birth. Artists and salespersons were the

¹⁹ See Eleanor Barrington, *Midwifery is Catching*, 1985, Toronto, NC Press, pp. 93-100 for an account of midwifery practice in Mennonite communities.

Table 6: Family Income: Home Birth Clients

Gross income	N	%
\$10,000–\$14,999	4	8.7
\$15,000–\$19,999	5	10.8
\$20,000–\$24,999	6	13.1
\$25,000–\$29,999	9	19.5
\$30,000–\$34,999	9	19.5
\$35,000–39,999	5	10.9
\$40,000+	8	17.5
Total	46	100.0

Source: Home Birth Records

two most frequent categories for these spouses. A full profile of occupations is impossible since most midwives did not indicate clients' occupations on their records. It does however appear that the home birth alternative is attractive to a fairly broad cross-section of people, and certainly not to a small range of occupations or incomes.

There is a considerable range in combined spousal (gross) incomes recorded on the birth records. While there are few people who were on social assistance in this sample, the combined family incomes appear to correspond to average family incomes. There are few couples whose income is far above the average family income.

There is a continuing debate over the advisability of attempted home births for women attempting a vaginal birth after caesarean (VBAC). The dictum, "Once a caesarean, always a caesarean" has been challenged by research findings that rupture of the uterine scar occurs in a small minority (.005% to 1.0%) of attempted vaginal deliveries after a caesarean delivery. It is revealing that the Society of Gynecologists and Obstetricians of Canada recently supported

a motion favouring VBAC trials of labour.²⁰ While there is sympathy among many community midwives for women wishing to attempt a VBAC at home, only 3.7% of the birthing clients in this sample attempted a VBAC. If the clients who had not given birth previously are excluded, about five percent of the remainder were attempting birth at home after a caesarean section.

Table 7: Previous Caesarean Section

	N	%
No births*	252	32.9
No previous C-sect.	496	64.8
Previous C-section	18	2.4
Total	766	100.0

Source: Home Birth Records.

*This indicates the number of women who had not given birth previously and therefore could not have had a previous caesarean section.

Diet and Alcohol Intake

A stereotypic interpretation of midwives' clients is countercultural, including a vegetarian philosophy. The birth records suggested a more cosmopolitan orientation regarding diet. In fact, the midwives' documents indicated that while a substantial minority of home birth clients were vegetarian (21.6%), over two-thirds included meat in their regular diet.

Contemporary concerns over alcohol intake during pregnancy include harm to unborn children if alcohol intake is heavy. Fetal Alcohol Syndrome (FAS) refers to fetal

²⁰ Editorial, "Health Views", *Today's Health*, 1987 (March), pp. 62-63.

Table 8: Home Birth Mothers' Diet

DIET	N	%
Meat	465	70.6
Vegetarian	156	23.7
Seafood	38	5.8
Total	659	100.1

Source: Home Birth Records

malformations such as dysfunctions of fine motor functions, slower rates of weight gain, linear growth, and head circumference, and mental retardation. The effects of FAS tend to persist after birth as well. ²¹

Table 9: Alcohol Use During Pregnancy: Home Birth Clients

	N	%
None	355	60.9
Occasional	220	37.7
Daily	8	1.4
Total	583	100.0

Source: Home Birth Records

Home Birth clients, while not wholly abstemious as a group, are clearly moderate in their alcohol intake during pregnancy *if* they consume alcohol at all. This measure, combined with the very high percentage of mothers intending to breastfeed, and the relatively low percentage of daily smokers (see below), supports the notion that these women tend to follow some standard advice directed toward pregnant mothers and to be responsible in preparing for

²¹ See Jensen et al., *Maternity Care: The Nurse and the Family*, St. Louis, C.V. Mosby, 1981, pp. 809-812; Ruth E. Little and Ann Pytkowics, "Drinking During Pregnancy in Alcoholic Women", *Alcoholism*, 2(2), 179-183.

birth.

Table 10: Smoking among Home Birth Mothers

	N	%
No smoking	560	86.6
Occasional	16	2.5
Daily	71	10.9
Total	647	100.0

Source: Home Birth Records

Approximately 80% of the clients reported not using drugs other than alcohol or cigarettes. The most commonly used of these other drugs was marihuana (13.9%), followed by painkillers (3.2%), and insulin for diabetes (0.3%).

Prenatal Visits

Community midwives generally place great emphasis on continuity of care throughout pregnancy. This is also true of nurse-midwives concerned with the problem of anonymity that often occurs when women deliver in hospital. ²² Of 466 birth records in which prenatal visits by the midwife were recorded, only a few cases with no visits or three or less visits by the midwife were found. The median number of visits was five, with over a quarter of the women being seen on seven or more occasions. It should be kept in mind that most women also had visits with general practitioners or obstetricians in addition to visits from their midwife (or midwives). Therefore, the statistics presented above do not represent *all* prenatal visits or consultations for the home birth clients.

²² For a detailed review of a midwifery demonstration project that emphasized the importance of prenatal care, see Elaine Carty et al., *The Low-Risk Clinic: Family Care Based on the Midwifery Model, 1981-1984*, Shaughnessy Hospital Education Services & University of British Columbia School of Nursing, 1984, 67 pp. (typescript mimeo).

Table 11: Prenatal Visits by Community Midwives

	N	%
No visits	7	0.8
One to Five	301	34.9
Six to Ten	460	53.3
Eleven or more	94	10.9
Total	862	99.9

Source: Home Birth Records

Midwifery Practice and the Course of Labour

Midwives usually claim that their training allows them to minimize interventions during labour and delivery. Specifically, midwives contend that they do not regularly artificially rupture their clients' membranes, are sparing in the use of oxytocin to induce or augment labour (or expedite delivery of the placenta after birth), and in relying on anaesthesia during childbirth. Immobilization of women in labour is also discouraged. Midwives encourage women to move about and to bathe during labour. Furthermore, in keeping with the premise that birth is a personal process, women are encouraged to use delivery positions other than the lithotomy position if they wish.

Rupture of Membranes

A key premise of the community midwives is that by respecting the normal course of labour they provide a service to their clients and this protects the unborn child. One measure of their practices is the rupture of the woman's membranes, releasing the amniotic fluid. The great majority of women attempting home birth experienced spontaneous rupture of membranes. *Artificial* rupture of membranes (A.R.M.) may be employed to induce labour, or more commonly as a procedure when the amniotic sac is bulging, and ready to burst. According to 1980-1981 data, artificial rupture of membranes occurred in 8.6% of all hospital

births in Canada. ²³ In discussing the increased incidence of artificial rupture (in the attempted home birth sample) with several community midwives, they expressed surprise that A.R.M. occurred in about 15% of the sample. Other community midwives have reported A.R.M. in 15.6% of the births they attended between 1980 and 1985. ²⁴ It may be that A.R.M. is used to induce labour, or because a number of women about to give birth at home had intact amniotic sacs just prior to delivery and the sac had to be ruptured to permit delivery of the baby. The national rate of A.R.M. may be lower since all women giving birth are included

Table 12: Rupture of Membranes: Attempted Home Births

	N	%
Spontaneous Rupture	659	80.4
Artificial (Home)	124	15.1
Artificial (Hosp.)	21	2.6
Born in caul	9	1.1
Trailing membranes	7	0.8
Total	820	100.0

Source: Home Birth Records

*Born "in the caul" refers to babies who are delivered within the amniotic sac. In most cases the membranes will either rupture spontaneously or be ruptured by the birth attendant.

Meconium Staining

The presence of meconium (feces expelled by the infant) in amniotic fluid may indicate fetal distress. All sourcebooks recommend careful monitoring of the infant's heartbeat during labour if meconium is observed, with special attention to abnormal heartbeats (decelerations or accelerations). Meconium is not however an automatic indication of fetal distress. It is

²³ Statistics Canada, *Surgical Procedures and Treatments, 1979-1981*, November 1984, Ottawa, Supply and Services Canada, p. 34.

²⁴ See Noreen Walker et al., op cit., 1986. The 15.6% A.R.M. statistic applies for women who had reached six centimetres dilation.

customary for the newborn infant to be suctioned with a DeLee catheter to remove meconium or mucous that may endanger the infant's respiratory system. ²⁵ It is significant that over a tenth of these attempted home births involved some meconium. It is not always clear from the home birth records what procedures were taken to protect against fetal distress (which may be manifested in passage of meconium).

Table 13: Meconium in Waters: Attempted Home Births

	N	%
Clear waters	610	83.7
Old meconium	13	1.8
Fresh meconium	30	4.1
Unspecified meconium	76	10.4
Total	729	100.0

Source: Home Birth Records

Oxytocin and Anaesthesia

The critique of obstetrical management of childbirth also rests on what is seen as the unwarranted, routine use of drugs to influence the natural course of labour. The use of oxytocin to induce labour, augment contractions, or as a routine procedure to assist delivery of the placenta is one case-in-point. The norm in attempted home deliveries was to avoid the use of oxytocins, although it is more prominent in the third stage of labour (between the birth of the child and expulsion of the placenta).

²⁵ See Elizabeth Davis, *A Guide to Midwifery: Heart and Hands*, 1981, Santa Fe, John Muir Publications, p. 104.

Table 14: Use of Oxytocin in Attempted Home Births

	N	%
No oxytocin given	606	81.8
To induce labour	7	0.9
To augment labour	12	1.6
Post-partum (bleed)	109	14.7
Delivery of placenta	7	0.9
Total	741	99.9

Source: Home Birth Records

Anaesthesia was used very sparingly in the home births. Epidurals and general anaesthetics can only be given in hospitals, so all births completed at home did not have any anaesthesia. Emotional support was often provided by the midwives and spouses during painful contractions. Again, this raises the issue of the community of women and how this level of support may reduce the conventional use of anaesthesia. Certainly there have been statements concerning the reliance on technological solutions to birth events, particularly how a technological approach to birthing may increase women's fear of labour and promote more instrumental deliveries, use of pain relief, among other things.²⁶ While administration of analgesics (for pain relief) was not recorded in the study, it was used very sparingly, according to the home birth records.

Table 15: Anaesthesia in Attempted Home Births

	N	%
No anaesthesia	767	95.6
Epidural only	31	3.9
General anaest.	3	0.4
Epidural & General	1	0.1
Total	802	100.0

Source: Home Birth Records

²⁶ Grantly Dick-Read, *Childbirth Without Fear*,

Immobilization of women during labour and delivery has been challenged by some birth attendants and researchers. Walking during labour is thought to be beneficial for the mother and the fetus. The duration of labour may be shortened, and blood supply to the fetus may be increased if the mother is not restricted to the lithotomy position and is active during the labour.

A majority of women in the home birth sample walked at some point in their labours. Some women who did *not* walk during labour were experiencing rapid, strong contractions. Others may simply have been more comfortable in a prone position.

Table 16: Walking During Labour : Home Birth Clients

	N	%
Walking	365	56.6
Not walking	280	43.4
Total	645	100.0

Source: B.C. Home Birth Records

Source: Home Birth Records

Delivery of the Infant

Place of Delivery

Studies of home birth attempts demonstrate that most births can be completed successfully at home. A report by midwives practicing in Alberta indicated that 7.3% (n = 34) of women seeking a home birth were transferred to hospital and 1.7% of babies were

transferred to hospital.²⁷ Table 17 indicates that 86.3% of mothers in the attempted home birth sample delivered at home. It appears that only eight of these 885 women gave birth at the midwives' home or the home of a friend or relative. There was one case of a mother giving birth in a vehicle during a transfer to hospital, and just over 13% of mothers gave birth in hospital after an attempted home birth.

Table 17: Place of Delivery

	N	%
Home*	852	86.3
In transit	2	0.2
Hospital	133	13.5
Total	987	100.0

Source: Home Birth Records

*Includes birth at a birthing centre, midwife's home, or relative's home.

The commonplace emphasis on complications requiring transfer of home birth clients might be turned on its head. There is very little media attention to stillbirths in hospital. Of 43,911 live births in B.C. in 1985, there were 193 stillbirths (of infants over 28 weeks gestation). This converts to a rate of 4.4 stillbirths per 1,000 live births and specified fetal deaths.²⁸ In contrast, stillbirth at home garners considerable media attention and is more likely to be followed by criminal charges against the birth attendants. It is clear, however, that congenital problems that cause the death of an infant are unlikely to result in criminal

²⁷ See Noreen Walker, Sandy Pullen, and Marilyn, "Birth Stats: Domiciliary Midwifery Report, 1980-1985", *Birth Issues: Safe Alternatives in Childbirth*, 1986 (March/April), 3(2), p. 6. The babies were admitted for various problems: meconium aspiration, congenital heart abnormality, fever, spinal abnormalities, respiratory difficulties, and aspiration pneumonia.

²⁸ See Statistics Canada, *Births and Deaths: Volume One*, 1986 (November), Ottawa, Supply and Services Canada, pp. 4-5.

prosecution of birth attendants whether they are physicians or midwives, in hospital or at home.

Delivery positions

The importance of matching birth management with the needs of the mother is clearly reflected in the variety of birthing positions adopted by women giving birth in this study. In contrast, the conventional position for spontaneous vaginal delivery and forceps delivery is the lithotomy position. The lithotomy position for delivery occurs when the woman lies on her back, with flexed knees, and her abducted (drawn away from the mid-body) thighs drawn toward her chest.²⁹ The conventional use of the lithotomy position in hospital deliveries has been criticized for prolonging labour since it does not utilize gravitational force, among other things. Attempts by physicians to control delivery positions have prompted consumer demonstrations, most notably at the Royal Free Hospital in Hampstead, England. The introduction of active delivery positions, such as delivering in an upright position, had been followed by measures to discourage any position other than on one's back. A protest rally was organized by the National Childbirth Trust.³⁰ Results of a recent survey commissioned by the Canadian Medical Association indicate that only 26 percent of women surveyed had their choices of delivery positions respected by the attending staff.³¹ Community midwives believe that birthing is very personal, that a woman in labour may choose from a variety of positions to find one that is most comfortable for her. Just over two-thirds of the birth records (for which delivery position was indicated) mentioned non-lithotomy positions. Table

²⁹ See Margaret Jensen et al., *Maternity Care: The Nurse and the Family*, St. Louis, C.V. Mosby and Company, 1981 (second edition), p. 952.

³⁰ For an account of this, see CSP editors, "Birth Rights: Radical Consumerism in Health Care", *Critical Social Policy*, 1982, 2(2), p. 64. Another instance of lobbying for improved maternity and infant services is reported in The Spastics Society, "A Charter for the Eighties", Joint Statement on Maternity and neonatal services supported by 14 voluntary and professional groups, May 1981.

³¹ The survey of 2,013 women who had babies within the previous two years was completed in the summer of 1986. Canadian Press, "Birthing care gets a 'satisfactory' rating", *The Vancouver Sun*, April 3, 1987.

17 provides a general outline of delivery positions taken by women attempting a home birth. Precise information on these positions is provided in Appendix F. Women who were transferred to hospital likely delivered in the lithotomy position or a supine position. It is difficult to establish the exact kinds of position in hospital because midwives' records tended to be weakest if the woman was transferred out of their supervision.

Table 18: Delivery Positions: Attempted Home Births

	N	%
Lithotomy	31	3.6
Supine	131	15.4
Other	689	81.0
Total	851	100.0

Source: Home Birth Records

A variety of birthing positions were used by women in the home birth sample. The most frequently used position was on hands and knees and squatting was frequently used. A key point here is that midwives believe that there is no one superior delivery position that is suitable for all women. Most records indicated that women used a single delivery position to deliver their children. In about 10% of the births, however, women used two positions – for example, squatting and then side lying, – in order to deliver their babies.

Type of Delivery

Community midwives, as well as nurse-midwives, have indicated that through skill and emotional support for birthing women, rates of instrumental deliveries such as Caesarean sections and forceps deliveries can be reduced. Indeed, community midwife attendance is accompanied by a dramatic reduction in the rates of instrumental deliveries. The national rate for Caesarean section was 15.9% in 1980-1981, compared with a rate of under five percent for the attempted home births. Likewise, the percentage of forceps deliveries among the attempted home birth sample (2.9%) is substantially lower than the nationwide rate of approximately 20 percent.³²

Table 19: Type of Delivery: Attempted Home Births

	N	%
Spontaneous vaginal	784	93.4
Primary c-section	33	3.9
Repeat c-section	1	0.1
Forceps	21	2.5
Total	839	99.9

Source: Home Birth Records

³² Statistics Canada, *Surgical Procedures and Treatments, 1979-1981, November 1984*, Ottawa, Supply and Services Canada, p. 34.

Episiotomies

Community midwives contend that with perineal massage and support and skillful management of birth, most women can deliver babies without resort to episiotomies (surgical enlargement of the vaginal opening). The episiotomy rate in Canada has been estimated at approximately 80% of all births in Canada and about 70% of births nationwide in the United States.³³ Nationwide figures indicate that 26.4% of births in 1980-1981 involved episiotomies.³⁴ These figures may reflect the higher rate of Caesarean section nationwide, for these births do not require episiotomies. The following table depicts the dramatic decrease in episiotomies among attempted home births relative to hospital statistics.

Table 20: Episiotomies: Home Births and the Low-Risk Clinic

	Home Births		Low-Risk Clinic		Grace Hospital	
	N	%	N	%	N	%
No	846	94.0	37	78.0	356	53.6
Yes	54	6.0	11	22.0	308	46.4
Total	900	100.0	48	100.0	664	100.0

Source: Home Birth Records; Elaine Carty et al., *The Low-Risk Clinic*, 1984, pp. 20-21.

In their review of the available literature on episiotomies, Thacker and Banta concluded that there is no clear evidence of the benefits of *routine* use of episiotomies. They added that episiotomies are associated with discomfort and pain for women during the postpartum period, and some maternal deaths have been attributed to infections following episiotomy.³⁵

³³ See respectively Candy Kerman, "Birth in a Small Town," *Kinesis*, 1982-83 (December/January), p. 13; Student Nurses Association of Illinois, "Episiotomy as an American Phenomenon," *Journal of Nurse-Midwifery*, 1979, 24(1), p. 31.

³⁴ Statistics Canada, *Surgical Procedures and Treatments, 1979-1981*, November 1984, Ottawa, Supply and Services, p. 34.

³⁵ Stephen B. Thacker and H. David Banta, "Benefits and Risks of Episiotomy: An Interpretative Review of the English Language Literature, 1860-1980", *Obstetrical and Gynecological Survey*, 1983, 38(6), 322-338.

Midwives argue that the interventionist training of many physicians promotes the routine use of episiotomies. Moreover, perineal tears can often be avoided through perineal massage and support of the perineal area during crowning of the infant's head. The following table presents a comparison of perineal tear rates at Grace Hospital, at the Low-Risk Clinic, and among the Community midwives. It should be noted that 20 *unspecified* tears were documented in the home birth records. Since the degree of the tear could not be assessed, they have been included as a separate row in the table. Deliveries over an intact perineum are most common in the home birth sample. As noted in the previous table, the Low-Risk Clinic clients had a relatively low rate of episiotomy (22%) compared with hospital-wide statistics collected at the Grace Hospital in March 1983.

Table 21: Perineal Tears

	Home Births		Low-Risk Clinic	
	N	%	N	%
Intact	362	41.8	7	14.3
1st d*	308	35.6	20	40.8
2nd d.	121	13.9	11	22.4
3rd d.	13	1.5	0	0.0
4th d.	1	0.1	0	2.0
Unsp.	20	2.3	N.A.	N.A
Epis.	40	4.7	11	22.5
Total	865	99.9	49	100.0

Source: Home Birth Records; Elaine Carty et al., *The Low-Risk Clinic*, 1984, pp. 20-21.

*denotes degree of the tear: e.g., 1st d indicates a first degree perineal tear.

Post-Partum Measures

Suctioning of the newborn baby is undertaken in a considerable number of home births in the study. In some cases this is a precautionary measure; in others where the infant is in respiratory distress it may be a life-saving measure. Suctioning is not routinely undertaken by the community midwives as a grouping. It can however be used as part of the midwives' repertoire, especially if the infant appears to have inhaled meconium or mucous during labour or delivery.

Table 22: Suctioning Techniques: Attempted Home Births

	N	%
No suctioning	405	53.9
Bulb syringe	103	13.7
De Lee	117	15.6
Unspecified suct.	126	16.8
Total	751	100.0

Source: Home Birth Records

Apgar Scores

The Apgar scoring method was developed in the 1950s by Dr. Virginia Apgar, an American anesthesiologist. The infant's health after delivery is conventionally assessed on five measures – heart rate, respiration, muscle tone, colour, and reflexes – at one minute after birth and five minutes after birth.³⁶ Thus, a child who is given a maximum rating of two points on each of these five measures would have an Apgar score of ten. A score of zero indicates that the child is stillborn. Intermediate scores indicate some deficits in the child's health *at the time the measure is taken*. Scores in the lower range can indicate serious

³⁶ See Suzanne Arms, *Immaculate Deception*, New York, Bantam, 1977, p. 84.

difficulties in the newborn's health.

This composite measure of newborn health is usually recorded by community midwives. The following Table sets out the distribution of Apgar scores for infants delivered at home. Apgar scores are generally within the normal range for newborn infants. As the table indicates, there is a predictable increase in the Apgar scores over time for most infants. The small number of cases coded for 10 minutes after birth (n = 215) occurs because midwives tended to not record Apgar scores at 10 minutes unless there was infant distress.

Table 23 : Apgar Scores: Infants Delivered at Home

	One minute		Five minutes		Ten minutes	
	N	%		%	N	%
Zero	5	0.6	5	0.6	5	2.3
One	3	0.4	0	0.0	0	0.0
Two	3	0.4	1	0.1	0	0.0
Three	8	0.9	2	0.2	1	0.5
Four	21	2.4	0	0.0	1	0.5
Five	22	2.5	12	1.4	0	0.0
Six	49	5.7	6	0.7	0	0.0
Seven	86	9.9	13	1.5	1	0.5
Eight	207	23.8	40	4.6	3	1.5
Nine	331	38.1	230	26.5	13	6.0
Ten	133	15.3	558	64.4	191	89.0
Total	868	100.0	867	100.0	215	100.0

Source: Home Birth Records.

The third stage of labour comprises the time lapsing between delivery of the baby's body and delivery of the placenta. Spontaneous delivery of the placenta occurs when it is expelled without partial (or complete) manual removal, and when oxytocics are not used to hasten delivery. Birth records often indicated "controlled cord traction" by the midwife; however, this procedure is classified as a spontaneous delivery provided that oxytocin or manual removal were not used.

Table 24: Delivery of Placenta

	N	%
Spontaneous	762	92.5
Assisted	62	7.5
Total	824	100.0

Source: Home Birth Records

Delivery of the placenta was assisted in hospital for 31 cases (3.8% of all cases). Manual removal of the placenta was undertaken in four cases (0.5% of all cases). The Alberta midwives reported that only a small minority of labours required manual removal of the placenta (0.7%) ³⁷ **Neonatal, Perinatal, and Infant Mortality: A Review**

The debate over whether community midwifery is dangerous or desirable is not simply ideological. There have been a number of research studies addressing the issue of safety in planned home deliveries compared with planned hospital deliveries and the nature of the attendants as correlated with birth outcome. Standard measures include: *perinatal mortality* (deaths between 20 weeks' gestation and of neonates between birth and the following six days), *neonatal mortality* (deaths during the first 28 days after birth), and *infant mortality* which refers to deaths between birth and the first year of life. In the discussion of the Canadian home birth study which follows, only the first two measures (perinatal and neonatal mortality) are used. The postnatal period recorded by the community midwives does not usually follow up through the first year of life. Some exponents of midwifery argue that trained midwifery attendance has always produced results – infant and maternal morbidity and mortality – that are superior to physician-attended births in a wide variety of countries. ³⁸

³⁷ Noreen, Sandy Pullen, and Marilyn, "Birth Stats: Domiciliary Midwifery Report," *Safe Alternatives in Childbirth*, Edmonton, 1986 (March/April), 3(2), p. 5.

³⁸ David Stewart, *The Five Standards for Safe Childbearing*, Marble Hill, NAPSAC, pp. 111-154.

An Illinois physician also concluded that home deliveries, if properly managed, could be safer than hospital deliveries. He believed that the home was generally bacteriologically safer, and that physicians assisting at home were more cautious.³⁹

Others have produced mixed findings regarding the home birth issue and the question of qualified attendants. A research team studying neonatal deaths in North Carolina reported that the neonatal mortality rate among the 242,245 babies delivered in hospital was 12 per 1,000 live births. For physicians attending a planned home delivery, there were no infant deaths among the 55 cases recorded. For trained lay midwives attending home deliveries the neonatal mortality rate was 4 per 1,000 live births; moreover, the three deaths among the 768 babies delivered were related to congenital abnormalities. In one study of home births in North Carolina between 1974 and 1976, Burnett and his associates found that the rate of infant mortality varied as a function of planning for such births and midwifery attendance. Specifically, planned home deliveries with lay midwives in attendance has a rate of three neonatal deaths per 1,000 live births. The corresponding rate for planned home deliveries without lay midwives was 30 per 1,000; for unplanned home deliveries the neonatal death rate increased dramatically to 120 deaths per 1,000 live births.⁴⁰

One study of Hutterite midwives used physicians' records and birth certificates for Hutterite children born in Montana between 1961 and 1970.⁴¹ The authors found that 63% of deliveries of Hutterite children in their sample were attended by indigenous midwives - without training in nursing or obstetrics - and that the infant mortality rate for these children was not significantly different than that for Hutterite children delivered by physicians or non-Hutterite, Caucasian children delivered by physicians. Nevertheless, the neonatal

³⁹ See Gregory White, "A Comparison of Home and Hospital Delivery Based on 25 Years' Experience with Both", *Journal of Reproductive Medicine*, 1977, 19(5), 291-292.

⁴⁰ Claude A. Burnett III et al., "Home Delivery and Neonatal Mortality in North Carolina", *Journal of the American Medical Association*, 1980, 244(24), pp. 2741-2745.

⁴¹ Thomas Converse, Richard Buker, and Richard Lee, "Hutterite Midwifery", *American Journal of Obstetrics and Gynecology*, 1973, 234 (5), pp. 719-725.

mortality rate for Hutterite births managed by indigenous midwives was higher than Hutterite births attended by physicians; specifically, 16.4 versus 8.1 deaths per 1,000 live births. Additional problems included the midwives' lack of instruments to monitor fetal and maternal vital signs, infrequent and inadequate prenatal visits, reliance on the lithotomy position, and difficulties associated with managing uterine dystocia, cephalopelvic disproportion, and abnormal presentation of the fetus.

The best evidence, however, is that with proper screening procedures, transfer of mothers experiencing complications, and trained attendants, home birth does not result in higher rates of infant or maternal mortality. A large-scale study conducted by Mehl and his associates in northern California studied 1,146 home births attended by midwives, physicians, or both. They found that birth outcomes and rates of complications compared favourably with average rates in California.⁴²

A variety of studies of home birth outcomes in Britain and Holland have been published. All confirm that home birth compares favourably with hospital deliveries in terms of neonatal and perinatal mortality, and with lower rates of medical intervention in the birthing process.⁴³ While the issue remains whether women electing home birth are a healthier population in general than women delivering in hospital, there is clear support for the safety of home birth *under some circumstances*. It is important that women are screened for complications, that there is adequate prenatal care, that birth attendants are skilled in

⁴² Lewis Mehl et al., "Outcomes of Elective Home Births: A Series of 1,146 Cases", *Journal of Reproductive Medicine*, 1977, 19(5), pp. 281-290.

⁴³ See the following: (1) R. Campbell et al, "Home Births in England and Wales, 1979: Perinatal mortality according to intended place of delivery", *British Medical Journal*, 1984, 289, pp. 721-724; (2) M. Klein et al., "A comparison of low-risk Women booked for delivery in two systems of care: shared-care (consultant) and integrated general practice unit. I. Obstetrical procedures and neonatal outcome. II. Labour and delivery management and neonatal outcome", *British Journal of Obstetrics and Gynaecology*, 1983, 90, pp. 118-122 and 123-128; (3) S.M.I. Damstra-Wijmenga, "Home confinement: the positive results in Holland", *Journal of the Royal College of General Practitioners*, 1984, 34 (265), pp. 425-431. These studies have been reviewed by M. Tew, "Place of birth and perinatal mortality", *Journal of the Royal College of General Practitioners*, 1985, 35 (277), pp. 390-394; and by Caroline Flint, *Sensitive Midwifery*, 1986, London, Heinemann, pp. 29-30.

domiciliary management, and that back-up (emergency) services are in place.

With respect to this study of Canadian births, three essential dimensions in infant deaths are employed. First, the accurate measurement of such deaths; second, careful comparisons of time-frames; and finally, *attribution* of responsibility for these deaths. Since reports of infant deaths must be made under the *Vital Statistics Act* in Canada, difficulty does not usually arise with respect to infants at or near term. There are however various forms of fetal loss at earlier stages of pregnancy including planned abortions (therapeutic abortions) and spontaneous abortions (miscarriages)

As noted earlier in this section, two standard measures of fetal and infant death were used. **Perinatal mortality** measures death of a fetus of 20 or more weeks' gestation or of a neonate between birth and the following six days. **Neonatal mortality** is a more specific measure, addressing neonatal deaths during the first 28 days after birth. Both measures are expressed as the number of deaths per 1,000 live births. The last dimension will be discussed at greater length after the following measures of mortality. It is important, however, to distinguish between unavoidable infant deaths that may be due to congenital malformations and those that may be attributable to caregivers' negligence. ⁴⁴

Perinatal mortality rates are arrived at by dividing the number of stillbirths plus the number of early neonatal deaths (during the first week after birth) by the number of live births and the number of stillbirths, then multiplying the result by 1,000.

⁴⁴ This is conventionally referred to as *iatrogenic* (physician-caused) death. I am speaking here of negligence generally associated with caregivers, be they physicians, nurses, or midwives.

Table 25: Perinatal Mortality: Home Births, B.C., and Canada (per 1,000 births)

	B.C.(Home)		B.C.(Prov.)		Canada	
	N	R	N	R	N	R
Perin. death	3	12.34	NA	10.9	NA	13.0

Source: Home Birth Records. The B.C. perinatal mortality rate is assessed from 1979 data; the Canada-wide rate from 1978 statistics. See Roger Tonkin, 1981 (below).

The perinatal mortality rate calculated above should be interpreted with caution. It is possible that the rate may have increased if all attempted home births in British Columbia and the other provinces had been analyzed. One reason is that the author has not sought access to birthing records of community midwives who were involved in criminal prosecution, nor is reference made to another community midwife who left British Columbia after an infant death following an attempted home birth. It is arguable that exclusion of these records may deflate the actual mortality rates of midwife-attended, attempted home births.

There are other possibilities, however. One community midwife who attended hundreds of births in B.C. provided a small sampling of records which included a few perinatal deaths, including a stillborn twin. She had not been the primary care midwife for the woman, and was reluctant to deliver twins out of hospital. Nevertheless, she agreed to assist the woman who was about to deliver the babies. The point here is that the sample of attempted home births is missing thousands of these births between 1972 and 1986, and it is not possible to measure precisely the safety of hospital birthing alongside home births. A second point is that community midwives did not always select the most healthy clients. There are cases of women who might be screened out of home birth guidelines who delivered at home, for example, and it should be kept in mind that many women delivering in hospital are healthy and many have received good prenatal care.

Reports from other community midwives in Canada indicate that perinatal mortality rates are not above those for populations intending to deliver in hospital. ⁴⁵ In his study of birth statistics in British Columbia, Tonkin concluded that: "The mortality rate for infants born at home is not markedly different from that of hospital born infants". ⁴⁶ A report on 465 home births in Alberta between 1980 and 1985 indicated that there were only three infant deaths and one stillbirth. This converts to a perinatal mortality rate of 8.68 per 1,000 live births. ⁴⁷ The measure of neonatal deaths also shows a similarity between domiciliary midwifery outcomes and province-wide and Canada-wide comparisons.

Table 26: Neonatal Mortality: Home Births, B.C., and Canada (per 1,000 births)

	B.C.(Home)		B.C.(Prov.)		Canada	
	N	R	N	R	N	R
Perin. death	4	4.97	NA	6.7	NA	8.1

Sources: Home Birth Records; Statistics Canada, *Births and Deaths: Volume I (1984)*.

These comparisons appear to support the community midwives' claims that planned home births are not necessarily more dangerous than hospital-based births. These findings are consistent with earlier, published reports of low rates of perinatal and neonatal mortality among women seeking home births supervised by trained midwives. The corresponding figures

⁴⁵ This issue does not necessarily revolve around community midwifery versus hospital births. For example, Penny Armstrong, an Ontario midwife who has practiced midwifery with Amish women, provides a contemporary account of midwifery practice at home and in hospital. See Penny Armstrong and Sheryl Feldman, *A Midwife's Story*, 1986, Toronto, Fitzhenry and Whiteside.

⁴⁶ Roger Tonkin, *Child Health Profile: Birth Events and Infant Outcome*, 1981, Vancouver, Hemlock Printers, p. 18.

⁴⁷ Noreen Walker, Sandy Pullin, and Marilyn, "Birth Stats: (Domiciliary Midwifery Report, 1980-1985)", *Safe Alternatives in Childbirth*, Edmonton, 1986 (March/April), 3(2), p. 1.

for births managed by midwives on The Farm in Tennessee was 11.1 neonatal deaths per 1,000 live births. ⁴⁸

Post-Partum Visits

There was considerable variation in the number of postnatal visits. The convention is for the midwife to make at least three post-partum visits to assess the mother and the newborn. There were exceptions. One midwife reported that a client disappeared from the area shortly after the birth (and without paying the midwife for her services). In other cases where the birth took place some distance from the midwife's home, the midwife might stay for a few days or several days after birth. It may be that midwives did not document *all* home visits. If this is the case it underscores the need for improved documentation of practice, including post-partum activities of community midwives. The author's impression is that charting of births and midwifery practice has become more thorough since the early to mid 1970s.

Table 27: Post-Partum Visits: Home Birth Clients

	N	%
No visits	15	3.2
1-5 visits	394	82.9
6-10 visits	59	12.8
11 or more	7	1.5
Total	475	100.0

Source: Home Birth Records

⁴⁸ Ina May Gaskin, "Spiritual Midwifery on the Farm in Summertown, Tennessee", *Birth and the Family Journal*, 1978, 5(2), p. 104.

Safe Practice: Guidelines and Peer Review

The issue of infant and maternal safety is central to discussions of childbirth. Along with the feminist critique ⁴⁹ of conventional obstetrics – the reduced freedom of parturient women and the substantial power vested in the (predominantly male) medical profession – it is also asserted that midwife attendance (at home, or in hospital) can be as safe or safer than physician-managed, hospital deliveries. In British Columbia, many community midwives have devised collective standards and peer review procedures to assess what constitutes safe practice. Most practicing community midwives are members of the M.A.B.C., with several members founding a separate Midwives' Collective. At this point the debate over guidelines for practice is discussed with respect to self-regulation.

The "Guidelines to Midwifery Practice" are taken from the experience of community midwives, the Board of Directors of the M.A.B.C., and general lists of contraindications to home birth. ⁵⁰ The M.A.B.C. Guidelines provide a comprehensive list of procedures for the community midwives. These procedures include initial and ongoing assessments of the client's social and family history, obstetrical and gynecological history, physical examination, and testing for urinalysis, blood pressure, pulse, and the like. The midwife may also refer the client to laboratory specialists for such work as RH antibodies, haemoglobin, and rubella titre. The schedule for pre-natal care is set out as follows: a monthly visit up to the 28th week of pregnancy; a bi-weekly visit thereafter until the 36th week; and weekly visits from that point until the birth. Measures of blood pressure, weight gain, fetal heart tones, fundal height and so on should be made by the midwife. The midwife is expected to maintain accurate records of these visits and to monitor whether these measures are "within normal limits".

⁴⁹ This critique also highlights the erosion of community control as childbirth becomes more centralized via the professions. See Gene Corea, *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs*, New York, Harper and Row, 1985.

⁵⁰ M.A.B.C., "Guidelines to Midwifery Practice", 1984 (sixth draft), typescript mimeo.

There is an accompanying list of guidelines that are presented as "definite" indications for a hospital birth.⁵¹ Midwives disregarding these contraindications may be brought forward for peer review. This is not however a formal disciplinary hearing.

Other contraindications to home birth are grouped under two headings. The first heading - *Obstetrical history* - includes women who have had three or more successive spontaneous abortions, a previous unexplained stillbirth, previous uterine surgery (which includes a previous Caesarean section), and others. The second heading - *Obstetrical Factors in the Current Pregnancy* - comprises intrauterine growth retardation, multiple pregnancy (e.g., twins), confirmed fetal heart abnormalities, and *inter alia*, premature rupture of membranes (before 37 weeks). There is also an extensive list of *possible* indications for a hospital birth. The midwife is expected to consult with a Physician when such situations occur as smoking during pregnancy, being more than 30 minutes away from the nearest hospital, maternal age less than 17 years old or over 40 years, and abnormal weight gain.

These guidelines, taken with subsequent guidelines for intrapartum care and post-natal care, appear to be a synthesis of international guidelines for midwifery and local debates over responsible midwifery practice. The key point here is whether midwives can be held accountable for practicing out of guidelines, especially when some of them are not very specific. What constitutes "drug addiction or abuse"? Should the woman be automatically screened out for home delivery if her membranes rupture at just over 36 weeks and other factors are well within guidelines?

The interpretation of the rules to this point in time appears less formal, allowing for the midwives to have some discretion in their work. What appears to be forged, then, is a

⁵¹ Definite contraindications to a home birth, as set out in the M.A.B.C. guidelines, include the following maternal Factors: cardiovascular disease, congenital heart disease, Essential hypertension, vascular disease, achondroplasia, drug addiction or abuse, acute psychiatric problems, renal disease, endocrine disorders, thrombosis, emboli, Addison's disease, hyp/hyper thyroid, diabete(s) mellitus, neoplastic disease, immunocomplex disease, history of subarchnoid haemorrhage, TORCH infections, uterine infection, active tuberculosis, and asthma.

middle-ground between mandatory hospitalization for birth and utter subjectivity on the part of community midwives.

In the Western world there has been a clear shift to almost complete hospitalization of birth. Once established as a viable alternative to hospital-based obstetrics, the practice of domiciliary obstetrics in Britain including the "flying squads" staffed by an anaesthetist, obstetrician, and a midwife in the event of birth complications⁵² - has given way to almost universal recourse to hospital obstetrics. It has been reported that approximately 97% of births in Britain take place in hospitals.⁵³ In Britain, the delivery of Prince Charles at home, by Sir John Peel has been followed by the general recommendation by a Commission headed by Dr. Peel that all deliveries in Britain occur in hospital.⁵⁴ The official policy in Britain has thus discouraged domiciliary midwifery.⁵⁵

"...despite the lip-service paid by successive Health Ministers to patient choice in the matter of home or hospital delivery under the Health Service (which, incidentally, means at no charge), any woman wanting a home birth on the National Health Service must possess the political skill of a Metternich, the patience of a Griselda and the persistence of a Pankhurst. If she is to succeed, she must begin to fight the Health Service bureaucracy as soon as possible in her pregnancy and be prepared to continue, perhaps for months, in order to overcome the almost insurmountable obstacles put in her way...."

It is important to note that the research underlying this policy against domiciliary births has been criticized in medical journals and other venues, and that there may be a more favourable outlook on domiciliary midwifery by government in Britain.

Setting aside official policy, there have been a number of initiatives to establish a more pluralistic maternity and infant care system. It is not at all difficult to establish the borders

⁵² V. da Cruz, *Bailliere's Midwives' Dictionary*, London, Balliere Tindall and Cassell (fifth edition), 1969.

⁵³ Sheila Kitzinger, *The Experience of Childbirth*, Harmondsworth, Penguin, 1978, p. 51.

⁵⁴ Sheila Kitzinger, *Women as Mothers*, Glasgow, Fontana, 1978a, p. vii.

⁵⁵ Jean Donnison, "The Development of the Occupation of Midwife: A Comparative View", in *Midwifery is a Labour of Love*, Vancouver, Maternal Health Society, 1981, p. 9.

of debate over the appropriateness of home birth. Some support out-of-hospital birthing clinics and home birth while others have held categorically that homebirths are "...the earliest form of child abuse...." ⁵⁶ and ought to be outlawed. Others encourage pregnant women to deliver at home and to lobby for the legal right for childbirth attendants to practice domiciliary obstetrics and midwifery. ⁵⁷ Clearly, then, the struggle over birth attendance is in large measure a political and ideological debate over power and women's freedom over reproduction. The political and ideological dimensions of this debate are brought forward in the next section, with specific reference to the role of the State in regulating birth practice.

State Control and Resistance

An understanding of the community midwife movement in British Columbia is best located within the broad paradigm of conflict theory within sociology. Childbirth became a battleground between lay midwives, doctors, nurses, and scientists. Writing of the struggle over childbirth attendance in England, Jean Donnison described it as "inter-professional rivalry". ⁵⁸ The nature of the conflict is complex, involving not only the economic interests of the established professions and the alternative practitioners, but conflicts with various groupings in the public over safety and standards, and the gatekeeping functions of State officials. The conflict approach as applied in the case of midwifery invariably addresses the self-interest of the medical profession in presiding over childbirth and the premise that medical attendance is

⁵⁶ Warren H. Pearse, "Home Birth Crisis", *A.C.O.G. Newsletter*, 1977; W. Pearse, "Home Birth: Editorial", *Journal of the American Medical Association*, 1979, 241, pp. 1039-1041.

⁵⁷ Sam Bittman and Sue Rosenberg Zalk, *Expectant Fathers*, New York, Hawthorn, 1978. For a statement from representatives of the Association for Childbirth at Home International (A.C.H.I.) see Tanya Brooks and Linda Bennett, *Giving Birth at Home*, Curritos, California, A.C.H.I., 1976.

⁵⁸ Jean Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*, 1977, New York, Schocken.

demonstrably superior to midwifery attendance.⁵⁹

One point worth emphasizing is that the nature of the conflict is not static. As Thompson noted in his critique of structural Marxism, even fairly powerless people can struggle against oppression, occasionally relying on the rule of law to secure their rights.⁶⁰ This is also true of community midwives since they reject unfavourable interpretations of their work, continue to practice midwifery, and lobby for legalization of midwifery. Public education campaigns and media submissions – most notably letters to newspapers editors – illustrate this action of a quite visible nature; workshops and educational initiatives reflect less visible, collective initiatives to improve community midwifery services.⁶¹

Other activities within the community midwifery movement include fundraising via benefit dances, gambling casinos, and mail solicitation. These fundraising activities are usually designed to benefit a group, such as the Midwifery School, or to defray legal costs associated with coroners' inquests or criminal prosecution following an infant death. A key point is that the resources of community midwives are indeed slight in comparison with the financial resources available in the State and through provincial and national Medical Associations. Midwives can innovate, however. Nine community midwives were also developing a collective in which education is ongoing and in which each of the members has pledged to contribute up to a thousand dollars in the event that any one of the collective faces legal costs.⁶²

⁵⁹ See Ronald Hamowy, *Canadian Medicine: A Study in Restricted Entry*, Vancouver, The Fraser Institute, 1984.

⁶⁰ E.P. Thompson, *Whigs and Hunters: The Origin of the Black Act*, Harmondsworth, Penguin, 1975.

⁶¹ On this point see Rose Weitz and Deborah Sullivan, "Virtuous Deviance and Identity Maintenance Among Midwives", Unpublished paper.

⁶² Information provided informally by one of the members of the Pacific Midwives' Group, 1986.

The New Midwifery is a hybrid form of midwifery in British Columbia. With ties to a tradition of local self-help and some linkages with modern New Age spiritual philosophy, a number of practitioners have formal instruction in nursing and a formal school curriculum has been designed and implemented. Guidelines for midwifery practice have been drafted (and redrafted) and peer review is one mechanism that mirrors a more professional approach to birth attendance by community midwives. The community midwives are not wholly united, however. Some midwives practice autonomously on the M.A.B.C. and there is disagreement over the appropriateness of attempting home birth without sufficient medical back-up, emergency services (ambulatory care), whether women who have been delivered via Caesarean section should attempt a vaginal birth at home, and so forth.

Community Midwifery has also been troubled from without. State measures are taken against community midwives. Criminal prosecution of midwives and other birth attendants has been implemented in B.C. (and elsewhere), as has prosecution under the provincial *Medical Practitioners Act* for practicing medicine without a license. The financial losses incurred for retention of a defence lawyer, loss of income (if the midwife is forbidden to practice midwifery, pending the outcome of a court case), along with the uncertainty of the eventual verdict reflect some influences of the State on these midwives.

Other State measures bear on our theoretical understanding of the State, the professions, and community initiatives. Despite years of lobbying for legal status for midwives and notwithstanding a substantial evaluation literature documenting the benefits of skilled midwifery practice, community midwives remain illegal practitioners under this provincial legislation. They are also excluded from the provincial Medical Insurance Plan and lack a substantial defence fund in the event that they are charged with criminal or quasi-criminal offences or if a private writ is served against them.

Currently, then, community midwives are relatively free to practice and even to declare themselves, to advertise their home birth practices, to develop an academic curriculum and

practical training, and to transfer women to hospital if a home birth is not successful. This freedom is circumscribed, however, by their complete exclusion from provincial health insurance plans. It is further constrained by the general powers of the Medical Associations *through the State* and the reluctance of State officials to further expand medical coverage. The preliminary evidence on the midwifery movement seems best suited to a "relative autonomy" perspective on the State. Liberal democratic States will vary in terms of the degree of their autonomy from Civil Society. The point remains that the State is not acting simply as an instrument of powerful interests, nor is it promoting the pluralistic principles often linked with liberalism.

In the wake of three Coroners' Inquests into baby deaths in Ontario, and following years of pressure by the Ontario Midwives' Association (composed of midwives and consumer advocates, among others) and other pro-midwife organizations, midwifery is on the verge of legal recognition in Ontario. The Ontario Minister of Health has proposed direct entry into midwifery (rather than mandatory nursing training aside from midwifery training). The arguments for legalized midwifery – on the safety of home births attended by trained midwives, the so-called "soft" measures of client satisfaction, and the fundamental democratic principle that the State should not interfere with private decisions of citizens – are quite strong as are the measures taken to stifle autonomous midwifery practice. The current inertia with respect to legalizing midwifery seems to reflect professional resistance to autonomous midwifery practice and the reluctance of the State to permit community-based, decentralized initiatives at a time when State trajectories are toward greater control.⁶³

Nevertheless, it must be emphasized that the State in Canada is relatively autonomous, and the degree of autonomy is neither a static nor a permanent feature of the capitalist State. The administration of health is a provincial responsibility, and there have been varying

⁶³ This is variously known as the "cunning" or "exceptional" State. See Stanley Cohen, *Visions of Social Control*, 1985, London, Polity Press, pp. 107–109. The use of "moral panics" as a strategy for consolidating State powers is set out in Stuart Hall et al., *Policing the Crisis*, London, MacMillan, 1978, pp. 219–222.

degrees of response among the provinces toward recognizing midwifery in law and public policy. Ontario and Quebec are in the forefront of legalizing midwifery, and B.C. has reviewed a number of submissions proposing direct entry midwifery training and a separate legal status from the nursing and medical professions.

The dominant status of the medical and nursing professions will likely not be set aside in maternity and infant care. Virtually all nation states actively promote medical and nursing education and practice, and there is a strong case for further developing the knowledge base and clinical practices associated with the medical and nursing professions. A related point concerns the artificiality of some constraints on birth attendants. As was set out in Chapter Three, the monopoly powers of the various Provincial Medical Associations and their Colleges have been achieved, in part, through the denunciation and prosecution of the ancestors of the New Midwives. The issues ahead will revolve around whether current midwifery initiatives are coopted by the established health professions in Canada and who controls licensure, training, and peer review.

NURSE-MIDWIFERY PRACTICE

Introduction

The first chapter established several differences between accredited nurse-midwives and community midwives. As a rule, nurse-midwives in Canada work as salaried employees in hospital settings. They belong to professional nursing associations, (e.g., the Registered Nurses' Association of British Columbia), and are usually not responsible for prenatal care of clients nor do they usually assume responsibility for the delivery stage of childbirth. Physicians tend to be responsible for prenatal visits and delivery in many settings.

Stereotyping nurse-midwives as a grouping is of course hazardous: there is great variation in the sphere of practice, especially in northern regions where midwives may be responsible for many decisions ordinarily assumed by medical personnel. In this chapter, the *role* of nurse-midwives is evaluated, with special attention to community midwifery practice. Significant initiatives are discussed: the attempt to establish an out-of-hospital birthing clinic in Vancouver, the Low-Risk Clinic which allowed more independent practice and continuity of care by nurse-midwives, and the succeeding Midwives' Project at the Grace Hospital in Vancouver. These initiatives illustrate central problems in nurse-midwifery as outlined below.

Central Problems in Nurse-Midwifery

Whatever the attempts to promote midwifery services, it is not uncommon for nurse-midwives to express resentment at the containment of their skills in attending women in childbirth. For some, the opportunity to apply these skills is truncated when they arrive in urban settings where physicians are dominant within the occupational hierarchy of hospitals.

"I worked on the obstetrical unit (of a 55-bed hospital in the North). That was really interesting I did quite a few deliveries because the medical coverage wasn't always that great. And basically I worked autonomously, with some limitations...I was allowed a lot of freedom to practice in my own way. I think if I had not had that I would have found it very limiting. The physicians who were there were very inexperienced in obstetrics...I realized why I was necessary, why they made a prerequisite of midwifery training for anyone who worked on the obstetrical unit...they really needed my skills.

The most shocking experience I ever had in Canada was when I moved to (a large city in Alberta) to work in a University Hospital. Every woman had an obstetrician. It was a high-risk unit, but many of these women were not high risk. There were 18 obstetricians on staff. Women literally came in and had birth done to them. It was incredibly shocking...." (Nurse-midwife #4, 1985)

The leitmotif of professionalism that appears throughout the definitions of nurse-midwifery has been criticized by some. A few community midwives have expressed their misgivings about what they see as the proprietary nature of obstetrical nurses, taking the baby as their property while disciplining errant parents and community midwives.

The converse may be found as well; that is, people who praise nurse-midwives for taking time with patients, for combining this rapport with clinical skills that are at least on a par with medical staff. ⁶⁴

The movement for greater recognition of nurse-midwives as birth attendants has contributed to an expanded role in conventional obstetrical settings. The recent proliferation of Nurse-midwifery programmes in the United States. ⁶⁵ has often been interpreted in terms of consumer demand for alternatives to standard obstetrical attendance at birth.

Midwives are active in tertiary care, and can collaborate with obstetricians and anaestheologists over decisions about pain relief in obstetrical care. ⁶⁶ A survey of practicing

⁶⁴ See Diana Scully, *Men Who Control Women's Health: The Miseducation of Obstetrician-Gynecologists*, 1980, Boston, Houghton Mifflin, pp. 125-126. Of course, this clinical style can be denigrated as unexciting "handholding" within the clinical hierarchy.

⁶⁵ Anne Scupholme, "Nurse-Midwives and Physicians: A Team Approach to Obstetrical Care in a Perinatal Center", *Journal of Nurse-Midwifery*, 1982, 27(1), p. 21.

⁶⁶ G.C. Ghosh-Ray et al., "An Integrated Pain Relief Service for Labour: Co-operation between obstetricians, anesthetists, and midwives", *Anaesthesia*, 1980, 35(5), pp. 510-513. The order of the professions in the title - obstetricians first, midwives last - gives some

midwives in the United States in 1976, which gathered data on 1,213 nurse-midwives, confirmed that the collaboration between physicians and nurse-midwives permitted a degree of treatment of birth complications by nurse-midwives. ⁶⁷

"In general, the more invasive and risky the procedure, the less likely nurse-midwives are to perform it. However, nearly as many (89 per cent) reported they managed the care of prenatal patients with some complications. A number of minor complications occur quite commonly in otherwise normal pregnancies, creating a gray area between 'normal, well, uncomplicated patients' and 'high-risk' or 'complicated' patients. Most nurse-midwives providing prenatal care have developed collaborative relationships with physicians in which they can continue to care for patients who experience certain kinds of prenatal complications"

One difference frequently suggested in the literature is that contemporary lay midwives are more politicized than nurse-midwives. There appears to be a sub-cultural approach by some community midwives, including a resolve to respect the woman's wishes during labour and delivery, and throughout the pregnancy and post-partum period. The lay midwife, according to this portrait, is more inclined to respect the wishes of women (or couples) during labour and delivery, and more likely to regard organized medicine as profit-oriented and male-dominated. In her practice she may contravene guidelines for practice (local or international guidelines) on the basis of her judgement of the situation and out of respect for the women. This appears to be linked with two major themes: the historical takeover of birth by physicians from community midwives, and the perception that nurse-midwives are greatly constrained within the hospital hierarchy and unable to apply their skills fully to the women they serve. Certainly, Cobb indicates that nurse-midwives have been coopted by the dominant medical profession. ⁶⁸

⁶⁶(cont'd) indication of the ranking that may affect patterns of decision-making within the team.

⁶⁷ This survey found that only 15% of nurse-midwives working in the general area of deliveries managed multiple births, and only 12% were responsible for breech deliveries. Nevertheless, 99% of C.N.M.s performed and repaired episiotomies. See Rooks and Fischman, *op cit.*, 1980, 992-993.

⁶⁸ Cobb, *op cit.*, p. 75.

The sub-cultural motif may be overdrawn with respect to many community midwives. The author's impression is that midwives tend to be oriented toward a community of *clients* and not toward a particular community or locality. In fact, the great majority of home births analyzed in this study took place in over 200 localities throughout Ontario, B.C., and Saskatchewan. It is also unsupportable to juxtapose community midwives against nurse-midwives as if the latter were not also serving a community or constituency. This constituency would tend to be disinclined to home birth and to be fairly positive toward conventional management of childbirth by physicians and nurses. ⁶⁹ Starr holds that even in the 17th and 18th centuries in the United States, the lay midwife was regarded as a competitor by many medical men while the nurse-midwife was not. ⁷⁰ Others are in agreement that nurse-midwifery in the United States is primarily a dependent occupation: ⁷¹

"It is perhaps a mistake to refer to midwifery in the United States as an emerging profession. Midwifery as it was known in Europe and England never really existed; decisions, political and economic, were made which led to the elimination of midwifery. What is slowly emerging is a health worker called a nurse-midwife - an assistant to the obstetrician and not an independent practitioner. Only 10% of American nurse-midwives are presently employed in positions that offer full use of their training..."

Another difference between lay midwifery and nurse-midwifery involves the apprenticeship in birth attendance. Unlike the formal training in midwifery, usually in conjunction with completion of nursing training, lay midwives tend to learn by their "empiric"; that is, through attending births and reading birth manuals. This differentiation of midwives trained in nursing, and other midwives, can in turn be linked up with comments

⁶⁹ There are of course instances of nurses taking action outside of the conventional hospital network. An Ontario nurse published a favourable account of her decision to give birth at home with medical attendance. Mavis Swedlo, "Childbirth at Home," *Canadian Journal of Public Health*, 1979, 70(5), pp. 307-353.

⁷⁰ Paul Starr, *The Social Transformation of American Medicine*, 1983, New York, Basic Books, p. 223.

⁷¹ P. Anisef and P. Basson, "Institutionalization of a Profession - Comparison of British and American Midwifery", *Sociology of Work and Occupations*, 1979, 6(3), p. 368.

on the "proleterianization" of nursing and the deflection of efforts to achieve greater autonomy by nurses in the United States. ⁷² A related point is that solidarity among nurses in Canada is narrowly defined. ⁷³ Deference to medical authority is pronounced, although the emergence of provincial and national organizations and of collective bargaining status has countered this historical situation. In Canada the direction of legal lobbying and professional recognition has been toward an expanded role of certified nurse-midwives. It is estimated that there are at least 100 certified nurse-midwives in British Columbia. ⁷⁴ Independent midwifery practice has generally been restricted to nurses working in remote regions with limited or non-existent access to physicians. ⁷⁵

The movement toward more independent practice of midwives in Canada was favoured by Louise Miner, past President of the Canadian Nurses' Association. She criticized general practitioners for simultaneously acknowledging their limitations while resisting midwifery practice; moreover, she felt that all normal pregnancies should be delivered by midwives and that they should practice independently. ⁷⁶ In 1971 a survey of members of the Society of Obstetricians and Gynecologists of Canada found that the majority of members responding to the survey accepted the premise of trained midwives taking more responsibility in prenatal and antenatal care. Nevertheless, there was a general reluctance to endorse *delivery* of babies by midwives and concern expressed about possible lack of supervision by physicians of

⁷² David Wagner, "The Proleterianization of Nursing in the United States, 1932-1946," *International Journal of Health Services*, 1980, 10(2), pp. 271-290.

⁷³ Suzann Buckley, "Ladies or Midwives: Efforts to Reduce Infant and Maternal Mortality," in Linda Kealey (ed.), *A Not Unreasonable Claim: Women and Reform in Canada, 1880s-1920s*, 1979, Toronto, The Women's Press.

⁷⁴ Paula Brook, "Midwives and Medicine," *The Magazine*, May 18, 1980, p. 6.

⁷⁵ A midwifery programme at the Master's level has been offered at Memorial University, Newfoundland, an Advanced Obstetrical Nursing Course is continuing at the University of Alberta, and outpost nursing - with a midwifery component - is available at Dalhousie University in Nova Scotia.

⁷⁶ Milan Korcok, "Health Planners Debate the Midwife's Role: Her Capabilities are Unquestioned, but Acceptance Hinges on Physician and Patient Reactions," *The Medical Post*, February 23, 1972, 8(4), p. 45.

midwives in maternity practice. ⁷⁷ This reluctance to endorse nurse midwives as birth attendants is also evident in the drafting of a document over regionalization of maternity and newborn care in the United States. The American College of Nurse-Midwives (A.C.N.M.) was not invited to contribute to the drafting of this document. ⁷⁸

A statement in support of nurse-midwifery practice was adopted by the Registered Nurses Association of British Columbia in June, 1979, following a 10-month investigation by a three-member Committee. This statement included resolutions that: the role of the nurse-practitioner should be established in British Columbia; that the practice of nurse-midwifery should be legally defined as "Part of the ordinary calling of nursing", thereby meeting an exemption from prosecution under section 71 of the *Medical Practitioners Act*; that standards of nurse-midwifery practice should be met; that various types of practice could be subsumed, domiciliary (home) births and management of low-risk and high-risk births in hospitals or clinics; and that refresher courses be made available for nurse-midwives (R.N.A.B.C., 1979). ⁷⁹

Home Birth and Midwifery Policy

The issue of home birth has generated some consensus on the preferability of hospital settings for delivery. The Western Region Nurse-Midwives Association registered their preference for working with obstetricians in clinical settings. ⁸⁰ More recently, a spokeswoman

⁷⁷ Ibid., p. 7.

⁷⁸ Muriel Sugarman, "Regionalization of Maternity and Newborn Care: Facts, Fantasies, Flaws, and Fallacies," in David Stewart and Lee Stewart (eds.), *Compulsory Hospitalization or Freedom of Choice in Childbirth*, 1979, Marble Arch, N.A.P.S.A.C., p. 69.

⁷⁹ Registered Nurses' Association of British Columbia, "Policy Statement - Nurse Midwifery," 1979, Typescript mimeo, 2 pp.

⁸⁰ Canadian Press, "Parents Must Decide on Home Childbirth," *The Province*, August 26, 1976 (no pages noted).

for the Registered Nurses' Association of British Columbia stated the Association's opposition to home deliveries as an alternative to hospital deliveries, adding that inadequate back-up services in British Columbia did not allow for safe home deliveries.⁸¹ The spokeswoman added that this policy position does not discredit home birth *per se* but instead emphasizes the importance of not undertaking domiciliary obstetrics without established access to emergency back-up services. The concept of nurse-midwives working in hospital settings, supervised by physicians, was recently endorsed by a joint Committee including representatives from the Registered Nurses Association of British Columbia and from the College of Physicians and Surgeons.⁸²

Another potential area of conflict between midwives involves attempts to legitimize community midwife practice. The Midwives Alliance of North America (hereafter, M.A.N.A.) comprises nurse-midwives and lay midwives, and the Midwives' Association of British Columbia encourages membership of nurse-midwives and community midwives. Nevertheless, some certified nurse-midwife members have opposed the lack of clear standards of education and practice for lay midwives.⁸³ M.A.N.A. representatives have sought to establish standards for "basic competency" for certified nurse-midwives and community midwives alike.⁸⁴ The tension between certified midwives and other midwives is linked with a general trend toward professionalized health care, including nursing. In organizational theory there is however a tendency for certain tasks to be delegated to subordinates as organizations become more complex: for example, record-keeping and scheduling, once deemed the bailiwick of doctors,

⁸¹ See Marilyn Carmack, "Birthplace pangs," *MacLean's*, 1980, 93(5), p. 13.

⁸² Tim Padmore, "Vancouver Hospital Tries Midwifery Program," *The (Montreal) Gazette*, February 21, 1983, p. A7.

⁸³ Shelley Campbell, "Midwives United: The Midwives Alliance of North America," *Mothering*, 1872, #24, pp. 75-76.

⁸⁴ Fran Ventre and Carol Leonard, "The Future of Midwifery - an Alliance," *Journal of Nurse-Midwifery*, 1982, 27(5), pp. 23-24.

have been delegated to nursing staff.⁸⁵

Alternative Birth Centres

The introduction of alternative birth centres (A.B.C.s) as a compromise between domiciliary birth settings and obstetrical wards is one example of innovation that rests, in part, on consumer demands for humanistic, flexible management of pregnancy and childbirth. For example, staff at a free-standing birth centre in Culver City, California encourage families to remain together throughout labour, and allow women to take a variety of delivery positions. Certified nurse-midwives are employed in the centre.⁸⁶ This apparently neat equation of birth innovations and public demands does not take into account the historically-rooted rivalry between various professional and non-professional associations.⁸⁷ It also must address suggestions that A.B.C.s do not in fact significantly alter the incidence of obstetrical interventions.

With direct reference to alternative birth centres, DeVries contends that the apparent freedom accorded patients in A.B.C.s is in fact used ideologically to consolidate the power of birth centre staff. Notwithstanding the home-like decor and nods toward unmedicated births, where possible, A.B.C.s thus are characterized by unjustifiably high rates of invasive treatment, including analgesia, anaesthesia, episiotomy, and forceps delivery.⁸⁸ In a more recent article,

⁸⁵ This is not a recent phenomenon. See Everett C. Hughes, Helen M. Hughes, and Irwin Deutscher, *Twenty Thousand Nurses Tell Their Story: A Report on Nursing Functions Sponsored by the American Nurses' Association*, 1958, Philadelphia, Lippincott, p. 7.

⁸⁶ Margaret Mettelbach, "The Midwife Crisis", *Los Angeles's Free Weekly: The Reader*, December 12, 1986, 9(9), p. 10.

⁸⁷ See for example Eliot Freidson, "The Organization of Medical Practice," in Howard E. Freeman, Sol Levine, and Leo G. Reader (eds.), *Handbook of Medical Sociology*, 1972 (second edition), Englewood Cliffs, N.J., Prentice-Hall, pp. 343-358.

⁸⁸ Raymond G. DeVries, "The Alternative Birth Centre: Option or Cooptation?" *Women and Health*, 1980, 5(3), pp. 47-60.

DeVries cites one study which documented a transfer rate of 46% of patients from an alternative birth centre to a conventional labour and delivery suite.⁸⁹ A recent documentary on home birth in the United States indicated that between 20 and 50 percent of women entering an A.B.C. will be transferred to operating rooms; (e.g., for a forceps delivery, Caesarean section, electronic fetal monitoring, and so forth).⁹⁰ Establishment of birthing rooms within hospitals is another method of adapting settings to consumer demands, although it has been reported that in some hospitals the birthing rooms account for only a small proportion – in some cases as low as three percent – of all births in hospital.

Some disagree that A.B.C.s 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.⁹¹

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 attributed to 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 professions.⁹²

⁸⁹ R.G. DeVries, "Humanizing' Childbirth: The Discovery and Implementation of Bonding Theory," *International Journal of Health Services*, 1984, 14(1), p. 98.

⁹⁰ C.B.S. News, Programme Featured on *Sixty Minutes*, March 21, 1982.

⁹¹ The critique of A.B.C.s is far from absolute. One author acknowledges that women giving birth in A.B.C.s tend to be satisfied with their experience, and she appears to have a "blind spot" with respect to the limitations of home birth arrangements. See Barbara Katz Rothman, "Anatomy of a Compromise: Nurse-midwifery and the Rise of the Birth Center," *Journal of Nurse-Midwifery*, 1983, 28(4), pp. 3-7.

⁹² Ruth Watson Lubic, "Alternative Maternity Care: Resistance and Change," in Shelly Romalis (ed.), *Childbirth: Alternatives to Medical Control*, 1981, Austin, University of Texas Press.

Demonstration Projects: Canada and the U.S.

The Low-Risk Clinic (Vancouver, British Columbia)

There have been few studies of midwifery practice by nurse-midwives in Canadian hospitals. The Low-Risk Clinic was a pilot project that operated at the Grace Hospital in Vancouver from September 1981 until May 1984. Four nurse-midwives and four obstetricians worked together in caring for 61 women. This pilot project in a major hospital in Canada's third largest city was designed to provide safe deliveries of babies, to demonstrate the competency of trained nurse-midwives in managing births with less interventions than conventional birth attendance. Continuity of care was sought with the women who were to give birth. Extensive prenatal care was provided by the midwives, along with consultation with the physicians and nursing staff.

The report on this project generally confirms the viability of more independent midwifery practice within a major hospital. A follow-up survey also indicated that the clients were generally pleased with the project. One measure of the success of the project was the increased rate of spontaneous vaginal deliveries among the Low-Risk Clinic patients in comparison with hospital-wide statistics at the Grace Hospital. As noted earlier, approximately 92% of the attempted home births with the community midwives resulted in spontaneous vaginal deliveries.

The report of the Low-Risk Clinic provides a useful portrait of specific policies and procedures for assessing the health of the woman and fetus throughout the pregnancy, as well as procedures for consultation with pediatricians, general practitioners, obstetricians, and nursing staff. An integral part of the Clinic was to accommodate the wishes of the couple where possible, and to ensure safe deliveries. The satisfactory results of the Low-Risk Clinic led to the development of a subsequent Midwives' Project in the Grace Hospital. This

Table 28: Mode of Delivery

	Low-Risk Clinic		Grace Hospital	
	N	%	N	%
SVD	40	73.0	N.A.	58.7
Forceps	9	16.0	N.A.	19.8
Caesarean	6	11.0	N.A.	21.5
Total	55	100.0	N.A.	100.0

Source: Elaine Carty et al., *The Low-Risk Clinic*, 1984. p. 25.

ongoing project is an established part of the Labour and Delivery budget at the hospital.

A continuing difficulty in assessing the nature of contemporary birth attendance, including attendance in alternative birth centres, is the lack of information on particular centres. To some extent this lack has been overcome by recently published accounts of birth centres and nurse-midwifery practice in hospital settings in the United States. Several of these published accounts will be outlined to indicate general themes and to underscore difficulties associated with evaluation studies from California, Arizona, Georgia, and Florida. These selected studies provide additional evidence in support of the safety of nurse-midwifery practice. Perinatal mortality rates are lower than the average rate in the respective states and well within expected rates of perinatal mortality generally. There also tends to be a reduction in caesarean section rates, forceps delivery, and the use of analgesia.

Table 29: Demonstration Projects in the United States

S. Francisco	New Mexico	Georgia	Florida
	1975-79	NA	1976-?? 1977-81
No. of births	1,005	838	2,050 6,313
Analg.	29.1%	NA	8.0% 51.3%
C-section	9.0%*	5.0	9.4% 2.1%
Forceps	7.5%	NA	5.0% 2.0%
Spont. vag.	80.3%	NA	85.6% 96.0%
Episiotomy**	NA	31.0%	27.0% 58.2%
Intact perin.	39.9%	37.0%	37.0% 22.7%
Lacerations+	NA	32.0%	36.0% 19.1%
Per. Mor.++	9.0	NA	9.3 NA

*In this study, 0.9% of births occurred with vacuum extraction and 2.3% of cases had no indication of the method of delivery.

**Episiotomy rates reported here exclude people delivered by Caesarean section.

+Indicates lacerations requiring repairs (suturing).

++Perinatal mortality rate per 1,000 live births.

The incommensurability of these reports highlights a general difficulty of reportage. Although reportage usually centres on conventional variables such as birth outcome, obstetrical interventions, and infant mortality and morbidity, there is nevertheless a tendency toward unstandardized reportage, with certain variables presented and others not, without a clear statement of why some are deemed salient to the evaluation of nurse-midwifery practice vis-a-vis other kinds of birth attendance. This unstandardized method of reportage, along with missing data, impede comparisons of findings pertaining to nurse-midwifery services.

These demonstration projects address a central tenet in the continuing debate over midwifery attendance: that midwifery attendance is uniquely suited to uncomplicated births. In

a recent editorial ⁹³ it was asserted that:

"Nurse-midwives are cost-effective because we can show improved neonatal and maternal outcomes with fewer medical interventions, because we provide safe births in less expensive out-of-hospital settings or for fewer hospital days, and because we can show that emotional support and education about nutrition, exercise, breastfeeding, and self-care are worthwhile".

Haire ⁹⁴ also contends that nurse-midwifery practice is superior to conventional medical attendance in many respects, particularly in promoting unmedicated births, reducing the incidence of episiotomies, instrumental deliveries, and so forth. Haire combines her observations of maternity hospitals in Great Britain, Russia, Western Europe, and other countries with more detailed observations of nurse-midwifery practice in the North Central Bronx Hospital, the Frontier Nursing Service in Kentucky, and the Su Clinica Familia in Texas. With specific reference to the North Central Bronx Hospital, of 2608 midwife-assisted births in 1979, a relatively high percentage (88%) delivered vaginally and spontaneously. Analgesia or anesthesia was resorted to in less than 30% of all labours, while forceps and vacuum extraction together accounted for just over two percent of deliveries. Over a third of women attempting a vaginal birth after a Caesarean (VBAC) did so successfully. Nearly half (45%) of births were done over an intact perineum, 26% required episiotomies, and 29% involved lacerations (a fourth-degree laceration occurred in one percent of births studied).

Haire's estimation of the importance of contemporary nurse-midwifery attendance is further reinforced by a study of a nurse-midwifery programme in a county hospital in rural California. The study documented significant decreases in the rate of prematurity (from 11% to 6.6%) and the rate of neonatal mortality (from 23.9% to 10.3%) during the period (1961 to 1963) in which the nurse-midwives were active.

⁹³ Nancy Kraus, "Cost-Effectiveness at Whose Cost?" *Journal of Nurse-Midwifery*, 1984, 29(1), p. 2. The reduced cost of midwifery care in a birthing centre (compared to physician attendance in hospital) was also raised in the *Nightline* special programme on Midwifery.

⁹⁴ Doris Haire, "Improving the Outcome of Pregnancy Through Increased Utilization of Midwives," *The Practicing Midwife*, 1981.

Two additional points are of interest: first, such dramatic changes in these rates were not manifested in other regions of the county during the operation of the nurse-midwifery programme; and second, rates of prematurity and neonatal mortality increased significantly after the programme was discontinued. Among other factors, the researchers suggest that women receiving care during the three-year programme were more likely to receive prenatal care and to begin prenatal contact earlier.⁹⁵ This special status accorded nurse-midwives appears also in a recent discussion on malpractice liability of nurse-midwives. Certified nurse-midwives differ in terms of client satisfaction and participation, while the C.N.M.'s expertise and reputation for safety is retained. Nevertheless, litigation against American nurse-midwives has increased in recent years and is expected to continue as midwives widen their ambit of practice.⁹⁶

Prestige and Professionalization

Nurse-midwifery practice in Canada, the United States, Britain, and elsewhere is characterized by the movement toward professionalized health care. The professional standard of care is achieved through specialized instruction (academic and practical), governing bodies such as Nursing Colleges and specialized associations, and formulation of overarching standards of patient care.

The current status of midwives with nursing accreditation may well be rising above the often-disparaged status of obstetrical nursing⁹⁷ even though in terms of prestige it is still

⁹⁵ Levy et al., "Reducing neonatal mortality with nurse-midwives", *American Journal of Obstetrics and Gynecology*, 1971, 109(1), pp. 50-58.

⁹⁶ Gail Sinquefield, "A Malpractice Dilemma: Defining Standards of Care for Certified Nurse-Midwives," *Journal of Nurse-Midwifery*, 1983, 28(4), pp. 1-2.

⁹⁷ See Hughes et al., op cit., p. 85.

conventionally ranked well below the prestige of medical specialties such as obstetrics.⁹⁸

Midwifery Practice and Formal Authority

The contradiction between professional training and the formally subordinate status of nurse-midwifery (whereby nurse-midwives may be supervised by doctors in order to practice) may lead to informal, covert tactics to circumvent legal and professional strictures on practice.⁹⁹ These informal tactics may be quite effective in allowing midwives to practice their skills and in reducing interventions deemed unnecessary by the midwives. An important point, however, is that circumventing physician authority is substantively different from direct challenges of a physician's judgement. Concerns over professional prestige can be linked with the manner in which formal authority impinges on, or threatens to impinge on, midwifery practice. Midwifery practice is subject to a variety of cultural, legal, and social rules affecting childbirth in British Columbia and other provinces. It is however important to remember that midwives can circumvent some of the intrusions of technology and official gate-keeping. Direct challenges to official authority are sometimes avoided through appeals to orthodox authority, even fictional ones. A senior community midwife offered this vignette:

"I did a birth up in Lund, near Powell River. I flew up there. The only problem I had, and this was something I hadn't considered, was that I had to fly from Vancouver International Airport and I had to go through the metal detector machine. And so the Security Officer said 'What's this?' when the birth kit was detected. I was quite embarrassed and I wasn't quite sure how to explain myself. I wound up saying that my husband was a doctor and that I was taking some equipment up there for him". (Community midwife #2, January 1985)

Skirting through an airport check is one obstacle; the threat of prosecution for criminal offences or quasi-criminal offences is quite another. The following excerpt from an interview

⁹⁸ See Nan Lin, 1976. The occupation of "midwife" is ranked much lower than that of physician in U.S. rankings of occupational prestige.

⁹⁹ See Hughes et al., op cit., pp. 64-72, 172-173 for a general discussion of these tactics.

with a senior community midwife illustrates some dynamics of State measures of power and offsetting resources drawn upon by a midwife under official scrutiny.

"The only time the legality issue came up for me was with a birth several years after I began doing primary care births. I had a really bad feeling about this birth and for the first time of all the births I attended I had three other primary care midwives assisting me with this birth. I still had this bad feeling but I couldn't pinpoint anything to screen her out (from attempting a home birth). Even her physician said I was being paranoid.

Anyway, the birth was fine and the baby was fine. Afterward I wondered why I had been so uptight about this birth. On the fifth day the mother called me to say that her baby had died in her sleep. I should have said that she shouldn't call anyone the police, ambulance - until I arrived.

It was a 20-minute drive to her place and when I arrived the police and ambulance were already there. Now, the unfortunate thing is that my client was a single mother on welfare and the police officers treated her badly, suspiciously. It was completely out of the question that this woman would have injured her daughter. The police officers found out that the baby had been delivered at home, with a midwife present, and by the time I walked into the door they had been given my name. I took the mother to the morgue to see the child. When we returned the police wanted to question us in separate rooms.

I was asked a few questions off the record. The policeman didn't understand this situation. He said, 'Who's illegal here? Is she (the mother) illegal? Are you illegal?' 'Who's in trouble?' is essentially what he was asking. I explained that midwifery is illegal and that if anyone was in trouble it would be me for practicing midwifery without a license. The police officer then asked me if I was a midwife. I said, 'Do you think I should answer that, or do you think it would be really incriminating?' He said that I probably shouldn't answer, and he agreed with me that the mother probably shouldn't answer any more questions at this time.

The mother needed to talk. She wanted to settle these questions immediately. But when the officers said they wanted to take her to the station for questioning, I said forget it. The mother was grieving, she was very shocky. The officers were angry with me for protecting her and said that they would get to me next, and that I would have to go to the police station. They asked the mom if she had beaten her baby - there were no marks on her body and I knew they didn't have any right to take her anywhere. I told them to get out. The mother wanted to be interviewed, however, in the house, so I told her not to answer any more questions. I glanced down at the officer's sheet. There were two questions: Was she your midwife? (yes) and Did you pay her? (yes). The last question made me feel 'Oh man, I'm in trouble'.

That night I cleared out birth records, equipment, books from my house. It is frightening to have your records confiscated by the police: they are invaluable to a midwife. I was informed by the police that I would be charged with *Criminal Negligence Causing Death* and that they were awaiting the results of the autopsy report. It took 48 hours for the report to be completed and the conclusion was that the baby died of SIDS (Sudden Infant Death Syndrome). Then I was threatened with a possible charge of *Practicing Medicine Without a License* under the *Medical Practitioners Act*.

I was so relieved that the criminal charge had been dropped. The Midwives' Association of B.C. held an emergency meeting to discuss strategies if I was charged under the *Medical Practitioners Act*. I was enthusiastic about the trial. We decided that we would encourage consumer picketing of the trial, and that we should invite experts from Holland the U.S.A. to speak to the issue of medical monopolization of birth in this province. However, my client contacted me after a visit from the police. She was told that the charge against me would be dropped. Now, they had plenty of evidence against me: her statement, for instance, and I had provided documentation of the birth (Apgar scores, and other details). My understanding was that the British Columbia Medical Association representatives were unwilling to launch a prosecution that would rally support for midwifery. I think that they wanted to make me sweat about it, but the charge never materialized." (Community midwife #4, March 1985).

This account of legal encounters draws together a few central themes in the control of deviance and legal measures. The first is that there are points of support that the midwife could call upon: careful documentation of prenatal care, labour, delivery, and prenatal visits; her efforts to check on the mother's and infant's health (through the physician and the presence of three other midwives); and her cooperation with the authorities to a point.

The broader point of support is the resources of the Midwives' Association and beyond that, plans to involve other practitioners in a direct challenge to the illegal status of midwifery in B.C. It seems that here is a clear example of of the danger of assuming that midwives are defenceless against official powers of the State and the interests of the medical profession. Women do organize against some restrictions on reproductive rights. This is clear from a variety of Midwives' Associations that have been founded in various provinces, branches of the National Association of Parents and Professionals for Safe Alternatives in Childbirth (N.A.P.S.A.C.), the Midwifery Task Force and the periodical *The Maternal Health News* based in Vancouver, to name only a organizations concerned with reform of childbirth practices. The general principle that the State ought not interfere in private matters *without good reason* is also a check on State intrusion. This seems especially so for the ordinarily private sphere of reproduction and family relationships.¹⁰⁰ Parents may act as a resource for midwives by vouching for the midwife, protecting her, and threatening to embarrass officials

¹⁰⁰ See Brian Burtch, Andy Wachtel and Carol Pitcher LaPrairie, "Marriage Preparation, Separation, Conciliation and Divorce: Findings From the Public Images of Law Study", *Canadian Journal of Family Law*, 1985, 4 (4), pp. 369-384.

for what the parents regard as inferior service.

Q: "Have you ever had pressure or interest expressed in your work by the police or the courts?"

"Every time the medical profession (in a city outside the Lower Mainland area) caught wind of my attending a home birth they reported it to the British Columbia Medical Association, the R.C.M.P., or both. I had a situation with a very fast, a precipitous birth with a woman who was a VBAC (vaginal birth after Caesarean section). The couple was over an hour from a major hospital and while I didn't agree outright to assist at a home birth, I said that I would respect the woman's wishes. I left their house while the woman was in labour, just to visit my children who were nearby, and I was called back because the woman was pushing.

By the time the other midwife and I returned, it was a precipitous birth, a good portion of the baby's head was showing. At birth the baby was totally shocky. We resuscitated the baby - which wasn't difficult to do in this case - and as a standard procedure in CPR we called for an ambulance. The paramedics took 20 minutes to get there and they were no help. I asked them to wait until the placenta had been delivered. (This was a precipitous delivery and there is a greater chance of haemorrhage with these deliveries). They asked "was this a planned birth?" and just snooped around the house. Then they said they couldn't stay in the house because they both had to listen to the radio (dispatches) in the ambulance.

What happened after that was that doctors, on reviewing the ambulance calls for that month, reported this incident to the police and the B.C.M.A. The police visited the mother several times. Every time the mother referred to me as "her friend": "It was lucky that my friend was there". She also promised to pull apart the ambulance service publicly. I got a real sense of persecution, if you like. To be on the safe side I moved my supplies and birth records to a friend's house. This was the only real occasion that the police were involved: I am aware that the B.C.M.A. and the police were contacted on a couple of other occasions, but nothing happened." (Community midwife #5, April 1985)

This also underlines the ways in which prosecutorial power can be restricted. An autopsy report that would be ammunition for the defence is pertinent here, just as the lack of witnesses and other events can hinder prosecution efforts. ¹⁰¹

It is however a mistake to exaggerate the powers of community midwives. Action has been taken against practicing midwives in B.C., Ontario, and Nova Scotia in the past several years and the power of authorities in these instances has been extensive. The power of arrest, interrogation, and the substantial discretionary powers available to police are sometimes

¹⁰¹ For a discussion of the limitations on prosecutorial power see Judith Osborne, "The Prosecutor's Discretion to Withdraw Criminal Cases in the Lower Courts", *Canadian Journal of Criminology*, 1983, 25, pp. 55-78.

invoked.¹⁰² An ex-physician and spiritual healer was acquitted of a charge of criminal negligence causing death after a baby died following a home birth; she was however convicted of the quasi-criminal charge of practicing medicine without a license.¹⁰³ Three midwives were charged with criminal negligence causing death after an infant died following an attempted home birth in Halifax. The charge was dropped at the preliminary hearing prior to the trial.¹⁰⁴ Nevertheless, two Vancouver midwives were convicted in 1986 on a charge of criminal negligence causing death.¹⁰⁵ Since community midwifery is primarily affiliated with home birth (although some community midwives also provide labour coaching in hospital and prenatal classes), their clientele is quite limited in number. Only about one percent of births in contemporary British Columbia occur out of hospital, and a number of these are not planned home births. There is thus a considerable difference between the community midwifery situation in B.C. and that of the village midwife in Third World countries where a great proportion of birthing in outlying areas is managed by traditional midwives.¹⁰⁶ The dominant cultural perspective on childbirth emphasizes risk to the mother and infant, the superiority of professional medical and nursing attendance, and the value of institutionalized birthing in hospital settings. Community midwives have drawn on a variety of evaluation studies of the place of birth and the issue of safety to argue against the assumption of greater safety in hospitals; they have also relied on their own experience in delivering well over a thousand infants through the past 15 years. This said, the cultural emphasis on hospital deliveries remains deeply rooted today and is unlikely to be dislodged

¹⁰² For a general discussion of the dependence of accused persons on police, prosecutors, and lawyers see Richard Ericson and Patricia Baranek, *The Ordering of Justice: Defendants as Dependents in the Criminal Justice Process*, Toronto, University of Toronto Press, 1982.

¹⁰³ See *Regina versus Marsh*, Supreme Court of B.C., 1979.

¹⁰⁴ *Regina versus Carpenter et al.*, 1983, Halifax, N.S., (unreported case).

¹⁰⁵ *Regina versus Sullivan and Lemay*, 1986, Vancouver, B.C. (unreported case).

¹⁰⁶ For example, many births in rural Malaysia are attended by *bidans* (village midwives). Approximately 43% of deliveries in Malaysia were attended by these midwives. See J.Y. Peng et al., "Village Midwives in Malaysia", *Studies in Family Planning*, 1972, 3, pp. 25-28.

substantially in future.

The legal rules surrounding childbirth are more closely aligned with the concept of State measurement. In a politically organized society laws are devised, ostensibly in the public interest. This is quite clear with respect to the formulation of provincial Medical Acts, specifically the *Medical Practitioners Act* in British Columbia. Such legislation affords medical practitioners a monopoly status over a variety of diagnostic, clinical, and prognostic activities; it also vests considerable powers of professional self-regulation via disciplinary hearings concerning professional misconduct and alleged incompetence. Time and again such monopolistic legislation is defended on the basis that it serves to protect the public interest; that is, professional monopoly status ensures the highest level of training and peer scrutiny. Clearly, this presumption cuts across another cultural belief in the value of competition as it may affect standards, along with the freedom to choose one's occupation. It becomes evident that as work has become more professionalized and bureaucratized, the legal regulation of work has heightened. This includes the attempt by occupational groupings to secure their market status by excluding rival groupings.¹⁰⁷ Alternative groupings such as the Midwives' Association of British Columbia are more likely to be assessed in terms of their "integrative function"; that is, the intrinsic value of such groups as perceived by their members.¹⁰⁸

The political dimension in some varieties of lay midwifery is quite vivid. A common theme is that obstetrical knowledge is deliberately restricted to medical (and nursing) personnel, that alternative practitioners continue to be outlawed while a medical monopoly is

¹⁰⁷ See Charles Reasons and Duncan Chappell, "Crooked Lawyers: Towards a Political Economy of Deviance in the Profession" in Thomas Fleming (ed), *The New Criminologies in Canada: State, Crime, and Control*, Toronto, Oxford University Press, 1985, pp. 206-222. See also the discussion of Frank Parkin's outline of strategies of exclusion and inclusion by Anthony Giddens, *Profiles and Critiques in Social Theory*, Berkeley, University of California Press, 1982, p. 188.

¹⁰⁸ Linda Light, *Feminism and Collectivity: The Integrative Function*, Unpublished M.A. Thesis, Anthropology and Sociology, University of British Columbia, September 1981. There are nevertheless *extrinsic* factors that impinge on collective groups. Midwives are encouraged to become more professional, to establish standards, to be governed by other, more established organizations such as a Nurses' College.

preserved, and that profit and male dominance in the structure of health care are essential to understanding current provisions for childbirth. This critique is accompanied by advocacy of collective, non-hierarchical options for women seeking to practice health care, and for their clients.

Summary and Discussion

This Chapter has brought together original data on birth attendance with some published accounts of nurse-midwifery and community midwifery practice. With specific reference to community midwives in Canada, they appear to be helpful in reducing rates of instrumental delivery - caesarean section, forceps, and so forth - also achieving comparable or superior results to conventional, hospital-based deliveries. This is a complex portrait of practice, however, when the viability of community midwifery services is set against some deficiencies in this *de facto*, informal type of practice, especially those that have been connected with unsafe home birth practices.

For nurse-midwives, there is little support in the research literature for past or continuing allegations that their work is inferior to physician-presided birth attendance. Indeed, there is decisive evidence that nurse-midwives can contribute in tertiary care settings as well as primary care settings. It is somewhat more problematic for the community midwifery movement. There is concern over an unregulated situation whereby midwives may practice outside safety guidelines. Some infant deaths in Canada have been attributed, at least in part, to unsatisfactory midwifery attendance. Its members operate without the protection of a *Midwives' Act* and without the material resources and organizational structures available to their medical and nursing counterparts. And when they initiate midwifery practices or establish a Midwifery School there is the threat of prosecution or the problem of limited funding for the School programme.

The significance of the community midwifery movement can be linked with other attempts to decentralize institutionalized processes, including the management of death in hospices or at home, the victims' movement in criminal justice, and efforts to minimize formal management of conflicts generally.¹⁰⁹ The situation of nurse-midwives in many jurisdictions is complex inasmuch as they are often highly-trained and in many countries assist fully in uncomplicated deliveries. Their presence, however, has been limited historically in Canada and continues to be fairly restricted to date. The current attempts to establish demonstration projects has only been partly successful. The proposal to staff a clinic outside of a hospital setting was not accepted in 1979 and the Low-Risk Clinic in the Grace Hospital has been replaced by a different format in which nurse-midwives do not work with the same continuity with expectant mothers. It is nonetheless a recognition that the nurse-midwife's conventional role can be expanded in response to consumer demand and to lobbying for greater autonomy from within the nursing profession.

This complex movement by nurse-midwives and community midwives indicates that while resistance to the hegemonic powers of the State and professions is evident, the end-result is not a marked diminution of these hegemonic powers. The following chapter reconsiders major criticisms of midwifery practice in Canada, and is followed by recommendations for future research and midwifery services in Canada.

¹⁰⁹ See in particular, Nils Christie, "Conflicts as Property", *British Journal of Criminology*, 17, pp. 1-15.

CHAPTER VI
CRITICAL REFLECTIONS ON COMMUNITY MIDWIFERY

Introduction

The New Midwifery appears to be 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 birth, in attending birth). It also undercuts the expanded powers of the State in regulating women's health, restoring childbirth to a more private matter and one that is conducted, where possible, in the sphere of civil society.

There is however little value in asserting the benefits of contemporary community midwifery without seriously considering problems associated with it. The following sections set out 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. Serious consideration is given to the value of legal regulation of health services and contributions to maternal and infant health under the auspices of the State and the professions. One achievement has been the comparatively low rate of infant mortality in Canada in recent years. ¹

¹ The rate of infant mortality in Canada was 8.5 per 1,000 live births in 1983. The infant mortality 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 (6.6) and the Netherlands (8.3) has lower rates of infant mortality. See Statistics Canada, *Births and Deaths: Vital Statistics, Volume I (1984)*, 1986 (March), Ottawa, Supply and Services Canada, p. 56.

"We and They": Oppositional Ideologies

Many have noted the danger of dualistic interpretations of social life. The apparent opposition 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 the discredited group. ²

Among some midwives there is 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. Just as midwives have complained that they have been unfairly caricatured 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 *uses* of professional resources are cut off.

One case-in-point involved 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 under hospital observation, this highlights a resistance to orthodox resources and an ideology that may well overemphasize maternal-infant bonding and the superiority of home environments over hospitals.

The 1980 trial of Margaret Marsh provided clearer evidence of an incident wherein a fetus presenting in a breech position died after transfer to hospital. The birth attendant, a spiritual healer and ex-physician, was alleged to have asked of the couple, "Don't you believe in angels?" when they said they wished to transfer to hospital. ³ This seems to

² The importance of irony and overlap is brilliantly drawn in David Matza's *Becoming Deviant*, 1969, Englewood-Cliffs, Prentice-Hall. See also Jock Young, "Left idealism, reformism, and beyond: from New Criminology to Marxism" in Bob Fine et al., *Capitalism and the Rule of Law*, 1979, London, Hutchinson, pp. 11-20.

³ *Regina versus Marsh*, 1980 [trial transcript].

undermine the precept that midwives should attend to the mother's sensibilities. A number of midwives interviewed by the author stated that midwives should transfer if the mother wished to transfer, even if there are no tangible signs of distress. ⁴

"Midwife means to be with woman": Serving Mothers

Another issue stems from the belief that the midwife should respect the wishes of the expectant mother. Some believe that midwifery (literally, to be "with woman") is best served by protecting the mother's wishes. Given the longstanding critique of professional disregard for women's preferences in childbirth – e.g., birthing positions, withholding unwanted anaesthesia, who may accompany women in labour – respect for the woman's preferences is clearly understandable. ⁵ But this may become problematic when a 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 home delivery. When the woman refuses, the midwife may support the woman's choice. The clash between respect for the client and professional obligations to protect the infant (and possibly the mother) is evident in instances where a breech presentation occurs, and two legal actions in B.C. (one trial and one warrant for the arrest of a midwife who fled the country) followed infant deaths after breech presentation in 1979 and 1980. This calls into question the thin line between professional judgement and the attitude that the unborn child's best interests are served by honouring the woman's wishes.

⁴ There is a contradiction here. Some records indicated "intensive counselling" for mothers who were fearful at home, and it is clear that the midwife's judgement is a factor in deciding to transport the mother or to encourage her to remain through painful contractions, for instance.

⁵ See *inter alia*, Barbara Katz Rothman, *Giving Birth: Alternatives in Childbirth*, 1984, Harmondsworth, Penguin, and Cynthia Carver, "The Deliverers: A Woman Doctor's Reflections on Medical Socialization" in Shelly Romalis, (ed.), *Childbirth: Alternatives to Medical Control*, 1981, Austin, University of Texas Press, pp. 122–149.

In one instance documented by a senior midwife in Ontario, the police and ambulance services were called when the mother refused to accept the midwife's judgement that a transfer was advisable. In such cases the midwife is following a professional protocol and presumably protecting her interests if legal action is considered against her.

It is precisely at this nexus of interests – the protection of fetal rights and the right of the woman to not consent to medical/midwifery advice – that this legal dilemma arises. There may be a strong argument for retaining the *parens patriae* approach as a safeguard for fetuses at term and limiting the "parent's rights" argument.

Opposition to medical intervention can also be criticized in light of the substantial improvements in medical care for premature infants and other newborns at risk. There is also a tendency for critics to interpret professional power in medicine as structured primarily to maintain "conspiracies of silence" to protect the profession's members. This instrumentalist outlook has been challenged by more appreciative studies such as Bosk's observations of surgical practice in the United States. ⁶

"My claim is that 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 mesial (dividing) line drawn between spiritual midwifery and medical attendance also obscures the hard-fought attempts of women to gain access to medical knowledge and to practice medicine. As set out in Chapter Five, however, there is clearly a substantial overlap between midwifery practice and more conventional resources (laboratory work, general practitioners, obstetricians, and hospital resources). It would thus be misleading to suggest that

⁶ Charles L. Bosk, *Forgive and Remember: Managing Medical Failure*, 1979, Chicago, University of Chicago Press, p. 190.

most community midwives adhere to a strict, oppositional ideology.

Class Composition of Clients

Historical sources seem to indicate that midwives have often assisted the poorer sections in many societies, the Frontier Nursing Service in rural Kentucky and the Maternity Centre Association in New York City being two examples. In recent times, however, the reemergence of community midwifery and of nurse-midwifery in North America has been tied with 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, while others focus on people choosing home births or nurse-midwifery services. A study of childbirth records from 13 hospitals in Erie County, 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 of spouses. These findings were reported to be consistent with earlier studies in New York City, Boston, and New Haven.⁷ Other researchers noted that women with high school matriculation or some post-secondary education had a greater need to establish personal control during labour than women with less formal education.⁸ Two reports on *out-of-hospital births* noted that people electing home births tended to have above-average education.⁹

⁷ C. Cave, "Social Characteristics of Natural Childbirth users and Non-Users", *American Journal of Public Health*, 1978, 68(9), 898-900.

⁸ Pushpa Butani and Ellen Hadnett, "Mothers' Perceptions of Their Labour Experiences", *Maternal and Child Nursing Journal*, 1980, 9(2), p. 77.

⁹ See Diane Divorky, "Resistance: Midwives Moving Into Physician Territory", *The Sacramento Bee*, April 29, 1981, p. A3. She refers to a study conducted in Oregon for births in 1976 and 1977. A nationwide study with similar results is available in Neal Devitt, "Hospital Birth vs. Home Birth: The Scientific Facts, Past and Present", in D. Stewart and L. Stewart (eds.), *Compulsory Hospitalization or Freedom of Choice in Childbirth?: Volume II*, 1979, Marble Arch, N.A.P.S.A.C., p. 486.

The issue of social class has been raised with respect to birthing in England. A representative of the Community Health Council noted: ¹⁰

"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 [National Health Service] 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".

There are serious problems with this general interpretation of class forces associated with childbirth reform. As set out in the previous Chapter, while there are few mothers in the Canadian home birth sample who 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 these Provinces 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 midwifery-middle class equation is fixed. There are possibilities for extending midwifery services if midwives achieve a legitimate standing among other health care practitioners.

Material Basis of Practice

One aspect of midwifery practice that has not been debated at length is the material basis of practice. Community midwives are self-employed. While some supplement their incomes with labour coaching in hospital or other work, most are dependent on client payments. This issue becomes clearer when transfer rates from home to hospital are examined, and greater attention needs to be directed to screening out procedures for clients

¹⁰ Carol Langridge, cited in CSP editors, "Birth Rights: Radical Consumerism in Health Care", *Critical Social Policy*, 1982, 2(2), p. 64.

(and fetuses) deemed at high risk.

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 however more frequently discussed than the material interests of community midwives. Subsequent work should explore the possible overlap between the ideal of midwifery and materialism. The ideal that midwives should attend even high-risk births may dovetail with some midwives' material interests in generating a sufficient income.

Dr. Sidney Sharzer, a chief of an Obstetrics and Gynecology Department in Los Angeles, raised the issue of monetary self-interest and, in his view, what appears to be a hypercritical approach by some midwives toward hospital-based maternity care.¹¹

"Sharver 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'."

Formal Structure, Idiosyncratic Practice

Another important issue is the need to establish standards of practice while allowing discretion to practicing midwives. Unlike nurse-midwives, obstetrical nurses, and physicians, the community midwife movement in B.C. has not as yet generated a clear set of guidelines for practice that are enforceable. To carry on without formal standards of practice, accompanying provisions for peer review, and a range of penalties, gives greater scope to the midwives. Nevertheless, there is 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

¹¹ Margaret Mittelbach, "The Midwife Crisis", *Los Angeles's Free Weekly: The Reader*, 1986, 9(9), p. 10.

from hospital and the slow transportation (ferry service) may be factors to be considered in deciding whether or not to attend a home delivery. As raised earlier, so also 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, or for complications of presentation such as shoulder dystocia where another midwife may be helpful.

This is not an isolated case. In 1986 a community midwife with only a few primary care deliveries attended a mother in labour on an island in B.C. This was apparently not in accord with existing guidelines for practice, but it was decided that the promise to attend the mother (who was intent on delivering on the island, whether the midwife attended or not) would be honoured. This again raises the dilemma between midwife direction of childbirth management and serving clients' wishes. It is arguable that the midwife could have refused to attend, given 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. The birth was uneventful; however, this dramatized the tension between private agreements between midwives and clients, and the public concern over safe practice.

Certainly the gap between the formal structure of midwives' Associations and specific practices of members has not been satisfactorily addressed. Doctors and nurses have been critical of delays in transferring women from home to hospital — for example, if bradycardia (a drop in the fetal heart rate) is manifested during labour — and other concerns have been voiced about misjudgements 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 LeMay-Sullivan trial in Vancouver.¹²

"(He) said he can understand the reasons people choose for (sic) 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'."

¹² Shelly Banks, "Witness backs home births", *The Vancouver Sun*, June 25, 1986, p. B6.

Documentation of Midwifery Practice

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. It is not helped, however, by uneven patterns of documentation in the 1970s in British Columbia. Some births have only cursory documentation; many others have precise, detailed notations of prenatal and postnatal care, and labour and delivery processes. A related problem is that since midwives have not as yet established a collation of attempted home births through a central agency, it is very difficult to establish patterns of practice, let alone the central issue of maternal and infant health.

These difficulties have been compounded by the apparent reluctance to establish a *standardized* set of charts for practice. Standardization would allow comparisons along such variables as time of the stages of labour, and the social class and occupation of the mother (and partner, where applicable). Socio-economic status 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 lack of standardized collection procedures hinders research and development possibilities for community midwives. It is virtually impossible to monitor transfer rates to hospitals, birthweights of newborns, types of deliveries, and a host of other variables unless there is a complete data base. The lack of such standardizations reduces the possibility of midwives learning from each other's practices, and weakens the kinds of statistical contributions they could make to other midwifery associations and publications. Knowledge is thus important for the practitioners, and it can be vitally important for the client and baby that a complete record of prenatal, intrapartum, and post-partum care is kept. ¹³

¹³ See the thoughtful discussion of keeping a thorough "booking history" for clients in Caroline Flint, *Sensitive Midwifery*, 1986, London, Heinemann, pp. 134-140.

It is promising, however, that as part of continuing education for graduates of the B.C. School of Midwifery, a session has been organized to discuss principles of research and writing, including development of standardized birth records that will facilitate computer analysis.

Availability of Services

One point of criticism involves the limitations of *de facto* community midwifery practice. Some express concerns over limited access to such midwifery services. Alan Schwartz, vice-chairman of a four member Task Force studying midwifery in Ontario, has noted this concern.¹⁴

"(The) vice-chairman of the (provincial government) task force, said it 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'".

One problem with this approach is that it can beg 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, and 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. This domiciliary approach would require adequate training of midwives, sufficient emergency response services, careful screening, and guidelines for practice.

¹⁴ Anne Kershaw, "Save home birth traditions: Midwife", *The (Kingston) Whig-Standard*, October 30, 1986, p. 21.

There is also a serious question concerning the structuring of exclusion. There is little evidence that most B.C. community midwives 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 or other parts of Canada.

Expanded Role of Nurse-Midwives and Hospitals

Additional possibilities for midwives and their clients can be considered. One possibility is that the role of obstetrical nurses could be expanded to combine safety with public demand for hospital-based midwifery. The argument against this is that nurses may be coopted into a dependent role, even if their sphere of practice is expanded. This argument may be too dismissive. Midwifery attendance could be brought within provincial nursing legislation such that nurses would be more self-directing in managing births. In fact, the legislation being developed in Ontario relies heavily on input from nurse-midwives for its implementation. It is also noteworthy that the Midwives' Programme in place in the Grace Hospital in Vancouver has been designated as a "Functional Programme" within the hospital budget. The Hospital Board has therefore endorsed the Programme as an integral part of labour and delivery services, and the Programme will be evaluated or reviewed by the Board. Moreover, the Toronto Doctors' Hospital 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.¹⁵

The expanded role of hospital services is a second possibility. It is 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

¹⁵ Whig-Standard News Services, "Toronto hospital makes bid to clinically train midwives", *The Whig-Standard*, October 9, 1986.

the consumers' demands for reformed childbirth practices as well as offering rapid access to emergency measures in the event of cord prolapses, haemorrhage, fetal decelerations, and other complications of childbirth. As some have suggested, however, it is questionable whether hospital staff are making drastic reductions in interventions. Birthing rooms are also not proliferating as yet within hospitals. Nevertheless, if the role of midwives is expanded so that they have hospital privileges or can manage births on a salaried basis, then the home birth option may become less frequent.

From community to bureaucracy?

A related point is that legalized midwifery, whether it is practiced 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 its current rivals in Canadian health care. This rekindles earlier commentary in this Chapter: what is lost as human services become more formal, and health practices increasingly controlled by the professions? A danger here 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 practiced independently.¹⁶ It is likely that a large measure of the 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 midwifery services if they are deemed to be at high risk. Once again the State or the professions emerge as mediators of community decisions, particularly if health services become more centralized and bureaucratic.

¹⁶ This point is brought forward through a discussion of Raymond DeVries' work (see Chapter Seven).

Summary

This section should not be read as an utter discreditation of community midwifery ideology and practice. First, it is wrong to speak of midwives as a totality, for practices and philosophies vary markedly among midwives. Some take on high-risk pregnancies, while others refuse, for instance. And second, some of these illustrations are truly unusual: they highlight concerns that may arise, but are not indicative of the usual processes of midwife-client interaction. Nevertheless, there is a danger in merely advocating community midwifery as a good for the reasons outlined above. There may be risks taken through the rationale 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 class composition of clients served by community midwives in British Columbia and elsewhere. Midwives may well 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 of the provincial medical billing plans) it will attract clients who can afford to pay for private midwifery services.

The self-regulation of their work has benefits with respect to the freedom of practicing 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 the bureaucratic personnel for their own interests.¹⁷ 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.

¹⁷ See Frank Parkin, *Max Weber*, London, Tavistock, pp. 87-89.

CHAPTER VII

CONCLUSIONS

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." ¹

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, ² and yet this legal framework can serve to constrain initiatives which might equally receive public support, such as alternatives to established health services. The illegal status of many practicing midwives in this country 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 by 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, generally, with considerable support from the nursing profession.

The contradiction is that while professing their monopolies to be in the general interest, these professions have failed to demonstrate that midwifery services are inherently inferior to

¹ John Locke, quoted in Peter Stein and John Shand, *Legal Values in Western Society*, 1974, Edinburgh, Edinburgh University Press, p. 184.

² Roger Cotterrell, *The Sociology of Law*, 1984, Toronto, Butterworths, po. 161-162.

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. ³

Two distinct forms of midwifery have appeared in British Columbia, Ontario, and other provinces in recent years. Nurse-midwifery as a practice separate from physician's decisions has been aligned with projects based in hospitals. At present, 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 key point of conflict, then, has occurred with State officials administering provincial and federal laws. That this conflict is intermittent⁴ in Canada should not obscure the importance of this struggle for control, the community midwives and nurse-midwives for recognition of their skills in managing births, and the State officials for ensuring compliance with legislative law. The dominant argument has been to view State regulation of midwives

³ Some practicing midwives have maintained a careful record of out-of-hospital births they attend. See Ina May Gaskin, "Birth in a Community Where Home is the Norm and Hospital the Exception" in David Stewart and Lee Stewart (eds.), *Compulsory Hospitalization or Freedom of Choice in Childbirth (Volume III)*, 1979, Marble Hill, N.A.P.S.A.C., pp. 935-942.

⁴ The conflict is intermittent in the sense that midwives are usually only prosecuted if there is an infant or maternal death or injury associated with a home birth. Furthermore, these 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 practicing medicine without a license.

as *legitimate*. Following the recent conviction of two Community Midwives for Criminal Negligence Causing Death, a newspaper editorial advocated the need for State control to ensure standards of competence and safety.⁵ This pressure to formally regulate midwifery practice 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. DeVries⁶ contends that licensed midwives are at greater risk of revocation or suspension of their licenses to practice. Furthermore, State sanction of midwifery practice can reinforce and formalize the dominance of physicians over licensed midwives.

At the same time that there has been 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 statist tendency may also be offset by a central contradiction in health care in Western nation-states. The fiscal crisis in these nations has led to measures to control State expenditures in health and social welfare. 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, surgical interventions, and to promote the use of

⁵ "...a situation in which unlicensed midwives operate in a *sub rosa* atmosphere is extremely unhealthy". Editorial, "Midwife Crossroads", *The Vancouver Sun*, October 11, 1986.

⁶ Raymond G. DeVries, *Midwives, Medicine, and the Law*, 1985, Philadelphia, Temple University Press, pp. 129-130 and 140.

less expensive paramedical workers as health practitioners.⁷ The tension between recognition of professional management of health care and the need to manage public expenditures emerges as a major internal contradiction within the State.

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."

Margaret Sanger's observations in *Woman and the New Race*⁸ are pertinent to an understanding of midwifery initiatives in the current day. While Sanger was concerned with the specific problem of access to contraception in the passage above, she is clearly concerned with the forms of subjugation of women. The theme of interference with women's freedom to determine the nature of birthing was consistently articulated by community midwives' clients when they stated their reasons for choosing a home birth.⁹ The issue of unnecessary interference with midwifery practice recurred in interviews with practicing 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

⁷ Ruth S. Hanft and Joseph Eichenholz, "The Regulation of Health Technology", *Proceedings of the American Academy of Political Science*, 1980, 33(4), p. 151.

⁸ Margaret Sanger, reprinted in part in "Birth Control - A Parents' Problem or Woman's?" in Alice S. Rossi (ed.), *The Feminist Papers: From Adams to Beauvoir*, New York, Bantam, 1976, p. 533.

⁹ This information was gathered from prenatal documents presented by the community midwives as part of their birth records.

physicians, nurses, and lay midwives in Europe, a conflict that encompasses the prosecution of midwives and healers as witches and that was marked by the superior position of the medical profession in managing deliveries in many countries. These historical conflicts are continued in contemporary debates over the place of midwifery. The B.C. College of Physicians and Surgeons has strongly discouraged its members from professional contacts with midwives practicing outside of obstetrical nursing. The B.C. Registered Nurses' Association, the Ontario Nurses' Associations, 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 over 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, and physicians either object to midwifery initiatives or allow for midwifery provided it is hospital-based and professionally accredited. The original research discussed in Chapter Five 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 and what it might be. 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 income¹⁰ and status of physicians and surgeons. The *Criminal Code* has also been activated on three

¹⁰ This instrumentalist view of the State does not explain why some physicians have stopped attending births. The physicians' explanation is that current fees for attending births are insufficient, and malpractice insurance rates for physicians who attend births are too high. Some contend that they would have to attend several births in the course of a year to 'break even' with their expenses.

occasions since 1979 against Canadian midwives or spiritual healers.

The conflict has been structured in terms of the *conserving* power of law. In this respect legal measures have acted primarily, but not exclusively, as a means of protecting a rational legal order that is alleged to protect a general public interest.¹¹ It is however crucial to combine abstract, jurisprudential principles with the effect of law on social relations. In other words, how are abstract principles of jurisprudence actually translated into the "living law"?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 actions) carries profound implications for the limits of social change with respect to midwifery. As Foucault notes of the disciplinary society, discourse and surveillance serve to produce "docile bodies". Obedience becomes normal, disobedience becomes suspect and may be dealt with punitively.¹³ The community of women thus becomes mediated through much larger structures of power and knowledge as these events become cast as medical events.¹⁴

¹¹ In this respect it is closely tied with Roscoe Pound's jurisprudential concepts of the rational basis of law. See Neil Boyd, "Law and Social Control, Law as Social Control" in N. Boyd (ed.), *The Social Dimensions of Law*, Toronto, Prentice-Hall, 1986, pp. 1-21.

¹² The *social* basis of law is thus required in a full assessment of the nature of effects of formal legal rules. See Roger Cotterrell, *The Sociology of Law: An Introduction*, Toronto, Butterworths, 1984, pp. 34-37.

¹³ Michel Foucault, *Discipline and Punish: The Birth of the Prison*, New York, Vintage, 1977.

¹⁴ See John O'Neill, "The Medicalization of Social Control", *Canadian Review of Sociology and Anthropology*, 1986, 23(3), 350-364. What is missing from this structuralist approach, however, is a sense of resistance to these larger structures. The development of nurse-midwifery practice in Canada and other countries is one example. The consumers' movement regarding childbirth practices is another example of resistance and influence.

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 also its complex relationship to obstetrical science and the State. Midwifery in Canada is an anomaly. Despite the legal presence of midwifery in other countries, even with the demonstrated competence of trained midwives, midwifery is either illegal or of uncertain legal status in Canada. 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 promotion of safe maternity and infant care (and the lag in legal recognition of midwives), and the promotion of women's choices in reproduction and work (and the contradictory pressures to mandatory hospitalization for birth, to 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 in many nations, and the intermittent **prosecution** of practicing community midwives in Canada.

Further Research and Policy Development

Research on midwifery has grown considerably through reports on birthing techniques and outcomes in professional journals, proceedings of International Conferences, and several scholarly and popular books. Nevertheless, there are several issues that warrant further research efforts.

At the political level, it would be useful to trace the kinds of pressures brought to bear on elected officials (e.g., Members of Provincial Legislatures) to either protect or contain midwifery practices. The responses of these officials, especially those responsible for administration of health services, could deepen our understanding of political conflicts and solutions. This could be related to the relative autonomy perspective: that is, regional

differences in political support of midwifery within the Canadian State. Future research could thus address the deliberations of government officials in pivotal positions: under what circumstances does one government of the day promote midwifery while others stonewall bids for legalization or launch legal actions against midwives? There may be partly a question of resources and scale: the three most populous provinces in Canada (Ontario, Quebec, and British Columbia) have been the most prominent sites for midwifery lobbying. This lobbying includes consumer petitions for broadened maternity services as well as lobbying by the nursing college and from within the medical community. There is support for midwifery legalization from representatives of the New Democratic Party in Ontario and B.C., but it appears that the midwifery issue can attract support from quite conservative and liberal political ideologies as well.

The *scope* of research could be broadened along two planes. First, inclusion of midwifery practices and politics in the Atlantic Provinces and Quebec, as well as the northern regions, would contribute to a national data base on midwife-related issues. The second axis is international. Canadian data should be integrated with international data bases, preferably with more detailed accounts than general measures of mortality and morbidity for mothers and infants. A comparison of inter-provincial variations in practice and outcomes in Canadian jurisdictions with, for example, several American jurisdictions and countries beyond North America would be helpful in this regard.

There is clearly a need for comparative analyses of midwifery practice in hospital and other settings. To accomplish this requires the cooperation of practicing midwives in documenting their work and charting the progress of labour and delivery. Standardized forms would be useful for comparisons within B.C. and this might be extended to other provinces and jurisdictions outside of Canada. The author's experience has been that community midwives will share their documents but few have time or interest in framing 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.

A recurring theme in this study is the importance of linking accurate documentation of birth practices with the political fate of midwifery in various provinces. Ethnographic and participant-observation studies of midwives would provide a more detailed, interpretive understanding of midwives in their practices and in other settings.¹⁵

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 alternative setting, and how many have a preference for a particular caregiver or combination of caregivers (obstetricians, midwives, general practitioners). Survey research would be useful in generating measures of public opinion, and these surveys could be supplemented by in-depth interviews about particular preferences and the logic underlying respondents' opinions. There is clearly a need to explore earlier suggestions of substantial challenges to physicians' authority in certain areas of health care.¹⁶

Policy Development

As demonstrated in this study and in previous research, including a large-scale controlled study of the safety of home birth, it is inaccurate to characterize home birth (either physician-attended or midwife-attended) as *intrinsically* unsafe. There are situations that are ill-advised due to the higher probability of risk to the mother or infant, but the literature to date and this study indicate that with proper screening of clients and training of attendants, home birth has been a viable alternative to conventional, hospital-based obstetrics. On the other hand, infant mortality may be comparatively high when untrained attendants are

¹⁵ The development of anthropological fieldwork in the Yucatan is presented in Brigitte Jordan, "Studying Childbirth: The Experience and Methods of a Woman Anthropologist" in Shelly Romalis (ed.), *Childbirth: Alternatives to Medical Control*, Austin, University of Texas Press, 1981, pp. 181-216.

¹⁶ One study of a "Midwestern State" in the United States is available. See Marie R. Haug and Bebe Levin, "Public Challenge of Physician Authority", *Medical Care*, 1979, 17(8), 844-858.

present at attempted home deliveries, and reluctance to screen out clients "at risk", delay in transporting mothers or infants to hospital when complications appear or are suspected, and the oppositional ideology against technology and the professions, may contribute to poor birth outcomes.

Birthing Centres and Women's Clinics

The introduction of alternative birth centres (A.B.C.s) as a compromise between domiciliary birth settings and obstetrical wards is one example of innovation that rests, in part, on consumer demands. This apparently neat equation of birth innovations and public demands does not take into account the historically-rooted rivalry between various professional and non-professional associations.¹⁷ It also must address evidence that A.B.C.s do not in fact significantly alter the incidence of obstetrical interventions.

With direct reference to alternative birth centres, DeVries contends that the apparent freedom accorded parturient women in A.B.C.s is in fact used ideologically to consolidate the power of birth centre staff. Notwithstanding the home-like decor and nods toward unmedicated births, where possible, A.B.C.s thus are characterized by unjustifiably high rates of invasive treatment, including analgesia, anaesthesia, episiotomy, and forceps delivery.¹⁸ In a more recent article, DeVries cites one study which documented a transfer rate of 46% of patients from an alternative birth centre to a conventional labour and delivery suite.¹⁹ A recent documentary on home birth in the United States indicated that between 20 and 50 percent of women entering an A.B.C. will be transferred to operating rooms; e.g., for a

¹⁷ See for example Eliot Freidson, "The Organization of Medical Practice," in Howard E. Freeman et al., (eds.), *Handbook of Medical Sociology*, 1972 (second edition), Englewood Cliffs, N.J., Prentice-Hall, pp. 343-358.

¹⁸ Raymond G. DeVries, "The Alternative Birth Centre: Option or Cooptation?" *Women and Health*, 1980, 5(3), pp. 47-60.

¹⁹ R.G. DeVries, "Humanizing' Childbirth: The Discovery and Implementation of Bonding Theory," *International Journal of Health Services*, 1984, 14(1), p. 98.

forceps delivery, Caesarean section, electronic fetal monitoring, and so forth. ²⁰ Establishment of birthing rooms within hospitals is another method of adapting settings to consumer demands. 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 three percent of all births in hospital. ²¹

Some disagree that A.B.C.s are in the best interest of pregnant women and infants. The growth of birth centres is tied with 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. ²² There is evidence favourable to alternative birth centres. The transfer rate in a Maternity Centre in New York City is approximately 15%, and most of the transfers are not for emergencies but rather for failure to progress in labour. ²³ It has also been suggested that these centres pose less expense to consumers and the State, while promoting safety of infants and mothers. ²⁴

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

²⁰ C.B.S. News, Programme Featured on *Sixty Minutes*, March 21, 1982.

²¹ Anonymous, "Nurse Says Hospital Avoids Night Births," *The Globe and Mail*, 1984, p. 14.

²² Rothman acknowledges that women giving birth in A.B.C.s tend to be satisfied with their experience, and she appears to have a "blind spot" with respect to the limitations of home birth arrangements. See Barbara Katz Rothman, "Anatomy of a Compromise: Nurse-midwifery and the Rise of the Birth Center," *Journal of Nurse-Midwifery*, 1983, 28(4), pp. 3-7.

²³ Mary Rossi, speaking on *Nightline*, ABC News, October 1986.

²⁴ See Ruth Watson Lubic, "Child Birthing Centres: Delivering More for Less", *American Journal of Nursing*, 1983, 83(7), 1053-1054 & 1056.

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 professions. ²⁵

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 are available in the British National Health Service. A common theme is that women are seen as "well" and not automatically as "sick", and technological devices are used judiciously in managing deliveries. ²⁶ These initiatives can be linked with modern concerns that women are 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. It appears to be a reshaping of the former "community of women".

Conclusion

This research study makes several contributions to the understanding of midwifery practice in Canada, gender-related conflicts, and the role of the State. The initiatives of nurse-midwives and community midwives are 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 both the dire portrait of midwifery practice as irresponsible and

²⁵ Ruth Watson Lubic, "Alternative Maternity Care: Resistance and Change," in Shelly Romalis (ed.), *Childbirth: Alternatives to Medical Control*, 1981, Austin, University of Texas Press.

²⁶ Katy Gardner, "Well Woman clinics: a positive approach to women's health" in Helen Roberts (ed.), *Women, Health and Reproduction*, 1981, London, Routledge and Kegan Paul, pp. 129-143.

hazardous, and the uncritical portrayal 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 idiosyncrasy and disagreement over midwifery practices and the implications of legalizing and formalizing these practices.

A second contribution stems from the core interest in ensuring maternal and infant safety. This study provides evidence that supports the safety of domiciliary midwifery relative to institutionalized birth outcomes in Canada. This is an extension of earlier research reports by community midwives in Canada in which rates of perinatal mortality and infant mortality appeared to be comparable to provincial or national statistics. The study is an extension in that it uses cross-provincial data over a longer time-frame (1972-1986) and provides a detailed data base on prenatal, labour and delivery, and post-natal phases of pregnancy and birth. 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.

The skill of nurse-midwives in attending women throughout pregnancy and during labour and delivery is also brought forward here. On the basis of research reports published outside of Canada, and in 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.²⁷

Historical and cross-cultural sources have been set in the context of gender struggles over childbirth as a woman's process, a community event, and a profession. It is suggested

²⁷ See Barbara Brennan and Joan Rattner Heilman, *The Complete Book of Midwifery*, 1977, New York, E.P. Dutton. The authors propose that midwives can preserve the midwife's philosophy of compassionate and skilled care within hospital settings.

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 generally. It is suggested that these struggles are not simply about men versus women. 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 simply reducible to class relations or to biology.

This research also brings together important contributions from feminist writers concerned about the control of reproduction.²⁸ The in-depth interviews, and the use of midwives' documents in the home birth analysis, complement these published accounts of women's experiences of birth.

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 possible only through substantial powers of sanction and subsidization through the State. The tangible effects of facilitating hospital construction, 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 in prosecuting these midwives. Furthermore, as with chiropractors,²⁹ community midwives have increased in numbers and gained in official recognition despite

²⁸ Ann Oakley, *Women Confined: Towards a Sociology of Childbirth*, 1980, New York, Schocken.

the resistance of the medical profession.

Theories of the State have been critically assessed with respect to the instance of 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 longstanding 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 pressures from within the State, in formulating health care policy.

The strong conflict between medical practitioners and midwives certainly has its roots in the economic status secured by physicians. And it is clear that physicians are unlikely to endorse the introduction of other, non-physician practitioners unless there is some material advantage to the profession. This may be secured through midwives as a source of referral to physicians, or simply if management of uncomplicated deliveries is not financially attractive to physicians.

The economic dimension in health care requires an appreciation of methods by which

²⁹(cont'd)

²⁹ See Donald L. Mills and Donald E. Larsen, "The Professionalization of Canadian Chiropractic" in David Coburn et al., *Health and Canadian Society: Sociological Perspectives*, 1981, Toronto, Fitzhenry and Whiteside, p. 237.

competitors can be constrained or eliminated when they attempt to provide health services.³⁰

"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...."

The sphere of law is very pertinent to this conflict. Community midwives practicing in violation of the *Medical Practitioners' Act* (in B.C.) have been somewhat constrained in establishing institutional supports for their work, most notably an out-of-hospital clinic or Midwifery Centre. There have been, however, very few prosecutions of community midwives under this Act, and only after an infant death following an attempted home delivery. This restricted use of law reflects, among other things, the general safety of infants and mothers secured in the great majority of home births documented here and in other jurisdictions than Canada. It also may reflect the folkway of women assisting women in childbirth³¹ and the tension within the legal sphere over civil liberties of individuals versus the prohibitory powers of the State over human conduct.

As has been suggested earlier, the collision of these perspectives has not produced a vindication of individual freedoms. In fact, State involvement has been to either proceed cautiously in favouring midwifery or to not establish midwifery services except in remote areas. It appears that a blend of structural constraints and of 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.³² It is suggested that the Canadian state acts in a complex

³⁰ See Robert G. Evans, *Strained Mercy: The Economics of Health Care in Canada*, 1984, Toronto, Butterworths, p. 345.

³¹ See William Graham Sumner, *Folkways*, 1960, New York, New American Library (first pub. 1906). Sumner contended that folkways were powerful norms that influenced the nature of social life and the nature of legal regulation of social life.

³² As indicated herein, this involves subsidization of orthodox health services and supplies and, occasionally, deployment of criminal law personnel to repress practices that are seen as

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

It may be anticipated that State initiatives will involve a gradual expansion of the qualified midwife's role and 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 various provincial governments in Canada will differ in the pace and scope of legalizing midwifery services. 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 historical evolution of midwifery practice and in its future development in Canada.

³²(cont'd) dangerous.

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APPENDIX A: GLOSSARY

The following items define terms commonly used in studies of pregnancy and birth outcomes. More comprehensive glossaries are of course available in Medical textbooks concerning obstetrics and gynecology. *Maternity Care: The Nurse and the Family*, by Jensen, Benson, and Bobak (1979) includes a helpful glossary appendix as does Roger Tonkin's *Child Health Profile*, (1981).

- abortion:** A *Spontaneous abortion* indicates a loss of pregnancy that occurs naturally, without interference. A *Therapeutic abortion* is performed when a pregnancy is intentionally terminated for medical reasons.
- afterbirth:** Lay term for the placenta and membranes expelled after the birth or delivery of the child.
- amniocentesis:** Procedure to assess fetal health and maturity, in which a needle is inserted through the abdominal and uterine walls into the amniotic fluid.
- analgesic:** any drug or agent that will relieve pain.
- antepartum:** Before birth.
- Apgar score:** Numeric expression of the condition of a newborn obtained by rapid assessment of heart rate, respiratory effort, muscle tone, reflex irritability, and colour at 1, 5 and 15 minutes (sometimes 10 minutes) of age.

breech presentation:

presentation in which buttocks and/or feet are nearest the cervical opening and are born first. Occurs in about 3% of all deliveries. *complete breech* occurs when buttocks, legs, and feet are presented simultaneously. Presentation of one or both feet is termed a *footling breech*, and presentation of buttocks, with hips flexed so that thighs are against the abdomen, is a *frank breech*.

Caesarean section: Incision through the abdominal wall and uterus to permit delivery of an infant.

intrapartum: During birth.

episiotomy:

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

infant mortality rate:

number of deaths under 1 year of age, excluding stillbirths, per 1000 live births.

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

meconium aspiration syndrome:

with fetal hypoxia (insufficient availability of oxygen to meet metabolic needs of body tissue), the anal sphincter relaxes and meconium is released; reflex gasping movements draw meconium and other particulate matter in the amniotic fluid into the infant's bronchial tree, obstructing the air flow after birth.

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

multipara: woman who has carried two or more pregnancies to viability, whether they ended in live births or stillbirths.

neonatal mortality rate:

neonatal deaths during the first 28 days after birth, excluding stillbirths, expressed per 1,000 live births.

perinatal mortality rate:

number of fetal deaths 20 or more weeks of gestation plus infant deaths under 7 days of age per 1000 total births. expressed per 1,000 live births.

perineum: area between the vagina and rectum (in the female).

placenta previa: *total separation* of the placenta involves the complete occlusion of the cervical os (opening); *partial separation* involves a partial occlusion; and *marginal separation* occurs when the placenta encroaches on the marginal of the internal cervical os.

Postneonatal: Period of infancy between 28 days to under one year.

premature infant: infant born before completing week 37 of gestation, irrespective of birth

weight.

Prenatal: period of pregnancy between conception and onset of labour.

primigravida: woman who is pregnant for the first time.

primipara: woman who has carried a pregnancy to viability without regard to the child being dead or alive at the time of birth.

quasi-criminal law:
a regulatory offence, to which a penalty is attached.

retained placenta: retention of all or part of the placenta in the uterus after delivery.

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

Stillbirths: The number of fetal deaths based on gestation per 1,000 total births. It is variously based on the basis of weight (500 grams or more) or on gestation; e.g., 20 or 28 weeks' gestation.

Term: A fetus between 37 and 42 weeks gestation.

APPENDIX B: CODESHEET FOR HOME BIRTH RECORDS

The following items of information were used in the documentary analysis, using home birth records from midwives in British Columbia, Saskatchewan, and Ontario.

1. Date of the baby's birth.
2. Mother and/or the infant transferred to hospital.
3. Mother's age (at the time of the first prenatal visit).
4. Place of birth: at home, in hospital, in transit.
5. Gravida of mother (number of pregnancies, including the current pregnancy).
6. Parity of mother (number of live births, at the time of the prenatal visit).
7. Past ectopic pregnancies
8. Past spontaneous abortions
9. Past elective abortions
10. Mother's Diet: vegetarian, meat in diet.
11. Alcohol consumption during pregnancy: Daily, occasional, problem drinking, abstention?
12. Tobacco smoking during pregnancy: no smoking, estimate of number of cigarettes daily.
13. Other drugs taken during pregnancy: painkillers, illicit drugs, insulin.
14. Mother intends to breastfeed her child.
15. Identity of primary care midwife.
16. Identity of assistant midwife/midwives at attempted home birth.
17. Identity of pupil midwife/midwives at attempted home birth.
18. Number of *prenatal* visits by midwife/midwives, excluding telephone contacts and prenatal consultation with physicians.
19. Midwife present at the birth: (yes; no, arrived late; delivery completed elsewhere; one midwife present, other en route).
20. Length of first stage of labour

21. Length of second stage of labour.
22. Length of third stage of labour.
23. Total duration of three stages of labour.
24. Time elapsing between rupture of the membranes (R.O.M.) and birth.
25. Number of vaginal examinations by the midwife/midwives between R.O.M. and birth.
26. Rupture of membranes: Spontaneous rupture; artificial rupture; premature rupture of membranes.
27. Mother walking during labour.
28. Mother had a bath or shower during labour.
29. City or locale of the birth attempt: e.g, Vancouver, Toronto.
30. Province (British Columbia, Ontario, Saskatchewan).
31. Liquids consumed during labour: water, tea, juice.
32. Solids consumed during labour.
33. Estimated blood loss after delivery, expressed in cubic centimeters.
34. Gestational age of the infant, expressed in weeks.
35. Source of referral to the midwife: self-referral; by another midwife; by physician; Health Collective.
36. Labour induced (if so, how: castor oil; artificial rupture of membranes).
37. Labour augmented (if so, specify procedures: oxytocin, nipple stimulation, tinctures).
38. Perineal tears (no tear, 1st degree, 2nd degree, 3rd degree, 4th degree, episiotomy).
39. Tears sutured by: doctor, midwife, nurse.
40. Episiotomy.
41. Appearance of waters after rupture of membranes (clear; meconium in water).
42. Number of stitches for tears or episiotomy.
43. Delivery Position/positions.
44. Eye medication given to infant; e.g., silver nitrate drops.
45. Apgar Score at One Minute after delivery.

46. Apgar Score at Two (or Three) Minutes after delivery.
47. Apgar Score at Five Minutes after delivery.
48. Apgar Score at Ten Minutes after delivery.
49. Outcome of pregnancy: live birth, miscarriage, stillbirth, neonatal death.
50. Baby's weight at birth.
51. Delivery of placenta: spontaneous, or assisted.
52. Duncan or Schultze presentation of placenta.
53. Techniques for delivering placenta: maternal effort, squatting, controlled cord traction, oxytocin, manual removal.
54. Number of post-partum visits by midwife or midwives, excluding telephone contacts or visits with physicians.
55. Sex of the baby.
56. Suctioning procedures for newborn: bulb, de Lee.
57. Stage of labour or postpartum at which transferred to hospital.
58. Transfer vehicle, where applicable: private vehicle, ambulance.
59. Emergency paramedics called during labour or post-partum.
60. Back-up doctor called during labour or post-partum, *excluding* simple notification that the mother was in labour. (This refers to consultation regarding suspected problems)
61. Hours and minutes of active labour.
62. Anaesthesia given.
63. Caesarean section done.
64. Oxytocin used for this birth:(augmentation, of labour, delivery of placenta, to stop post-partum bleeding).
65. Type of delivery: spontaneous vaginal delivery, forceps, primary (or repeat) Caesarean section).
66. Previous Caesarean section (prior to attempted vaginal birth).
67. Mother's Occupation.

68. Father's Occupation.
69. Mother's Gross Annual Income.
70. Father's Gross Annual Income.
71. Combined (Family) Gross Annual Income.

APPENDIX C: LETTER OF CONSENT

Project: Midwifery Practice in British Columbia

Agency: Department of Anthropology and Sociology, University of British Columbia

I understand that the purpose of this project is to study the nature and implications of midwifery practice in British Columbia.

I understand that my comments will be kept **absolutely confidential**. Interview notes or tapes will be destroyed following completion of the project. The researcher will not reveal my identity under any circumstances.

I understand that I am free to conclude the interview at any time, and to refuse to answer specific questions without prejudice to myself or explanation to the researcher.

Signed,

(Interviewee)

Signed,

(Interviewer)

Dated,

APPENDIX D: INTERVIEW FRAME

Date 19—

Time began —— Time ended ——

Duration hrs. min.

Place of interview: ——respondent's home

——interviewer's home

——interviewer's office

——other (specify)

BECOMING A MIDWIFE

1. To begin with, I would like to know more about why you became a midwife. That is, when you decided to become a midwife, why you chose this, how you went about learning midwifery, what makes you feel good about being a midwife.

(a) When did you become a midwife?

(b) Why did you become a midwife?

(c) How did this develop?

(d) What makes you feel good about midwifery?

2. What kinds of work had you done previously?

3. Do you consider yourself to be a nurse-midwife, a community midwife, other designation?

(a) yes__

(b) no__

4. If yes, what kind of midwife are you?

- (a) Lay midwife
- (b) nurse-midwife
- (c) Spiritual midwife
- (d) Community midwife
- (e) other (specify)

B. Midwifery as an Occupation

1. How many births have you attended to date in any capacity (i.e, observer, assistant, apprentice, primary care attendant)? Please be as specific as possible.

number =—— births (specifically)

1-20

21-40

41-60

61-100

101-200

201+

300+

How many of these births involve primary care attendance by yourself?

When did you first attend a birth (in any capacity)?

19_ (specify)

And when did you first attend a birth as a primary care attendant?

19_ (specify)

What time period have you been attending births?

19_ to 19_ [list interruptions or variations]

Have you had years in which your attendance has fluctuated or has this been constant?

Please elaborate.

2. Could you tell me about the first few births you attended: what was your role at these births?

apprentice midwife

neighbour

domiciliary nurse

obstetrical nurse

nurse-midwife

Where did these births occur? (1st occurrence)

01. home

01. hospital

03. clinic

04. alternative birth centre

50. other——(specify)

97. N/A

98. D/K

Where did these births occur? 19__ to 19__

(see above)

90. No other occurrence

Does your work include prenatal visits?

always__ almost always__sometimes__never__

how many visits? n = ____

when are they usually scheduled? ___wks _wks__

Do you provide prenatal classes?

always__ almost always__sometimes__never__

Do you deliver babies by yourself yes__ no__

or do you deliver babies with other birth attendants?

yes__ no__ (probe for exceptions)_____

Who assists you in these births?

Medical personnel__

Nursing personnel__

other midwives__

friends__

fathers__

other_____ (please specify)

Are the women you assist ever transferred out of your care?

yes__ no__

How frequently does this occur?

Rarely_sometimes__often__almost always__

Can you indicate if there is a "transfer rate" (where applicable)? What is it: ___transfers per __attempted deliveries.

What circumstances have required such transfers?

Do you have documentation regarding birth outcomes for the people you have attended?

yes__no__ partial__(indicate missing data)___

Birth outcomes:

Spontaneous vaginal deliveries___

Forceps deliveries__

Vacuum extraction___

Caesarean section__

Other___ (specify)___

Pain medication:

paracervical block__

local anaesthesia__

general anaesthesia__

Other__ (specify)___

Perineal tears & episiotomies:

episiotomy__

no episiotomy__

1o tear__

2o tear__

3o tear__

4o tear__

C. Philosophy toward Contemporary Birthing

1. What advantages do you see in the contemporary birthing (obstetrics/midwifery) resources in B.C.?

2. What recommendations do you have for improving these resources?

legalization of nurse-midwives__

expanded ambit of nurse-midwives__

legalization of lay midwives__

humanized hospital settings__

alternative birthing centres__

domiciliary midwifery__

3. In your opinion, what then would be the optimal structure of birthing in the province.

D. Legal Regulation of Midwives

1. What are your feelings regarding the appropriateness of inappropriateness of legal regulation of midwives?

2. Do you feel that your practice is within the framework of law or not?

yes__

no__

uncertain__

3. Would you agree or disagree with the statement that the practice of medicine should be licensed through the Medical College?

SA__A__N__D__Strongly Disagree__

Through the College of Nursing?

SA__A__N__D__SD

Through another grouping (specify): _____

4. Have you had any legal conflicts in your practice to date?

Yes__No__

Amplify:_____

E. Autobiographical Information

Sex M F

Age __years

Marital Status:__ Single__ Married__ Sep—— Div—— Widow——Remarried——

Educational Attainment:

1. Some primary
2. Primary
3. Some secondary
4. Secondary Matriculation
5. Some post-secondary
6. Completed post-secondary

Specify: ___

Income (1984 approx): \$1-5000 5001-10000 10001-15000 15001-20000 20001-25000 25001-30000
35000-40000 40001+ \$____(Specify)

Indicate: gross income net income

family income personal income_____(breakdown)

Religious or Spiritual Affiliation:_____(specify)

APPENDIX E: OCCUPATIONS OF HOME BIRTH MOTHERS AND FATHERS

Occupation	Mother	Father	Total
Homemaker	54	2	56
Unemployed	16	2	18
Clerical	29	3	32
Labourer	1	4	5
Police Officer	0	2	2
Engineer	0	7	7
Lab technician	1	1	2
Bus Driver	0	1	1
Electrician	0	2	2
Bartender	1	1	2
Social Researcher	2	1	3
Architect	0	1	1
Teacher	8	4	12
Waitress/waiter	5	0	5
Plumber	0	2	2
Flight Attendant	1	0	1
Manager	0	5	5
Mechanic	0	2	2
Artisan	9	14	23
Computer Designer	0	1	1

Cook/Baker	3	1	4
Counsellor	3	3	6
Printer	0	3	3
News reporter	0	6	6
Computer Prog.	2	2	4
Stockbroker	1	0	1
Carpenter	0	8	8
Veterin. Ass't.	2	0	2
Academic	0	2	2
Midwife	4	0	4
Nurse	10	0	10
Doctor	1	2	3
Farmer/Agric.	0	2	2
Janitor	4	5	9
Self-employed	7	3	10
Salesperson	1	9	10
Day Care	3	0	3
Architect	1	0	1
Firefighter	0	1	1
Harness maker	0	1	1
Manufacturer	0	1	1
Yoga teacher	2	0	2
Interior dec.	1	0	1
Manag. cons.	1	0	1
Archaeologist	1	1	2
Logging	1	0	1

Civil service	1	1	2
Truck driver	0	2	2
Athlete	0	3	3
Contractor	0	3	3
Student	2	6	8
Postal worker	0	1	1
First aid	0	1	1
Lawyer	1	1	2
Film director	0	1	1
Seamstress	1	0	1
Tailor	0	1	1
Tree planter	0	1	1
Lineman (Tel.)	0	1	1
Advertising	0	1	1
Draftsperson	1	0	1
Entrepreneur	1	0	1
Total	182	128	310

APPENDIX F: DELIVERY POSITIONS: ATTEMPTED HOME BIRTHS

	Home Births	
	N	%
Supine	133	15.2
Left lateral	73	8.4
Hands and Knees	91	10.4
Semi-sitting	150	17.2
Squatting	59	6.8
Right Lateral	37	4.2
Reclining	36	4.1
Sitting	25	2.9
Lamaze	151	17.3
Side Lying	56	6.4
Lithotomy	31	3.6
Sims	8	0.9
Standing	14	1.6
Supp semi-stand.	1	0.1
On Knees	8	0.9
Total	873	100.0

Source: B.C. Home Birth Records