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**Reclaiming The Birthing Experience:
An Analysis Of Midwifery In Canada From 1788 To 1987**

by

Lois James-Chételat, B.A., M.A.

**A thesis submitted to
the Faculty of Graduate Studies and Research
in partial fulfilment of
the requirements for the degree of**

Doctor of Philosophy

Department of Sociology and Anthropology

Carleton University

Ottawa, Ontario

May, 1989

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RECLAIMING THE BIRTHING EXPERIENCE:
AN ANALYSIS OF MIDWIFERY IN CANADA FROM 1738 to 1987

submitted by Lois James-Chetelat, B.A. M.A.

in partial fulfilment of the requirements for
the degree of Doctor of Philosophy

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Anthropology

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May, 1989

Abstract

Within contemporary Canadian society, the dominant birthing practices are based upon an understanding of childbirth as a pathological event requiring supervision by a physician, in a hospital, and with technological intervention. It is the contention of this study that this view of birthing is a result of a particular historical process which has occurred in Canada in the past two hundred years. Birthing practices were initially controlled primarily by women, appropriated by a predominantly male medical profession, and are in transition once more as women and midwives seek to repossess the power they once held over birthing. Obstetrical practices are the result of certain social conditions: (1) gender attitude; (2) the economic status of women; (3) the quality and degree of institutionalization of medicine; and (4) state intervention into the health care system. In accordance with a particular configuration of these four social conditions, various midwifery practices have evolved in Canada.

The study traces the development of midwifery from the original statute of 1788, which required all midwives within the towns of Quebec and Montreal to be licensed, to the Ontario task force report on midwifery in 1987. Three phases of appropriation of midwifery (1788

to 1850, 1850 to 1900, and 1900 to 1940) are outlined. In the early 1970's a fourth transition occurred. Women, who were dissatisfied with a system of maternity care which overemphasizes technology and de-emphasizes the woman's role, sought assistance from midwives. This has set into motion a fourth phase, that of reclaiming of the birthing experience by women and midwives. Involved in this reclamation process are the following: (1) society's acceptance of parturition as a natural process; (2) the defining of what is meant by "normal" pregnancy and delivery; (3) the granting of midwives a monopoly over the care of normal parturition; and (4) the recognition of the need for and the development of alternative theories for midwifery. This will be achieved partially through state intervention into the health care system.

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discussing it with me.

I am also most grateful to Marian McGee. When I returned to Canada from working in developing countries, for a number of reasons I found it difficult to reenter nursing. However, while working upon my masters degree, I realized that at heart, I remained a health care worker. Therefore I wanted to know more about the state of nursing in the 1980's. I approached Marian, who at that time was very busy as Associate Dean of the Faculty of Health and Sciences, and Professor and Director of the School of Nursing at the University of Ottawa. She agreed to give me a tutorial, at which time I studied nursing theory. Since then she has been an important member of my committee. Marian has contributed both to the development of this study, and to my realization that I continue to have a role to play as a health care professional.

I wish to thank the many faculty members and fellow graduate students at Carleton with whom I have discussed my topic. Caryll Steffens has helped me on the revision of the chapters and the focusing of my argument. Karl Froschaur's suggestions, particularly as they related to the theory chapter, were gratefully appreciated. And I wish to thank Debbie Webster an under-graduate student for the information

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Chapter 1

Introduction

Sociology, as an activity, is a systematic restatement of consequent research of socially relevant issues. According to Forcese and Richer (1983: 3) this systematic restatement involves two related components. They are:

- (a) the specification of variation in the phenomenon. (Since ... inequality is the major social science preoccupation, the variation specified will typically be in terms of differential possession of, or access to, salient societal resources by various groups - i.e. males, females, ethnic groups, regions, social classes, etc); and
- (b) the casting of the issue in more abstract concepts in order to explain the variation.

These two components transform a social issue into a *sociological* one and reflect the general concerns of the discipline (ibid 4).

In the past ten to fifteen years, midwifery in Canada has become a social issue. Two major social trends have have set the stage for this revival of midwifery; (a) the reemergence of the women's movement; and (b) increased consumer demands for changes in contemporary obstetrics. My interests in midwifery began several years prior to this, in the early 1960's, when I worked as a nurse in the Northwest Territories. While in a nursing station in Aklavik, I assisted women in childbirth. However, the incident which remains etched in my memory is that of accompanying a

parturient woman in a Cessna aircraft from a small outpost, to the main hospital in Inuvik. She was in labour with a breech presentation (an abnormal position as the buttocks or legs of the foetus are forward rather than the head). On our journey we flew into a storm. With no room to maneuver, a woman who was moving quickly along in her labour, and a storm which bounced us around, I felt several moments of sheer panic. Fortunately the women gave birth in hospital, not in the turbulent air above the Arctic tundra.

This interest in midwifery was renewed during the period from 1968 to 1970, when I was employed as director of a program for the education of auxiliary nurses in Santa Rosa de Copan, a small town in Honduras. Because of the shortage of registered nurses, the R.N.'s assumed only supervisory roles, while the active nursing care was completed by auxiliary staff. I was supervised by a director from the ministry of health for the Honduran government. Under her direction, we set up a pilot project in which auxiliary nurses were educated not only in routine nursing care but in midwifery. A physician was on call for problematic births. After observing the competency with which these young nurses handled their roles as midwives, I seriously questioned a Canadian system of maternity care which delegated well educated registered nurses to the position of physicians' assistants.

In Indonesia, where again I was employed as a nurse, I observed the practices of both the formally trained midwives and the traditional birth attendants. It was also in Indonesia, on a remote island called Sulawesi, that I experienced, first hand, the qualities of a good midwife. I was assisted in the birth of our first son by an Indonesian midwife educated in the Dutch system of maternity care. My memories of the event, other than those of the normal pain of childbirth, are of simplicity in environment and techniques, open windows to patios, flowering hibiscus, birds, and the gentleness of the midwife. This unfortunately contrasts with the birth of our second son which took place in a modern hospital in Canada. Since our family practitioner was on holidays, I fell under the care of a physician who knew nothing about me, and appeared uncomfortable with the task at hand. Memories of this event are of a spinal anaesthesia that did not function properly, busy nurses, crowded quarters, and a sea of nameless, faceless green in the delivery room. It is partially because of these life experiences that I have taken the decision to examine the social issue of midwifery in order to systematically transform it into a sociological one.

According to Forcese and Richer (1983) two components are a part of this transformation. The first examines the specification of variation in the phenomenon; the second is the casting of the issue into more

abstract concepts. Variation in the phenomenon of midwifery is illustrated by the four major changes which have occurred in birth attendants in Canada over the past two hundred years. Prior to about 1850, the majority of pioneer women were assisted in childbirth by traditional birth attendants; middle age women who were highly respected within the community; who had also given birth; and who were called upon because of their expertise. Women from the upper class were generally assisted by physicians, although a few used the services of formally trained midwives. A second pattern in midwifery occurred between 1850 and 1900 when midwifery was in transition. As midwives were developing extensive practices, the physicians through professional institutions and state intervention into the health care system sought to eliminate competition through licensing laws. The traditional birth attendant began to disappear. This resulted in a third development within midwifery. Birthing fell under the authority of the medical profession. With an increasing population, physicians found it difficult to meet the needs of all the parturient women. Out of this need there developed the occupation of the public health nurse or nurse midwife. These nurses assisted women in childbirth where physicians were not available, but they remained under the jurisdiction of physicians. The fourth change in birth attendants occurred in the late 1960's and early 1970's when women

who were dissatisfied with the over-use of technology in our present system of maternity care sought assistance from either nurses or lay midwives. This in turn has led to the demand for an autonomous profession of midwives who will be recognized as the experts in normal pregnancy and childbirth.

Involved in the transformation of the social issue of midwifery into a sociological one is a second component. It is the casting of the issue into more abstract concepts in order to explain this variation. Therefore it is necessary to place the issue of midwifery within the context of the discipline.

It is the claim of this dissertation that birthing practices were initially controlled primarily by women, then appropriated by a predominantly male medical profession, and are in transition once more, as midwives seek to repossess the role they once occupied. Midwifery practices are the result of certain social conditions: (1) gender attitude; (2) the economic status of women; (3) the quality and the degree of institutionalization of medicine; and (4) state intervention into the health care system. In accordance with a particular configuration of these four social conditions, midwifery was established as an occupation administered primarily by women, was appropriated by a mostly male medical profession, and is in transition once more as midwives seek to

rec! . it

It is the contention of this dissertation that midwifery is linked to four particular social conditions which in turn are influenced by the prevailing ideology. Therefore, ideology effects the development of midwifery. Because of the interconnection between midwifery, the social conditions, and ideology, I will construct a theoretical framework which is based upon an ideology-critique. In chapter 2, the theoretical component of the study will be introduced. The general model of social thought which I will employ is that of critical social science as outlined primarily by Fay (1975). One element of the critical approach is ideology-critique. Based upon specific concepts from *Dominant ideology thesis* by Abercrombie, Hill, and Turner (1980), Bourdieu's (1977) concepts of *symbolic capital*, *habitus* and *modes of domination*, and Fay's (1975) work on the institutionalization of science, I will develop the theoretical framework.

Chapter 3 begins the historical account of midwifery dating, from 1788 to 1850. Women within the "toiler society" (Johnson 1974) were central to economic production and were esteemed by society. Because of a belief in the capability, intelligence, vigor, and strength of character of women of this class, parturient women sought assistance from other women i.e. traditional birth attendants. On the other hand, women of the

aristocracy, whose primary function was to provide heirs, were perceived by themselves and their class as dependent and frail. They sought assistance in childbirth from physicians. Medical treatment was limited to about four remedies (blood letting, the use of leaches, emetics, and purgatives), and as a result was not particularly effective. The physicians also did not begin to organize until about 1848. State intervention into health care was minimal although in Upper Canada, it sought to protect midwives. Because of these social conditions and an ideology which allowed for an open system of health care, midwifery flourished side by side with medicine, relatively free from tensions and conflicts.

In chapter 4, I will outline the transition period for midwives from 1850 to 1900. With increased agriculture specialization and the development of a cash economy as well as the removal of children from the home economic production in order to attend school, women's economic status was weakened. The role of women of the upper classes remained fundamentally the same. This decrease in the status of women was accompanied by an increased emphasis on encouraging women to understand themselves as dependent and frail, an ideology which had its origins within the upper classes and was increasingly perpetuated by the medical profession. At the same time as the belief in women's

dependency on men was filtering down from the upper, to those classes beneath it, midwives were establishing larger practices. This resulted in conflict among the health care personnel. The quality of medicine was improving as allopathic medicine began its transition into biomedicine which is rooted in science. Physicians across Canada established professional institutions, and provincial governments intervened on behalf of the physicians giving them full powers to license midwives. This allowed for the appropriation of midwifery by the medical profession, and by the end of the nineteenth century, the number of traditional birth attendants in practice had declined considerably. In this period of transition, because of the evolving social conditions and clashes in ideology, there were considerable conflicts and tensions between midwives and physicians.

Chapter 5 describes the period between 1900 and 1940 when nurse midwives emerged as an occupation under the authority of physicians. Women in the lower, middle, and upper classes were channeled into lower paying work. Gender attitudes had crystallized into a perception of women as frail and dependent. This belief was accepted by many women, was integrated into the health care system, and became an integral part of birthing. By the turn of the century, the ideology, that of technical solutions determined by the impersonal forces of science, had become

central to the Canadian way of life. This coincided with allopathy's transition into biomedicine, and contributed to more effective medical practices (i.e. decreases in mortality and morbidity rates). The physicians' professional institutions were strong, and the state intervened on their behalf by transferring birthing directly under their jurisdiction. Nevertheless, as the population burgeoned there were not enough physicians to attend women in childbirth. Because of the lack of traditional birth attendants and a need for childbirth assistants, there developed an alternative occupation, that of nurse midwives, women who worked under the supervision of physicians. There was little tension and conflict between the nurse midwives and physicians as the social conditions implied that women were of an inferior status, and as the majority of women had internalized this as well as the prevailing ideology which emphasized their dependency upon men.

In chapter 6, I discuss the final period (1940 to 1987) of midwifery as it is in transition once more. Although by 1961 more than one-quarter of all workers were women they were paid only slightly better than half that of their male counterparts (Ostry 1968). The realization of this economic gap as well as other gender issues triggered a response from many women. Under the umbrella of the feminist movement, they worked to change gender attitudes in order that women would be more highly

esteemed by society. At the same time, some women rejected the prevailing maternity system which over emphasized technology and de-emphasized the women's role in birthing. They sought to establish a system of birthing which would recognize it as a natural rather than a medical, technological event, and one which would fall under the supervision of midwives. The medical professional organizations remained powerful, and rejected all efforts for home births assisted by midwives. Nevertheless, because of consumer demand, midwifery flourished within Canadian society. This resulted in tensions and conflicts between midwives and physicians as midwives worked to repossess the occupation of midwifery.

Chapter 7 deals with the task force report on midwifery for Ontario. A jury inquiry into the death of an infant born at home recommended that midwives be licensed in Ontario. The Minister of Health appointed a task force which was to report back to him. In chapter 7, I will outline the recommendations of the task force and analyse them in order to determine whether they will lead to the achievement of the midwives' goal, that of an autonomous profession of midwives who are the recognized experts in normal pregnancy and childbirth.

In chapter 8, I will offer a program which may be helpful to midwives in their reclaiming of the birthing experience. This program is

determined by what I have perceived as their felt grievances and their desires for the profession of midwifery. Included in this chapter is a discussion on the labelling of parturition as natural; the defining of what is meant by *normal* pregnancy and delivery; the granting of midwives a monopoly over the care of normal parturition; and the recognition of the need for and the development of alternative theories for midwifery. In the conclusion, chapter 9, I will examine critical theory and its usefulness in understanding the "quasi-causal and functional laws" (Fay 1975) as they relate to the four social factors which I have discussed in each chapter, and the role of these conditions in the development of midwifery in Canada in the past two-hundred years.

According to Forcese and Richer (1983) sociological activity is a function of societal context, discipline context, and individual background. In this study these three facets are integral to the transformation of the social issue of midwifery into its systematic restatement as a sociological one. In the remainder of this chapter, I wish to contextualize the Canadian experience by placing it within an evolutionary and cross-cultural framework. I will also describe midwifery in Holland as my experience in Indonesia with this particular approach to obstetrical care both sharpened my perception and focused my attention on the differences which exist in contemporary maternity care

within Western societies. Through an examination of the Dutch system of obstetrics, I have been able to more acutely reflect upon the Canadian experience.

An Evolutionary and Cross-Cultural Examination of Midwifery

The anthropologist W.R. Trevathan (1987) has constructed an overall model of the human reproductive strategy. She has demonstrated five major transitions in human biology and culture which in turn have resulted in changes in parturition and mother-infant relations. They are as follows:

- (1) the origin of bipedalism and associated greater difficulties in parturition;
- (2) secondary altriciality of the neonate associated with encephalization in the genus *Homo*;
- (3) the behavioral adaptation of the obligate midwifery with further encephalization;
- (4) postpartum separation and decreased contact between mother and infant following agriculture and sedentism; and
- (5) technological effects on birth and infant care in the industrial age (ibid 221).

Each of these transitions was a result of a long series of compromises; each placed different demands on the female giving birth and in caring for

dependent young.

The first transition was concerned with the adaptation of the pelvis for bipedalism (Hominadae: 5-10 million years ago). Trevathan argues that the fact that birth takes place through the pelvic canal imposes upper limits on both the neonatal brain and body size of mammals. It is the locomotor habit which determines the rigidity and arrangements of the bones of the pelvis. This in turn effects the size of the birth canal and ultimately foetal size at birth.

Almost all primates can assume a bipedal stance for short distances. However, major morphological changes were necessary for habitual bipedalism. Such changes included "elongation of hindlimbs relative to the forelimbs, reorientation of the pelvic girdle, including a further shortening of the distance between the sacroiliac and ... acetabulum, and reorientation of most of the musculature involved in locomotion" (ibid 18). This resulted in a pelvic girdle which is very different from other primates: "the ilium is shorter, broader and expanded front-to-back; the ischium is also shorter and broader. The point at which the ilium articulates with the sacrum is larger, providing greater stability and support in this region" (ibid 19). Efficient habitual bipedalism requires a narrow pelvis.

This, then, is in direct conflict with the second major transition,

that of increased encephalization. Increased brain growth in utero requires an expanded birth canal. Approximately two million years ago the brain reached the maximum physical size that could be born to a mammalian lineage. At this point there was a shift in growth pattern. Rather than increasing the size of the birth canal to meet the needs of increased encephalization, the genus *Homo* produced young "prematurely" in that the foetus was born before s/he reached normal neonatal size. The neonatal brain and motor development for the human infant is far lower at birth than any other closely related neonate. It is Trevathan's contention that the human infant can be considered as an extero-gestate foetus for the first few months of life. At this stage human infants share the growth patterns of other primate foetuses, not other primate infants. For example, cranial plates in ape infants are fairly well developed at birth. In contrast the cranial plates of the human skull show a great deal of molding at birth as the cranial plates slide over one another to allow the head to pass through the pelvic canal. Later fusion of the cranial sutures is necessary to allow the brain to grow for several years after birth.

At birth, it is about 25% of the adult size, measuring approximately 350 m^3 (21 in^3). By one year, it will have more than doubled in size, averaging about 800 cm^3 . By age 3, the child's brain will have grown to more than three times its birth size and will be 75 % of adult size. In contrast, nonhuman primate infants are born with brains averaging one half the size of adults of their species (e.g. rhesus: 65%; chimpanzee: 41%)(ibid 143).

And the liver and gastric enzymes as well as the central nervous system (CNS) are far less developed than in nonhuman primates.

These two major trends, increased brain size and increased efficiency of bipedal locomotion, have dominated the course of human evolution. Each has contributed significantly to the survival and success of our species. With dependency upon two limbs in locomotion, coupled with increased intelligence, hominids have been able to manipulate, modify and eventually control to a great extent the environments they have inhabited. Nevertheless, these two major transitions have also created a greater altriciality of the neonate. Increased demands are placed on the females in delivery and in caring for the more helpless infant. The female's ability to provide optimal care as well as the amount of assistance she received from others in the social group, ultimately contributed to survival for the genus *Homo*.

It is these two major trends, bipedalism and increased encephalization which led to the third major behavioural transition, that of obligate midwifery. Manipulative assistance was important in reducing mortality. Human infants rarely emerge facing the pubis. This type of presentation is associated with increased perineal laceration and prolonged delivery. It is suggested that this presentation (which is common among nonhuman primates) changed during the evolution of the

female pelvis associated with bipedalism and encephalization. Such a change affected the entire emergence pattern of the foetus with a resulting change in the mother's response. If the female in labour uses her hands to assist herself in delivery, she pulls the infant against the normal flexion of his/her body. This procedure results in infant injury, particularly to the nerves of the neck. This type of injury can be prevented through the use of an assistant who intervenes to help guide the neonatal head as the shoulders emerge. With the assistance of another adult, mortality is reduced. "Eventually, as selection favoured further assistance during birth, the behavior became a part of normal parturition in hominids" (ibid 225). Even if only one or two used a birth attendant during delivery, the survival differentiation would be sufficient to allow for the eventual incorporation of the practice into group tradition. Whereas, Trevathan has used a neo-Darwinian explanation, I would suggest that the development of midwifery was due to socio-cultural adaptation, rather than to genetic selection. Because of their own experience older women both anticipated and recognized birthing problems. As a result, the use of a birth attendant during parturition became a part of a total adaptive strategy for increasing the life expectancy of the species under particularly difficult circumstances.

According to Trevathan, by the time of the fourth transition, the

period of increased sedentism (35 000 years ago), midwifery was well established as a tradition if not a profession. And there is today a wide range of variation in the ways in which midwifery is practiced in various cultures of the world. Cross-culturally birth assistants may be categorized in three major ways. First, and probably the most ancient is the older female relative who has given birth but has received no training in midwifery. In her survey of more than three hundred cultures in the HRAF (Human Relations Area Files) and other sources, Trevathan found that twenty-six cultures require the woman's mother attend her, five require the mother-in-law as the primary attendant, and on Yap and Easter Island, it is normal for the father to act as an attendant at birth (ibid 110).

The second category, which is the most common, is the traditional birth attendant or village midwife. She is not necessarily a relative but because of her expertise is called to assist in the delivery. These women are usually passed the child bearing stage highly respected within the community and have given birth.

Professional midwives make up the third category. These assistants have had formal training or have attended so many births that their knowledge and experience are recognized in the community. They often receive compensation for their services. Some of the women begin

practising as traditional midwives but later in life receive formal training. Others are educated in government sponsored programs and licensed as midwives. Such programs usually attract younger and better educated women. However, these licensed midwives are not always preferred by the village people.

The attendance of men at birth varies cross-culturally. On Manus, a man is forbidden to be present at the birth of his child. Yet in other cultures such as on Yap, Easter Island, and in contemporary Western society fathers actually assist in the delivery of their offspring.

Trevathan found that of the three hundred cultures she surveyed, the literatures of only one hundred and fifty-nine make any mention of men with regards to parturition. Of those mentioned, thirty-one cultures encourage husbands to attend and assist; forty-two may attend but rarely do; and eighty-six societies prohibit all men including husbands from attending childbirth. Among the reasons cited for such prohibitions are those of pollution uncleanness and danger to men (ibid 114). This analysis indicates that in most cultures women act as birth attendants while in only a limited number of societies are men encouraged to assist their wives during parturition.

A second interesting facet of birthing is the location for the act of parturition. In general women choose a familiar place. For example !Kung

San gave birth in the bush and women of the nomadic Pitjandara tribe of Australia simply drop behind the group to deliver (ibid 110). In an analysis of maternal mortality rates in nineteen villages of District Kaliangkrik, Central Java, Indonesia, Dr. J. Achmad (1984) found that although village women do seek help from government trained medical personnel during their pregnancy, they prefer to deliver in their homes with the associated risk, rather than enter into hospital.

Birthing Practices in Holland and Canada

It is the difference in maternity care within Holland and Canada which provides a view of the diversity in birthing practices within contemporary Western societies. In Holland birthing is supervised by a professional midwife, a woman who has received some form of formal education. (For a historical chronicle of the development of midwifery in Central Europe, England, and Canada see appendix one). It is important to note that Holland has one of the lowest infant mortality figures in the world. Yet fifty-five percent of the births are home births; delivery by midwife is common at home as well as in the hospital (Jordan 1983: 33). (This figure may vary according to the source. Figures, as low as forty and as high as sixty percent, have been quoted.) Birthing in Holland is understood as a natural process, one in which the Dutch mother in the overwhelming majority of cases expects to receive no medication of any

kind.

In Holland prenatal care is free, comprehensive and universal. Pregnancy is not regarded as a pathological event although the risks of complications are recognized. It is the role of prenatal care worker to organize (among other things) and to distinguish normal pregnancies from those with current or foreseeable complications, and to assign an appropriate environment to each. This routine prenatal care is the domain of midwives. They are educated to do the standard examinations and laboratory tests, and are proficient in recognizing potential abnormalities. The examinations are conducted in a relaxed unhurried atmosphere, one in which there is an openness usually found in woman to woman interaction. This kind of prenatal care has the side effect of relieving physicians from the responsibilities for normal routine pregnancies, giving them more time for cases which clearly fall into the medical domain.

Responsibility for the course of normal pregnancy and birth is given to the individual woman. She is conscientious about routine supervision of the course of pregnancy, eager to inform herself about the physiology of birth, and the mechanics of labour, and collaborates knowledgeably during the birthing process.

Socialized medicine eliminates differential treatment of the poor,

making equal access to both medical supervision and natural childbirth education available to all women (ibid 42).

In Holland participants believe that the baby will be born when it is ready, whenever that may be. The birth team consists of the mother, a midwife, her assistant and a non-specialist attendant who keeps the mother company. No medication is given during birth and labour. All discomfort is handled through breathing and relaxing techniques. Midwives are skilled in such technical procedures as doing and repairing episiotomies, operating the vacuum extractor (used in Europe in preference to forceps), giving some form of anesthesia, operating resuscitation equipment for the new born if necessary etc. She is well educated in assisting at normal births, and in recognizing abnormalities. Physicians are on call. The Dutch midwife understands her role as one in which she provides encouragement and support when necessary. The parturient woman is not a patient to be delivered but a person who is capable of giving birth on her own. "The mid-wife's [sic] function is to stand by, watch for complications, give encouragement and do the few technical tasks such as cutting the umbilical cord that the woman can't do for herself" (ibid 46).

The decision-making with regard to the routine of birthing is left to the mother. The majority prefer to give birth at home. Birthing decisions are separated from strictly medical ones. Since the general

conception of birth is that of a natural process, there are, in fact, few decisions to be made. Dutch midwives work under the assumption that a woman knows what her body is up to. They are not likely to give "doctor's" orders such as "It's time to push now" but to inquire "Do you think it's time to push now?". It is only with indications of complications that formal decisions are made. In normal births, the woman is treated as a competent being who is able to manage the natural process of birthing.

This is in contrast to birthing in Canada. Here, all babies excepting for those whose mothers have chosen to defy the clearly established medical norms for birthing (less than 1% in Canada (Statistics Canada 1971-77)) are born in hospital. A typical birth is characterized as physician-attended and professionally managed; each of which is orientated towards the use of medical technology and pharmacological methods to relieve pain. Birthing is a medical event. The mother, upon entry to a hospital, becomes a patient. All decision-making power and responsibility for her state pass from her to the hospital personnel and physician in charge.

Maternal mortality rates in Ontario did not drop below the one death per one thousand live births until 1950, and today nearly two percent of children die before they reach their first birthday (Oppenheimer 1983:

39). Up until the second world war, Ontario maternal mortality was lower in rural areas among women who tended to give births at home. The Ontario, Department of Health, in its *Annual Report* of 1934, describes a study which had been conducted to examine maternal mortality in the province. Some of the findings are as follows:

- (1) In twenty-five years there was no significant reduction in mortality from puerperal causes;
- (2) In women of childbearing age mortality due to pregnancy and childbirth was second only to tuberculosis;
- (3) Estimated specific puerperal mortality was 5.7 among "urban" women, 4.7 among "rural" women. In general, increased mortality in the urban group was due to puerperal sepsis and abortion;
- (4) According to the type of delivery, the estimated specific mortality was 2.3 per 1000 births in the "spontaneous" group and 8.2 in the "operative" group;
- (5) For those women who delivered in hospital and who died there, the specific puerperal mortality rate was 5.3 per 1000 births; 2.3 in domiciliary cases. The death rates were 1.7 and 0.7 per 1000 respectively;
- (6) Cesarean section was performed in 18 percent of "delivered" cases. The incidence of mortality in these cases was found to be more than

twice as high among "urban" mothers than among "rural" ones (ibid 54).

The results of this study indicate that maternal mortality increased with hospital delivery. There were 5.3 deaths per 1000 births in hospital, as compared to 2.3 maternal deaths per 1000 home births. This increased death rate was associated specifically with puerperal sepsis although a rising abortion rate (spontaneous or otherwise?) in the urban population was mentioned. Where birthing was physician controlled (operative) maternal mortality was 8.2 per 1000 births; where there was no medical interference (spontaneous), the rate was 2.3 per 1000 births. It would appear that puerperal infection was a leading cause of maternal deaths. Studies in the United States, in this same period, tend to draw similar conclusions.^{2*}

The decrease in maternal mortality rates began only after 1935 when sulfa and 1941 when penicillin were introduced. They declined even more so after 1946, when legislation went into effect making available one complete medical examination during the period of pregnancy. With third-party payment in Canada mortality rates declined considerably in Canada. Table I indicates that maternal mortality rates per 1000 live births remained about the same from 1921 to 1931. 1941 shows the first real drop in deaths due to diseases of pregnancy and childbirth and by

* All numbers refer to the appendix

**Table 1 - Births, Deaths Due to Diseases of Pregnancy
and Childbirth, and Maternal Mortality Rates
Per 1 000 in Canada, 1921, 1931, 1941, 1951.**

Year	Live Births *	Deaths due to diseases of pregnancy and childbirth	Maternal mortality per 1 000 live births
1921	168 979	868	5.14
1931	240 473	1 215	5.06
1941	255 317	901	3.52
1951	380 101	405	1.07

Data taken from the Dominion Bureau of Statistics 1921, 1931, 1941, 1951.

*exclusive of stillbirths

1951 the rate is down to 1.07 per 1000 live births. I would point out that the mortality rate is calculated using live births. This means that only pregnant women who delivered live infants are included in the data.

Those women who had stillbirths are not included. It is probable that the inclusion of pregnant women who had stillbirths would have a marginal effect on the data. The pattern of decreasing maternal mortality in Canada would remain the same. This decrease is believed to be due to the introduction of sulfa and penicillin after 1935, and the availability of third-party payment for prenatal care after 1946.

In Canada there is no institutionalized mechanism for separating the normal from the complicated births. Therefore all types of births are treated in the same manner. Although physicians may recognize that for a

normal birth it is best to do nothing, the availability of medical technology to speed up birthing, as well as their professional training and work orientation militate against such an attitude. The obstetrical ward itself is designed with a view to organizational efficiency and the availability of medical technology. It has a hospital-like atmosphere, one which is associated with suffering and illness. The woman upon entry into the hospital is frequently immobilized in bed (although walking during labour is both physiologically and psychologically beneficial). She becomes a passive patient, submissive to the authority of a physician. Birthing occurs on the physician's territory, a fact which allows for greater control.

Birthing in Canada is a medical, technological event. There are instruments, machinery, equipment in the labour and delivery rooms, X-rays, laboratory facilities, the set up of the operating room for Cesarean sections, newborn resuscitation equipment etc. Probably the two most common practices are the use of medication (analgesics and pituitrin) and forceps. By the time women reach the delivery-room, they are often only semi-conscious due to medication and unable to cooperate fully. Furthermore, they are frequently anesthetized and as a result unable to feel the contractions of the uterus. Therefore, forceps are necessary to replace the muscle effort required to push the baby out. "It

is in this sense (among others) that the woman is aptly described as being delivered rather than as giving birth ..." (Jordan 1983: 61).

Medical literature indicates that the lithotomy position, so firmly established as a Canadian practice, may not be a birthing position which is in the best interest of the mother and child. For example, this position has been shown in numerous studies to have negative effects on the mother's blood pressure, cardiac return and pulmonary ventilation. It also decreases the strength of the uterine contractions, thereby increasing the need for artificial stimulation in birth (ibid 62). In the United States, a country whose birthing practices mirror those of Canada there are indications of:

- (1) the indiscriminate use of electronic fetal heart monitors and ultrasound,
- (2) the growing rate of Cesarean section,
- (3) the increased incidence of elective inductions of labour, and
- (4) the excessive use of drugs during pregnancy and delivery (McBride 1982: 414).

In his book *Confessions of a Medical Heretic*, R.S. Mendelsohn (1979) writes of the problems created by over-medicalization of birthing. One problem is that which is related to foetal heart monitoring. In this procedure electrodes are attached to the foetus scalp. In order to do this, the amniotic sac must be artificially broken. According to

Mendelsohn: "This results in instant depression of the fetal heart rate. In one study, children whose birth was electronically monitored were sixty-five percent more likely to suffer behavioral or developmental problems later in life" (ibid 98). (Mendelsohn does not indicate why such behavioural changes occur). This mode of practice with its consequences may not prevail in all institutions. For example, there may be different expectations and practice patterns manifested between teaching hospitals and community hospitals. Each may present different pictures.

Induced labour tends to lead to premature delivery. Foetal lung disease, failure of normal growth and development, and other mental and physical disabilities are dangers associated with prematurity. Half of all women who deliver by Cesarean section develop postoperative complications and maternal deaths are twenty-six times higher than for those who deliver vaginally.

Hyaline membrane disease or respiratory distress syndrome is a condition which develops in full-term, regular size babies delivered by Cesarean section. "One study concluded that the incidence of this disease could be reduced at least fifteen percent if obstetricians were more careful about Caesarean deliveries" (Mendelsohn 1979: 100). From the works of critics such as Mendelsohn (1979), McBride (1982), and Jordan (1983), it is not difficult to conclude that many problems exist within

current obstetrical practice.

Besides the over-medicalization of the birthing process, the lack of decision-making powers for the parturient woman is central to the issues associated with birthing in Canada. A woman in labour, regardless of whether her pregnancy is normal or medically complicated, is defined as incompetent, relieved of responsibility for her state and required to submit to the professional competence of the physician. The assimilation of childbirth into the medical realm subjects birthing to medical decision-making criteria "whose appropriateness and justification stem from a pathological view of pregnancy and birth" (Jordan 1983: 65). In Canada birthing is no longer understood as a natural event but as something pathological. As such the responsibility and achievement (the physician *delivers* the baby) is assigned to the physician. Because of this transfer of responsibility and achievement, the initiative, interest, and motivation of the mother are not officially acknowledged as instrumental in achieving a quality of prenatal care.

The insistence that women be hospitalized for childbirth is a relatively recent event. (This insistence by physicians will be elaborated on in further detail in chapter six). For example, in 1926 when statistics were taken for the first time, only 17.8% of women in Canada gave birth in hospital. Fifty years later in 1976, 99.7% of all women were

hospitalized for childbirth (Statistics Canada 1971-1977). The trend towards hospitalization was accompanied by two other processes; the transformation of birthing from a natural to a pathological event; and the replacement of the female birth attendant by a male physician. This transformation of birthing occurred between approximately 1850 and 1940. However, birthing is once more changing and evolving as women who have rejected the present system of birthing and midwives seek to reclaim the birthing experience.

Currently Canada is the only Western industrialized nation and one of only nine countries throughout the world that does not recognize midwifery as part of its health care system. It is my belief that the divergent system of maternity care in Canada can be better understood through an examination of the historical factors which were instrumental in the development of midwifery. However, before beginning this historical account, I will first outline the theoretical approach of the study.

Chapter 2

The Theoretical Framework

In the first chapter, I indicated that midwifery was originally an occupation under the authority of midwives, was appropriated by physicians, and is presently being reclaimed by midwives. The major social factors which influenced this social process are gender attitude; the economic status of women; the quality and degree of institutionalization of medicine; and state intervention into the health care system. In this study, the state is defined as the governing institutions such as the legislature; the executive and courts; the laws and policies; and the civil authorities such as the police who implement them. The social construction of midwifery is influenced by a particular configuration of these conditions at any given time. It is my contention that these four social conditions are linked to the prevailing ideology. Therefore, the social construction of midwifery is influenced by ideology. As ideology changes so too does midwifery. Because of the interconnection between ideology, the social conditions, and the types of midwifery practices which occur, I will develop a theoretical framework which is primarily based upon an ideology-critique.

The approach of this study is that of the critical perspective particularly as it is outlined by Fay (1975). Three elements of the

critical approach will be employed. They are; (1) ideology-critique; Included under this topic is a discussion of the relation of the control of the means of material production to the control of the means of mental production; the concept of hegemony; the construction of the social machinery for the self perpetuation of power; and the concept of dual consciousness. All of this is related to the establishment of the dominant birthing ideology. (2) a critique of the philosophical underpinnings of science; In this section I will briefly examine the philosophical bases of science, the establishment of science with its link to technology as a 'root ideology' and the effects of this upon the development of maternity care; and (3) the subjective point of view of the actors as well as the "emancipation" of these same actors. Based upon the concepts included within these elements, I will construct a theoretical framework in order to explain the original development of midwifery, its appropriation by physicians, and the attempt by midwives to reappropriate it today.

The Critical Approach

The general perspective for social thought is that of the critical approach. It seeks to mount a critique of the social relations that involves the oppression of one segment of the population by another (Turner 1982: 417). Through a critique of successive social relations, the

model endeavors to describe how to construct alternative social relations that liberate people in order to realize their full potential.

The critical model is 'critical',... in that it sees theories as analyses of a social situation in terms of those features of it which can be altered in order to eliminate certain frustrations which members in it are experiencing, and its method of testing the truth of a social scientific theory consists partially of ascertaining the theory's practical relevance in leading to the satisfaction of human needs and purposes (Fay 1975: 92).

According to Fay, critical social science is characterized, in general, by three main features. The first is that it accepts the necessity of interpretive categories in that there must be an attempt to understand the intentions and desires of the actors which are being observed as well as in the rules and constitutive meanings of their social order. Fay states that " a critical theory is rooted in the *felt* needs and sufferings of a group of people, and therefore it is absolutely necessary that the critical theorist come to understand these actors from their own point of view, at least as a first step" (ibid 94 original italics).

A second characteristic of the critical approach is that it recognizes that many of the actions that people perform are caused by the social conditions over which they have no control. Often people have no conscious knowledge or choice in what they do to one and other. Therefore it is necessary to uncover those systems of social relationships which determine the actions of individuals and the

consequences of such actions . "The critical model is one which requires that its practitioners seek to discover the quasi-causal functional laws of social behaviour in particular social contexts" (ibid 94).

Fay considers the third characteristic of critical science as its most important. This is the fact that the critical model takes the hidden connection between theory and practice as one of its starting points and because of this " *it ties its knowledge claims to the satisfaction of human purposes and desires*" (ibid 95 original italics). It offers an approach which seeks to better humankind; the view that ideas should be produced for ends and goals; and the idea that knowledge should "expose alternative futures and ways of realizing these futures" (Turner 1982: 418). A study must not simply explain the sources and nature of discontent experienced by actors, but demonstrate how this discontent can be eliminated by removing the structural contradictions which underlie it. Therefore it should not only account for the sufferings and felt needs of the actors, which are the result of certain structural/functional conflicts in the social order, but to offer the appropriate course of action which has the potential to change the social order. Through the use of the critical model, I will not only articulate the felt grievances of midwives, but offer a program of action which is intended to meet with satisfaction their desired ends.

Three major elements of the critical approach are useful in the understanding of the development of midwifery in Canada. The first is that of ideology-critique. In ideology-critique, there is a demonstration of the ways in which ideologies of the actors are illusions. It is believed that such a demonstration will strip the ideologies of their power. "It tries to show men [women] how they have been deceived, given their experiences, aims, and desires, and in the process it seeks to reveal to them the rational way of going about getting what they really want" (Fay 1975: 98-99).

A second major element of the critical approach is a critique of the philosophical underpinning of scientific inquiry. Scientific knowledge is not neutral, objective, or impassive. By simply recording what exists or is, or by understanding the essence of what is:

social science supports the status quo and makes it appear to be a universal truth. Thus, the so-called value-neutrality of positivism turns out to be one of many ideological efforts to legitimate current patterns of constraint and oppression (Turner 1982: 418).

According Ritzer (1988: 130) positivism leads the actor and the social scientist to passivity.

The third element is the active participation of the actors in the study through their subjective accounts. Through the actors' description of their felt needs and sufferings as well as through the understanding of

the inherently contradictory social conditions, the critical approach allows the researcher to learn the ways in which the social order is repressive and as a result, the kinds of action which must be understood by the actors in order to emancipate themselves. The goal is the enlightenment of the actors. This is the fundamental difference which distinguishes it from the positivist model. According to Fay (1975: 105), the purpose of positivism is to obtain certain sets of relationships which will work to achieve certain ends efficiently; the purpose of education in terms of knowledge provided by the critical social science is " the transformation of the consciousness of the actors it seeks to understand, a transformation which will increase their autonomy by making it possible for them to determine collectively the conditions under which they will live".

Ideology-Critique: A First Element of the Critical Analytical Perspective.

It is the role of critical theory to show how the manifest content of the actor's ideas mask the latent content which is a source of power over those who hold them. Ideology-critique seeks not only to point out the error in the ideas men/women have, and the way this error helps to maintain a social order which has a tendency to thwart them, but " it also attempts to reveal the truth which these ideas contain by demonstrating how they point to an important dimension in the psychological economy of

their proponents, and how they suggest a new self-conception which makes explicit what they only implicitly contained" (ibid 99). Yet the understanding of the role of ideology must first begin by defining how term ideology is used within the context of this study.

I will employ the term ideology as it is understood in the sense of sets of practices or as *real* social relations which conceal the nature of their ideological content from human subjects . Taussig (1980) illustrates this perception of ideologies in his discussion of the doctor-patient relationship. In times of illness a person is vulnerable and open to manipulation and moralism. This provides the doctor with a powerful entry into the patient's psyche and the opportunity for the physician to restructure the patient's conventional understanding and social personality i.e. to bring him/her back into the fold of society, into the epistemological and ontological groundwork from which the society's basic ideological premises arise. The moral and metaphysical components of disease and healing are concealed through the use of a natural science model, and the issue of control and manipulation is hidden by an aura of benevolence. Biomedicine, an effective social practice, does not divulge its ideological content to its human subjects.

An analysis of the historical changes in the Canadian birthing system indicate that two dimensions of ideology have influenced this

process. They are; (1) the gender ideology which arises out of particular class interests: and (2) the ideology associated with the development of science.

Within the Canadian context two perceptions as to the nature of birthing have existed at one time or another. The first understands birthing as a natural event, requiring the supervision of a midwife, in the home, and with little or no intervention by the birthing assistant. The second view presents childbirth as a pathological event requiring hospitalization and technological intervention by a physician. In the past eighty to one hundred years this second perception of birthing has gained dominance within Canadian society. In order to understand how one perspective has gained acceptance, while the other was displaced, it is necessary to examine four major concepts in the critique of a dominant ideology.

The major components of the dominant ideology thesis as outlined by Abercrombie et al. (1980 1-2) can be summarized as follows:

The thesis argues that in all societies based on class divisions there is a dominant class which enjoys control of both the means of material production and the means of mental production. Through its control of ideological production, the dominant class is able to supervise the construction of a set of coherent beliefs. These dominant beliefs of the dominant class are more powerful, dense and coherent than those of subordinate classes. The dominant ideology penetrates and infects the consciousness of the working class, because the working class comes to see and to experience

reality through the conceptual categories of the dominant class. The dominant ideology functions to incorporate the working class within a system which is, in fact, operating against the material interests of labour. This incorporation in turn explains the coherence and integration of capitalist class .

The particular set of coherent beliefs or dominant ideology which will be referred to in this work is that of the birthing ideology, one which understands childbirth as a pathological event requiring hospitalization and technological intervention by a physician. The acceptance of this particular perception of birthing can be understood through a discussion of the four major concepts. The first one states that those who control the means of material production and therefore the means of mental production control ideology. In other words the class interests and education of physicians were important factors in controlling birthing ideology. A second, is the notion of leadership, one which fuses the elements of control by repression with control by ideological persuasion i.e. hegemony. Within the Canadian context, physicians attempted to persuade women of the efficacy of their birthing system through the improvement of obstetrical care, and to repress opposing views through rigid licensing laws and socio-political repression. A third factor, in the successful establishment of the dominant birthing ideology was through the construction of the social machinery for the self-perpetuation of power. Physicians, by developing professional institutions, standardizing

education, and licensing regulations, and by gaining authority over the activities of related health care occupations, were able to set up the objective mechanisms which would allow for the continual perpetuation of their power. The final factor which is important for understanding the conflict within our present system of birthing is related to the concept of dual consciousness or the acceptance or internalization of the dominant ideology. Those who are "victimized" do not uniformly have a consciousness imposed upon them but tend to retain a dual consciousness. In this study, the "victims" referred to are both women and midwives. An examination of the historical changes within the Canadian birthing process suggests that although women appear to have internalized the dominant birthing ideology, when the appropriate configuration of social conditions presented themselves, women sought to reclaim the birthing ideology which had originally arisen out of a women's culture – that of natural childbirth, in the home, and under the direction of a midwife. There is one other element which was important to the establishment of the prevailing birthing ideology and that is society's acceptance of science as the 'root ideology'. This topic will be explored under a description of the second element of the critical approach – that of a critique of the philosophical underpinnings of science.

Class, Education, and Control of Ideology

Within Marxism, the view which is characterized as the dominant ideology thesis originates in a particular work of Marx and Engels

"Concerning the Production of Consciousness". I quote at length:

The ideas of the ruling class are in every epoch the ruling ideas: i.e., the class which is the ruling material force of society, is at the same time its ruling intellectual force. The class which has the means of material production at its disposal, has control at the same time over the means of mental production, so that thereby, generally speaking, the ideas of those who lack the means of mental production are subject to it. The ruling ideas are nothing more than the ideal expression of the dominant material relationships, the dominant material relationships grasped as ideas; hence of the relationships which make the one class the ruling one, therefore, the ideas of its dominance. The individuals composing the ruling class possess among other things consciousness, and therefore think. Insofar, therefore, as they rule as a class and determine the extent and compass of an epoch, it is self-evident that they do this in its whole range, hence among other things rule also as thinkers, as producers of ideas, and regulate the production and distribution of the ideas of their age; thus their ideas are the ruling ideas of the epoch (Marx and Engels 1970:105).

In this passage, Marx and Engels place at the center of their analysis the idea that those who control the material production have also secured the apparatus for mental production. Since it is the ruling class which has economic control, it is this same class which produces the ideas, and these ideas are necessarily ruling ideas. The imagery appears as one of activity, of one class (the ruling class) doing, while the other class is "more passive and receptive". However, for Marx and Engels, it is the

dominated class which is active in the sense of physical action. This class has less time to make up illusions and ideas about its self (ibid 106,107).

Within society, intellectuals have an important role. In the view of Gramsci, everyone is an intellectual in some sense but not all persons function in society as intellectuals. There is a specialized group of intellectuals whose profession is to function as such. Gramsci states that there is no such thing as an autonomous intellectual stratum. All intellectuals are attached to a social class and they articulate a view of the social world which is appropriate to their class. As a result, the intellectual stratum that refines and presents its world-view is an important apparatus for the transmission of the ideological component of the ruling class (Abercrombie et al. 1980:13).

In examining the development of the dominant birthing ideology, it is apparent that physicians who became the specialized group of intellectuals with regard to birthing assistance integrated within their practices their particular class view of the female gender. As a result of this integration, birthing practices became an important apparatus for the transmission of their ideological perception of women. However, if it is to be assumed that class ideology was perpetuated through the practices of the physicians, it is then necessary to establish the

relationship of the physicians to a class.

Z.A. Jordan (1971) in his book *Karl Marx: Economy, Class and Social Revolution* states that there are two interpretations of social class in Marx; one that is sociological, and the other historical. The sociological interpretation contains two elucidations of the term *social class*. In the first instance the term *class* is used in the collective sense. Marx spoke either of *class* "as a whole" or of "a certain class property which only a class as a whole ... may have" (ibid 23). *Class* may be used also in the distributive sense. This term assumes the existence of class members. As such, it is not an entity but "a construct by means of which we can speak of each and every member of the class" (ibid 23).

Marx also offers a different concept of social class when it occurs in his historical writings. In one of his works, Marx listed six classes, (financial bourgeoisie, industrial bourgeoisie, petty bourgeoisie, peasant class, proletarian class, and *Lumpenproletariat*) (ibid 29). In a second work he listed seven classes. These classes appear as groups with distinct economic, and/or political interests as well as common social and/or political attitudes which are played out in the development of events. According to Jordan "bankers, industrialists and land-owners can be considered as a single class or as several depending on the demands of the enquiry" (ibid 30). In this case, the term 'class' is used in the purely

descriptive sense. It is a classificatory device in that people are classified according to some relevant criterion, usually an economic characteristic such as income (Lee and Newby 1983: 121).

Here we *are* dealing with actual groups of people. These are simply listed as major social groups, the chief actors on the historical stage. Classes in this sense are bound to be numerous and their number will vary according to the historical situation which is being described. (ibid 121-122 original italics).

Bearing this in mind, it is now possible to question the relationship of physicians to the dominant class within Canadian society. Prior to the turn of the century and a report by one Abraham Flexner, regular physicians were classified as middle to upper class, while those who practised empiric medicine were lower class. With a grant from the Carnegie Foundation, Abraham Flexner investigated medical education in Canada and United States, and the report he completed has been hailed by medical historians as the most decisive turning point in American medical history (Ehrenreich and English 1979: 87). Up until the time of the report there was an enormous overproduction of uneducated and poorly trained physicians. This overproduction of poorly qualified medical practitioners was due to the existence of a large number of commercial schools, particularly in the United States, whose primary function was to make money. What Abraham Flexner (1972)³ did in 1909 was to travel to every medical school in Canada and United States in order to assess the

quality of education for physicians. His report was used as the basis for change in medical education in North America. First, the number of medical schools was to be severely reduced. Second, standards for admission were set and a program of study was elaborated in detail. Third, graduates of medicine had to apply for a license to practice. After examination, a state board could reject an applicant. Because this program prolonged training, it tended to restrict the recruitment of physicians to mostly middle and upper class white males as only they could afford the four years of college based training. (I will discuss this in greater detail in chapter five). It can be argued that these measures were necessary to upgrade standards. Nevertheless, they also ensured that the middle to upper classes govern medicine in North America.

Based upon the understanding of class in the historical sense, it may be concluded that physicians belong to a particular class which in turn refines and presents its world-view. Because of this, a class ideology particularly as it relates to gender has become integrated within medical practices. As a result of this ideology, birthing practices which eventually gained acceptance within society reflect middle to upper class perceptions of women. This has had the effect of establishing in Canada a system of maternity care which presents a specific gender ideology, one that understands women as frail and dependent, and therefore requiring

technological intervention, as well as supervision by a male authority figure.

Hegemony

A second concept in ideology-critique which helps to explain the incorporation of the dominant birthing perspective into contemporary Canadian society is that of *hegemony*. According to Abercrombie et al. (1980) Gramsci rejected economic reductionism and accepted the relative importance of superstructures. His concern is with ideology and politics, as he understands these areas as offering creative possibilities to the individual. For Gramsci 'the will and initiative of men themselves cannot be left out of account'. He expresses a general antipathy to economism and wishes to establish theoretically that politics and ideological practices are autonomous. Based on this, Gramsci defines the term *hegemony*. He expresses the notion of leadership, one which fuses all the elements of leadership together i.e. control by repression with control by ideological persuasion. For example, Gramsci writes:

The methodological criterion on which our own study must be based is the following: that the supremacy of a social group manifests itself in two ways, as 'domination' and as 'intellectual and moral leadership'. A social group dominates antagonistic groups, which it tends to 'liquidate', or to subjugate perhaps even by armed force; it leads kindred and allied groups. A social group can, and indeed, must, already exercise 'leadership' before winning governmental power ... ; it subsequently becomes dominant when it exercises power, but even if it holds it firmly in its grasp, it must continue to

'lead' as well' (1971: 57-58).

Gramsci's distinctive contribution is his insistence on understanding leadership as being both intellectual and moral. Hegemony involves ideological domination; there is a balance between *coercion* by those who dominate and *consent* by those who are dominated.

Between 1850 and 1900, and 1940 and 1987, two periods of time in which there were outstanding conflicts and tensions between midwives and physicians, medical practitioners sought to achieve ideological domination of birthing through the use of both coercion and consent. In the first instance, women and midwives were persuaded as to the efficacy of the emerging "new" obstetrics because of its reliance on science and technological intervention. Physicians believed in their ability to reduce maternal morbidity and mortality rates, and they set out to prove this to their potential clientele. On the other hand, in order to ensure that they achieved their objectives, that of control of the birthing process, medical practitioners also employed coercive measures. By applying their knowledge of anatomy to women's feminine nature, they were able to coerce women into believing that they were physiologically frail and therefore in need of male protection, a fact which once accepted led to the rejection of female birthing assistants. They also established licensing procedures with the consent of the state which virtually

eliminated lay midwives from competition. In the latter period (1940-1978), physicians relied only on coercive measures to prevent any reinstatement of home births and midwifery practices. The medical professional organizations threatened punitive measures against all those who participated in the resurgence of midwifery in Canada. This included physicians, midwives, and parturient women.

The Construction of the Social Apparatus for the Self-Perpetuation of Power

In the process of achieving authority over birthing practices and thus, the acceptance of their particular birthing ideology, physicians not only had to gain the desired power but to legitimate it within society. According to Habermas legitimation may be achieved by through three basic means: (1) the steadily increased level of material rewards; (2) recognition by institutions and practices of formal parliamentary democracy; and (3) the ability to exercise political decision making through a bureaucracy (Abercrombie et al. 1980:16). From about 1850 to 1930, medical practitioners in Canada legitimated their authority over maternity care through the formation of professional institutions, state recognition as the preeminent authority over birthing, and increased economic capital.

Once power over birthing practices was obtained, it was necessary

for the medical professional organizations to set up the mechanisms to allow this power to continue uninterrupted. Bourdieu (1977) provides an insightful analysis on the construction of the social apparatus for the self-perpetuation of power. In simple societies where there are no educational systems, no judicial apparatus, and no state, relations of domination can only be maintained through strategies which must be renewed endlessly. Power relations are made, unmade, and remade once again. They are impermanent. By contrast, domination no longer needs to be exerted in a direct personal way when it is mediated by objective, institutionalized mechanisms. I refer to such things as licensing regulations and academic degrees. Relations of domination have then an opacity and permanence of things escaping the grasp of individual consciousness. This is a genuine saving, as strategies designed to establish or maintain lasting relations of dependency are in general very expensive and time consuming.

The objectification of symbolic capital (prestige) through the educational system is of prime importance; "academic qualifications are to cultural capital what money is to economic capital" (ibid 187). Through a process of giving the same value to all holders of the same certificate, the educational system minimizes "the obstacles to the free circulation of cultural capital which results from its being incorporated

in individual persons" (ibid 187). All qualification holders are related to a single standard thereby setting up a single market. This guarantees the convertibility of cultural capital into money at a determinate cost in labour and time. Academic qualifications have a conventional fixed value, which in a sense is guaranteed and does not need to be continually proven. The objectification accomplished by academic degrees guarantees power by defining permanent positions. Once this has been accomplished relations of power and domination no longer exist between individuals but between institutions. This results in socially guaranteed qualifications, socially defined positions, and the social mechanism to produce and guarantee both. It is the educational system which plays an important part in setting up, and concealing lasting relations of domination. A social world is provided which contains within itself its own continuation, freeing the agents from the endless work of creating or restoring cultural capital.

The greater the extent to which the task of reproducing relations of domination is governed by objective mechanisms which serve the interests of the dominant group, the more indirect and impersonal become the strategies orientated towards its reproduction. Once the mechanism has been constituted and is capable of ensuring the reproduction of the established order, the dominant class has only to " *let the system they*

dominate take its own course in order to exercise their domination" (ibid 190 original italics). Until such a system exists, individuals have to work daily, personally, to produce, and reproduce conditions of authority which can never be totally trustworthy. Because they have not yet constructed the social machinery for the self-perpetuation of power, they are obliged to resort to elementary forms of control. This is, in other words, direct domination of one person by another, "the limiting case of which is appropriation of persons" (ibid 190).

The development of the social machinery for the self-perpetuation of power was an important aspect in the institutionalization of the dominant birthing ideology. As discussed previously, the report of Abraham Flexner assisted in restricting the recruitment of physicians to mostly middle to upper class white males. The Canada Medical Act of 1902, which was proposed in parliament by the celebrated physician Dr Thomas Roddick, standardized medical licensing procedures across Canada. This was accompanied by qualification upgrading, and according to Torrance (1981: 17) it had the side-effect of raising incomes through creating an artificial scarcity. "High incomes and high education enhance social prestige which further consolidates a profession's position" (ibid 17). Added to this were state apparatuses such as the police and court systems which were at the disposal of the physicians, once the medical

practitioners were officially recognized by the state as having jurisdiction over birthing.

Only in Quebec, with the legislation of 1848, did individual physicians have legal authority to dominate individual midwives through licensing procedures. Throughout the other provinces and territory, it was professional institutions which had the power to license midwives. At the turn of the 20th century, the medical professional organizations for the first time exercised power over another health related institution when it attempted to prevent the formation of The Victorian Order of Nurses. Presently, institutional to institutional domination is exemplified by the authority that the medical profession has over related health care activities.

Dual Consciousness

From about 1970 to the present, some Canadian women have rejected the dominant birthing ideology. They are no longer able to accept maternity care which they believe over-emphasizes technology and deemphasizes the woman's role in childbirth. They believe that birthing in the hospital with technological intervention and under the authority of physicians has led to a loss of control by women over their bodies. This loss of control is a major issue within the women's movement and because of it, feminists have lent support to midwives for the

reappropriation of their occupation. This apparent acceptance of the dominant birthing ideology, and then its latter rejection by some women may be understood through the examination of the concept of *dual consciousness*.

According to Marx and Engels, the working class has a dual consciousness. It carries with it both its own world view which unites its members, and that of the dominant ideology which tends to be superficial, explicit and verbal. In a similar manner, Gramsci argues that the subordinate classes do not uniformly have a consciousness imposed on them by the dominant class. He points out that everybody is an intellectual in some form or other as everyone has a conception of the world. For the subordinate classes this conception is at the level of common sense. Its most fundamental characteristic is that it is "fragmentary, incoherent and inconsequential, in conformity with the social and cultural position of those masses whose philosophy it is" (Gramsci 1971: 419). Although this results in the working class as tending towards 'moral and political passivity' it does cope in the end with a dual consciousness: one which unites its members with all their fellow workers in the practical perception of the real world; and one which is superficial, explicit and verbal, as it is integrated from the past and is uncritically absorbed. By linking this concept of dual

consciousness to women as an exploited group, it is possible to understand the reemergence of midwifery in Canada.

Marxist theory locates the origin of women's oppression in a particular system of social organization. There is a focus upon the "relationship between the way a society organizes production and ideologies which develop to protect the class interests of those who control production" (Saunders 1983: 229). Traditional Marxism understands women's oppression as originating with the introduction of private property. The limitation of private ownership of the means of production to relatively few persons, and those all male, is at the basis of a class system. Contemporary corporate capitalism and imperialism are the latest phase, and the position of women is but a reflection of the class relations which emerged within a capitalist form of production. Women are exploited as workers in the labour force. In terms of the family institution, women are seen as having relations with their husbands which reflect a property relationship. This leads to oppression. Marxist theory understands women's "victimization" as being identical to that of the generally exploited.

Since the turn of the century, physicians have become a part of the larger dominant class. As members of the dominant class, they are a ruling intellectual force. Since approximately 1850 in Canada, a great

deal of this intellectual force has been channeled into the development of birthing practices which are primarily rooted in science and technology , and which have incorporated middle and upper class gender ideology . Because women are identified as being exploited and oppressed, domination can occur during birthing and through birthing practices which are rooted in the dominant ideology. Nevertheless, as Marx, Engels and Gramsci have stated, subordinates do not uniformly have consciousness imposed upon them.

It can be argued that women in Canada have retained a dual consciousness as it relates to the birthing process. Although they have submitted to the prevailing ideology, that of parturition controlled by physicians and within a hospital setting, some have retained, albeit passively, a belief in the naturalness of childbirth and the expertise of the female birth attendant. It was only with the reawakening of the feminist movement in the 1960's that women began to express this consciousness. Once women began to recognize and vocalize their suppressed beliefs, a resurgence in the view that childbirth was best accomplished through non intervention and under the supervision of a midwife occurred . The dominant birthing ideology was then under attack as some women sought to restore childbirth practices to that form which had originally existed within a women's culture; natural childbirth

within the home, and under the supervision of a midwife who uses a non interventionist approach. This then is the issue which divides birth attendants today.

A Critique of Science: A Second Element of the Critical Analytical Perspective.

The dominant birthing ideology contains two distinct connotations. The first understands women as frail and dependent and therefore in need of a male authority figure during childbirth. In the last section, I dealt with ideology-critique, particularly as it related to the influence that class and gender ideology have had upon the development of the dominant birthing ideology. The second implication of the dominant birthing ideology, that of childbirth as the implied pathological event since it requires scientific and technological intervention by physicians, is related to the second element of the critical perspective; the philosophical basis of science. The integration of science into birthing practices has not only influenced childbirth through the obvious means i.e. technology, but through more subtle measures which are not readily apparent. The covert effects that science has had upon the development of maternity care may be understood through a critique of science.

The critical approach argues that scientific knowledge is not

neutral, objective, or passive. When social scientists simply record what exists in the social world, in order to understand the essence of what is, they support the status quo and make it appear to be "a universal truth" (Turner 1982: 418). This so-called value neutrality of science has the tendency to legitimate patterns of oppression and constraint. The formal logic which is central to theoretical deductions and the rigor of scientific method may also have the effect of, depersonalizing, throwing out intuition and spontaneity, precluding speculation about what can be, and separating "the 'subjective' realm of consciousness from the 'objective' products of such consciousness" (ibid 419). Vital to all scientific inquiry is "control" and it is this "control" which has become integral to modern birthing practices.

The medical profession began to integrate the scientific methodology into allopathic medicine in the latter half of the 19th century. By the beginning of the 20th century, and with the acceptance of science and technology as the 'root ideology' by society, allopathic medicine completed its transition into biomedicine. The issue of a 'root ideology' within society is explained by Habermas through his use of the concept of a *central belief system* or *world-view* (Abercrombie et al. 1980). Traditional societies are legitimated typically by religion. Legitimation for the society is founded on this belief. With the rise of

capitalism legitimation through a religious belief system was called into question. In early capitalism religion is replaced by belief in the reciprocal exchange in a market. Legitimation of capitalism comes upward from the economic base rather than downward from some cultural superstructure.

Habermas has noted a distinct difference in legitimation between early and late capitalism. The difference is that the 'root ideology' founded on market mechanisms that characterized early capitalism lost much of its power. Contemporary capitalism required a new form of legitimation which provided it with the justification for the state. "Such a form will be rather like that needed in traditional society in which legitimation was 'direct' and founded in an over-arching system of values rather than arising from the economy itself" (ibid 18). Habermas contends that it is science and technology which have provided the necessary belief system in the legitimation of late capitalist societies. I would suggest that it is the legitimation of science and technology as a 'root ideology' within Canadian society which was instrumental in the successful acceptance of the dominant birthing ideology by women.

The acceptance of science and technology as the 'root ideology' and its further integration within the healing system and obstetrical care has had repercussions that are both subtle and complex. From the time that

science was integrated into economic production to its contemporary use, for example in ultrasonography (which will be discussed in chapter 8), its long term effects have been little understood. According to Fay (1975) the most important aspect of modern social life which has become organized along rational lines is that of economic production. The scientific enterprise has provided the means by which continued expansion of the forces of production can be guaranteed. It is not only through the improvement of productive technique and the development of new products that the use of rational science can be observed, but also through the provision of the information needed to organize and administer the humans involved in the process of production. Exploitation of nature for the production of goods and services can only occur if the men and women are organized in a co-operative effort to do the work involved. There must be a rational, self-conscious organization of labour. Because of the complexity of the organization and tasks, all activities must be performed according to some highly abstract and general plan, one provided by the social sciences. As a result of this need for rational management of the special functions within labour, bureaucratic planning and bureaucratic forms of organization have become central to modern life.

Moreover, because increasing areas of life are brought under the

same set of 'rationality' as that which occurs in the economic sphere, rationalization has moved outward to include those institutions involved in trade, to networks of transportation, communication, financial administration etc. " But as the process continues another factor, namely the growing status accorded to the type of thinking, begins to assume importance as well, and thus it comes to be employed in dealing with all facets of life" (ibid 46).

In the initial stages of the development of the industrial society, the economic sphere was separated from political control. In late capitalism there is a progressive massive increase in state intervention in the economic affairs and social organization of a country. This state intervention is due in part to the inherent instability of the industrial system if left to its own devices. As a result of this increased intervention, the public perceives the function of the state as being primarily one of supporting and smoothing the development of production among the various sectors. In other words, the politics of the state has become synonymous with the administration of the industrial system.

Science has gained its level of authority because of its link to the industrialization and economic development of the state. The dominant class controls both the means of economic and mental production. For this class the scientific enterprise is the basis for economic production

and labour organization. With increased industrialization and intervention of the state, science took on a new importance, one which saw it articulated as a more powerful set of coherent beliefs, i.e. a dominant ideology. Such beliefs are integrated into all facets of life. It is the integration of the dominant ideology into medicine which has had an effect on women and midwives.

Within the healing systems, it is principally science which has legitimated biomedicine. The biomedical model is based on chemistry and molecular biology. Sickness is understood as the interaction of pathogens and 'host' as well as the process of congenital deformity or natural degeneration. The primary assumption is that it is distinctive because it bases its findings on modern science. It states a set of assumptions and rules of conduct based on the scientific method. This constitutes a blueprint for research. The language of chemistry and physics is ultimately used to explain biological phenomena, and the only conceptual tools available to characterize and experimental tools to study biological systems are physical in nature (Engel 1977: 130). Because it is based on scientific methodology it is assumed to be effective. As a result of separating social interest, it is now "pure" and "neutral", free from the influence of symbol and value. It connotes a view of disease as an asocial and amoral process. Man/woman is viewed as the decontextualized host,

"a set of unmediated and natural processes which call for technical intervention" (Comaroff 1982: 59).

As a system of healing, biomedicine has become progressively disengaged from the language of cosmology and morality and from a system of knowledge which addresses the relationship of man to his fellow men, to nature and the spirit. While ostensibly replacing values and symbols with empirical objectivity, the epistemology underlying the medical process remains as a cultural construction. Biomedicine continues to exist in a dialectical relationship within a wider social context.

It asserts a cogent, if implicit world-view, centred upon man as a self-determining, biologically contrived individual, who exists in a contest of palpable facts and material things. In this context, events are regulated by impersonal 'natural' laws rather than by social ties and interests (ibid 57).

Once the dominant ideology of science was incorporated into medicine, the medical establishment extended its activity into all aspects of health care. Besides medicine, there are several occupations, (nursing, midwifery, physiotherapy, psychotherapy etc.) which provide services related to healing. Many of these occupations are in competition with physicians' services. However they are useful to physicians, and necessary for their practices even though they threaten their monopoly. Because of the threat, the physicians, instead of driving the occupations

out of practice, sought to gain control of their activities from the state. This resulted in medicine having the authority to limit what these occupations can do, and to supervise or direct their activities. Through state intervention, physicians were able to make it illegal for those other than physicians to compete in medicine, and to retain the right to direct the activities of related occupations. Biomedical physicians, whose system of healing is rooted in the dominant ideology, have been able to control not only medicine but the health care system as well. This right, to exercise authority over other health care workers (nurses and midwives), will be discussed in chapters six, seven, and eight.

The integration of science into healing and maternity care has had two major effects. The first is in the philosophical roots of the medical process. In, for example maternity care, birthing is understood as (1) a medical event which calls for technical intervention; and (2) a process which requires depersonalization and the severance of the "subjective" realm of consciousness from the "objective" products of such consciousness. The second major effect is in the social construction of the healing system. The incorporation of the science into the healing system has provided the rationale for gaining jurisdiction by the medical profession over other related health care activities.

The Subjective Point of View: A Third Element of the Critical Analytical Perspective

A major element of the critical approach is the attempt to understand the intentions and the desires of the actors who are being observed. Their *felt* needs and grievances must be expressed. This creates certain methodological problems. In a study such as this, it is the needs and sufferings of midwives and their clients over a period of two hundred years which must be taken into account. Although literature surveys of books, medical and other journals, newspapers and government data, etc. are the usual means of gathering research, the information obtained through this method has the potential of reinforcing a perception of midwifery which has been presented at the level of those who support the dominant birthing ideology. It is these ideologues' construction of frameworks of meaning which legitimated the emergent new order of obstetrics. Therefore, it was necessary to search out information on those whose universe was thrown into turmoil by this transformation process, i.e. midwives who operated at the level of the "common folk" in rural Canada. The most appropriate means for obtaining the required information was through the journals, narratives, and oral histories of pioneer women. Even this presented problems as women who could write,

such as Mrs. Susannah Moodie who published her book in 1852, were members of the English middle to upper class. Nevertheless, such writings along with oral histories provided insights into midwifery in Canada during the 1800s.

The critical approach requires that a detailed and extensive attempt be made to articulate the conscious and unconscious schemes of thought, perceptions, and interests of the actors under study. This creates a second problem. How may these subjective accounts be understood in light of the objective social conditions which existed at that particular time? The anthropologist Pierre Bourdieu (1977) remedies this situation by offering the necessary concept which integrates these two elements, the subjective accounts and the objective conditions.

The concept, I refer to, is *habitus*. Bourdieu notes the necessity of avoiding all theories which explicitly or implicitly treat practices, such as those related to birthing, as a mechanistic reaction. These practices are not completely determined by antecedent conditions which allow them to be reduced entirely to mechanical functioning according to preestablished configurations of stimuli. Although he rejects mechanistic theories, he does not imply that there is some sort of creative free will. Structures, which determine birthing practices, can

neither be reduced to mechanical reactions, nor to the conscious and deliberate intentions of their authors.

Habitus is a system of *dispositions*. Bourdieu defines *dispositions* as, the material conditions and the unconscious schemes of thought, perception and action of existence, that are predisposed to function as though they were objectively "regulated" or "regula", but in fact are not obedient to any objective rules. They adapt to goals without consciously aiming towards these ends, although they express mastery of the operations necessary to alter their goals and appear to be "collectively orchestrated". According to Bourdieu, they are not a product of any such orchestration. Nevertheless, they are determined by their past conditions, and as a result of this tend to reproduce the objective structures of which they are a product (ibid 72).

Habitus as a product of history, "produces individual and collective practices, and hence history, in accordance with schemes engendered by history" (ibid 82). The systems of past dispositions survive into the present, and tend to perpetuate themselves into the future. There is a principle of continuity and regularity. Although an objective analysis would discern this in the social world, it would have difficulty finding a rational basis for it. Therefore, neither extrinsic mechanistic sociology nor purely internal voluntarist or spontaneist subjectivism

are capable of accounting for this phenomenon. There is a dialectical relationship, between *habitus*, understood as a system of lasting, transposable dispositions which integrate past experiences and function at every moment achieving infinitively diversified tasks, and an *objective event*, which exerts its action of conditional stimulation, demanding a response. Bourdieu in his use of the concept *dialectic* is referring to the concrete unfolding of linked but opposite principles of change. The dispositions and situations which combine synchronically are never wholly independent as they are engendered by the objective structures, "that is, in the last analysis, by the economic basis of the social formation in question" (ibid 83).

The other point I wish to make is that *habitus* cannot be considered as a singular scheme of perception, conception, world view, and action common to all members of the same group or class. This would suggest "singular intuitions of space which, according to Kant, reflect none of the peculiarities of the individual ego" (ibid 86). In fact there is a diversity within the homogeneity. This diversity is a reflection of the individual's social conditions of production. The different members of the same group or class are united in a single *habitus*. Within this singular *habitus* are different points of view which are a result of an individual's particular history, position within the class or group, personal style etc. The

individual variant is never more "than a *deviation* in relation to the *style* of a period or class so that it relates back to the common style not only by its conformity - like Phidias, who, according to Hegel, had no 'manner' - but also by the difference which makes the whole 'manner'" (ibid 86 original italics).

The concept of *habitus* is of particular value in a critical analytical perspective which seeks to analyse midwifery. It demands that not only the objective social conditions, such as the economic status of women or the state of medicine, be discussed, but that the perceptions of women, their conscious and unconscious schemes of thoughts etc. (in other words their subjective accounts), receive the appropriate attention also. These two dispositions together form the *habitus* and it, in a dialectical relationship with objective event (which in this case is the art and practice of assisting women in childbirth), combine synchronically to produce a particular cultural construction of midwifery practice. Implicit within this conceptual scheme is the idea that birthing practices are never static but continually evolving and changing over time as both the social conditions and the the conscious perceptions of the actors alter.

Bourdieu (1977) provides a second concept which is of lesser importance but still operative in the analysis of midwifery within the

Canadian context. It is that of *symbolic capital*. There is a tendency within Marxism to accept a "restricted definition of economic interest". This form of economism knows no other interest than that universe of relations between men based as Marx says on "callous cash payment" (ibid 177). Analysis of this type does not allow for symbolic interest. In fact symbolic interest, often described as "spiritual" or "cultural", is set up in opposition to strictly economic interests. It is Bourdieu's contention that this theory of "strictly economic practice is simply a particular case of a general theory of economics of practice" (ibid 177). There must be an extension of economic calculation to *all* goods, material and symbolic, which are considered as rare and worthy of being sought after in particular social situations. These may be fair words "smiles, handshakes or shrugs, compliments or attention, challenge or insults, humour, ... powers or pleasures, gossip or scientific information, distinction or distinctions, etc." (ibid 178).

Symbolic capital which may be in the form of prestige and attached to a family or name, has the potential for being converted back into economic capital. The acquisition of this form of capital requires that considerable labour be devoted to maintaining relations and symbolic investment. Because it is time that is invested, symbolic capital is attained at the expense of economic capital. Often economic interests

are disguised or repressed in order to make the accumulation of symbolic capital the recognized legitimate form of accumulation. Individuals draw upon symbolic capital for power and authority. Nevertheless, Bourdieu emphasizes that in most instances these two forms of capital are inextricably linked. In a "good faith economy" a good reputation is the best if not the only economic guarantee. In the earliest historical period outlined in this study, midwives received little or no economic compensation for assisting their neighbours in childbirth. However, these women gained a great deal of symbolic capital and in a society where commodity exchange was carried on primarily through debt relations, the accumulation of prestige was of significance.

The Theoretical Framework

As I have discussed previously, midwifery is influenced by social conditions which in turn are linked to ideology. Therefore, ideology affects the development of midwifery. The claim of the dissertation is that midwifery initially was an occupation practised primarily by traditional birth attendants, was appropriated by a predominantly male medical profession, and is in transition once more as midwives work to repossess their occupation. There are three dimensions to the claim. The first deals with the initial phase of midwifery in Canada i.e. assistance at childbirth primarily by traditional birth attendants. To explain this, I

have relied in general on the concepts of *habitus* and the relationship of class to education and to ideological production. The second aspect of the claim, that of appropriation of birthing by physicians is best understood through the development of the concepts of hegemony, science as a 'root ideology' and the social construction of the apparatus for the perpetuation of power. These concepts provide information as to the objective mechanisms involved in controlling and dominating ideology and therefore are important to the understanding of appropriation. The final facet, that of the reclaiming of their occupation by midwives, relies primarily on the concept of dual consciousness. This is, however, a general scheme as the ideas contained in the major concepts are integral to the total development of the study.

I would note that the the theoretical framework explains only the claim of the study, not midwifery's social construction. Although the three issues of the claim are of major importance in the development of midwifery, it cannot be assumed that the analysis which follows automatically explains how midwifery was socially constructed. This is a different topic. In the following chapters, only the social conditions as they relate to the original development of midwifery, its appropriation by physicians, and the efforts of midwives to reclaim it, will be discussed.

Based upon the previous theoretical discussion, I would hypothesize

that the development of midwifery in Canada consisted of four phases. The first phase, I would suggest, occurred in the late eighteenth, early nineteenth century, at a time when no single system of healing prevailed. Instead, there were three main practices of medicine, allopathy, homeopathy and empiric medicine, as well as a lay system in which women were the main practitioners. Midwifery was a part of the lay system. In Canada, midwifery and medicine evolved out of a particular *habitus*. As I have indicated previously, the *habitus* consists of two elements; the objective social conditions and the conscious and unconscious schemes of thought. *Habitus*, in a dialectical relationship with the objective event, produced the healing and midwifery practices of this period. At this time the 'root ideology' which legitimated the state and groups within was based on the reciprocal exchange in the market place. Legitimation came upward from the economic base rather than downward from the cultural superstructure. This open system in the market place was reflected in the health care system as midwifery and the medical sects existed side by side with little tension and conflict. However, towards the end of this period, allopathic medicine took the first step to gain greater control of midwifery through the establishment of licensing procedures for midwives in Lower Canada.

The second phase of appropriation occurred in the period from the

mid 1900's to 20th century. Allopathic medicine in its effort to control greater economic and symbolic capital sought jurisdiction over health care matters. It formed professional organizations, provided academic degrees, and tried to extend its influence through a more pronounced leadership in the development of practices related to maternity care. Through the use of coercion as well as persuasion, members extended their authority over an area which previously had never been possessed by a predominantly male group, that of childbirth. However at this time they lacked all the objective mechanisms with which to ensure and perpetuate their interests. This led to a period of direct control of persons (rather than of institutions), one in which the physicians used various means to corrode the confidence of women in the capabilities of the midwife. Allopathic medicine was itself in a period of transition from a system of healing based on intense physiological reactions as a form of treatment to one which was founded on the new 'root ideology', that of a science which is grounded in anatomy, chemistry, and molecular biology.

Then there is the third phase, from the beginning of the 20th century to about the 1940's. At this time, there are three important factors which contributed to the appropriation of midwifery by medicine. First, there is a distinct difference in the 'root ideology' of the state. A new over-arching system of values, that of technical solutions determined by

the impersonal forces of science prevailed within Canadian society. This coincided with allopathy's transition into biomedicine. Second, there is increased state intervention into the market place. As previously indicated, the government of Canada in 1902 granted the medical profession the right to standardize the licensing of physicians in Canada. Third, the Flexner report provided a basic system of standardized medical education throughout the country. It also brought medicine under the jurisdiction of mostly middle and upper class white males. Through legitimation by the state and standardized academic qualifications and licensing procedures, an objective institutionalized mechanism was set in place which would ensure lasting relations of domination. Once this system was constituted, medical practitioners were free from the endless work of creating and restoring economic and cultural capital. From then on the medical profession was able to let the system take its own course in the exercise of its authority. This resulted in the expropriation of the role of midwife by the predominantly male profession of obstetricians, and the establishment of the dominant birthing ideology as the prevailing approach to maternity care.

The dominant birthing ideology, that of childbirth in the hospital and under the supervision of a physician who uses technological intervention, appeared to prevail unchallenged within Canadian society

until about 1970. With the reemergence of the women's movement, and the resulting conscious raising activities, some women began to question the system. They observed that male professional supremacy within the delivery room carried the regrettable corollary of female passivity. They saw the doctor as a ritualistic figure, a representative man who identified and enforced sexual roles in a particular critical life experience for the female. Maleness became a symbolic attribute of safety; femaleness became a condition in need of male medical control (Wertz and Wertz 1981: 181). Obstetrics had acquired a basic distortion in its orientation, a gender bias. It was this, along with the escalation of technical interference in the birthing process, which prompted some women to demand that childbirth be returned from the domain of pathology to one of naturalness and a choice of a midwife in the birthing experience. This has set into motion the fourth phase, that of the reclaiming the birthing experience, by an occupation of midwives. Involved in this reclaiming process are four major dimensions . They are; the labelling of parturition as natural; the defining of what is meant by *normal* pregnancy and delivery; the granting of midwives a monopoly over the care of normal parturition; and the recognition of a need for and the development of alternative theories for midwifery.

The critical model of social science calls for the development of an

historical account with the purpose of revealing how the social actors come to be what they are, the particular purposes and needs of the actors, and at the same time, how and why these purposes and needs are unsatisfied. Through an examination of the historical process, it may be shown how the social order was incapable of satisfying some of the needs it engendered, as well as the structural conflict and perceived accompanying social discontent. Such an examination of midwifery in Canada begins with the first period of appropriation between 1788 and 1850.

Chapter 3

The First Phase Of Appropriation: 1788 To 1850

This chapter examines the historical conditions which were instrumental in the development of midwifery between 1788 and 1850. I will discuss gender attitude and women's crucial role in economic production in order to show how these factors influenced the type of assistance women sought during childbirth. Three other conditions will be described; the variation in the quality of medicine; the real lack of any professional institutions; and the minimal degree of state intervention into the health care system until 1848. Based upon this discussion, I will explain the quasi-causal and functional laws which have assisted in determining midwifery practices and the relationships between midwives and physicians.

The analysis of the first phase of appropriation of midwifery in Canada begins in the late eighteenth century and extends to about the mid nineteenth century, i.e. approximately 1850. It was in 1788, that England enacted its first bill to regulate midwifery in Canada. "An Act or Ordinance to prevent persons practising Physics and Surgery within Quebec or Midwifery within the Towns of Quebec and Montreal without a License" (The British American Journal 1846, 1847) was the first official legislation by parliament to license midwives. This statute was enacted

at a time when there was no single predominant system of healing in Canada. Instead there were several types of practices, allopathy, homeopathy, empiric medicine etc., as well as a lay system in which women were the main practitioners. Midwifery was a part of this latter system. Each of these systems, i.e. medicine and midwifery can be described as evolving out of what Bourdieu refers to as a *habitus*

At this time, the 'root ideology' which legitimated the state and groups within it was based on the reciprocal exchange in the market place. According this concept legitimation came upward from the economic base rather than downward from the cultural superstructure. Allopathic medicine true to the prevailing ideology set out to capture a greater share of both economic and cultural rewards. It did so through the formation of professional organizations which in turn put pressure upon governments for licensing laws. Until 1850, true gains were minimal. The 'root ideology' of this period precluded major interference by the government in economic transactions which in the case of midwives tended towards the exchange of symbolic capital. In the years between 1788 and 1850 the practice of medicine and midwifery had the unregulated character of an open market system. It is this period which constitutes the first phase in the appropriation of midwifery by the medical profession.

The Habitus of Midwifery

Midwifery is defined as the act or practice of assisting women in childbirth. As discussed in chapter two, *habitus* is a system of durable, transposable dispositions, structures which are predisposed to function with objective regularity without in fact being the product of obedience to rules. *Habitus* objectively adapts to goals, without a conscious aiming by the actors at these ends. All of this is done without orchestration by a conductor (Bourdieu 1977: 73). Midwifery appears to fit well into this concept of *habitus*.

The *habitus* of midwifery is the system of durable transposable dispositions surrounding birthing which are inclined to be similar or regular although they are not collectively orchestrated. Within a society such dispositions adapt to similar goals without presupposing a conscious aiming at such ends and the goals are achieved. The fact that practices related to midwifery are inclined to be similar is not due to any conscious orchestration but to structures which are constitutive of a particular type of social environment.

Neither a mechanistic science of social and cultural factors, nor a purely internal voluntarist or spontaneist subjectivism is capable of accounting for midwifery practices. Between a system of objective regularities i.e. objective midwifery practices, and a system of

behaviours which are observed, i.e. midwifery practices within a cultural context, is a mediator (a connector between the subjective and objective realities) which is the *habitus* (Bourdieu 1965: 22). The practices of midwifery within a given culture are constituted in the dialectical relationship between habitus on the one hand and the objective event, midwifery on the other. Bourdieu uses the concept *dialectical relationship* in the Hegelian sense. This refers to successive triadic sets of concepts which are complete. The individual relationships within the triad are pronounced necessary and the whole dialectic is contained within the realm defined by the concepts and their necessary relationships of opposition and sublation. Future use of the term *dialectic* in reference to Bourdieu's concept of *habitus* should be understood in this sense. According to Bourdieu, the situations which combine synchronically to constitute the habitus "are engendered by the objective structures, that is, in the last analysis, by the economic basis of the social formation in question" (Bourdieu 1977: 83). In this analysis, there appears to be a complex interplay between the economic base and superstructural elements. The integration of economic conditions with the ideology of the central belief system of the state results in particular practices surrounding women in childbirth.

A description of the objectified subject, i.e. midwifery in Canada,

refers to the description of the interiorization of the objectivity. The three steps of the scientific methodology as outlined by Bourdieu (1965) are inseparable. They are; the immediate life experiences understood through expression which hide the objective meaning but also reveal it. In this case study, this would refer to the subjective oral histories and letters written by women in childbirth. This is related to the analysis of the objective meanings and social conditions i.e. economic, social and historical; in other words, an interpretation of the subjective event in relationship to the objective conditions. Such an analysis calls for the construction of a link (or rapport) between the actors and the objective meanings of their behaviour.

Midwifery Within the Indigenous Population Prior to 1850

The information on midwifery within the native population prior to 1850 is scant. This is not surprising, due to the fact that the majority of historical accounts are written by men who would have neither access to nor in all probability a great interest in birthing activities. The exception is Mrs Jameson (1965: 123). Her information although interesting is so unusual that it does not fit with the other facts which have been outlined. The practices described by the various authors cannot be placed within their context, i.e. their economic, social and cultural conditions. Of interest but unfortunately not recorded are the beliefs

which have surrounded the birthing experience.

Within the available information, four themes dominate descriptions about birthing. The first refers to the physical courage, vigor, and endurance of the parturient native woman. The oldest and most general description is that by Father J.F. Lafitau (1744) first published in the 1700's. He writes:

The Indian tribes of North America are not populous and do not multiply very much. The women, although of a strong and robust bodily constitution have not the fecundity seen elsewhere, especially in northern Europe....

Pregnant women take very little care of themselves during their pregnancy. They work as they usually do, and the nearer they come to the time of delivery, the harder they work. They go into the fields, carry heavy burdens without difficulty and claim that these violent exercises facilitate their delivery and make their children more robust. One cannot deny that ease with which they give birth is somewhat surprising. They get some other woman of their household to help them...without anyone's being appointed to this task. If they are caught unaware on their way home from the fields, they perform this duty for themselves, wash their children in the first cold water which they find, return to their lodge as if nothing had happened, and, from that very day, they seem capable of their usual duties (ibid 355).

D.W. Harmon, a partner in the North West Company who joined the service in 1800 and who was married to an Indian woman reinforces this view of the hardiness of pregnant women with his description of birthing among Indian women in Upper Country (Western Canada).

Indian women appear to suffer less pain in childbirth than women in civilized countries. They rarely take any medicine at the time of

delivery, though they do, at times drink water in which the rattle of a rattlesnake has been boiled. In the season of labour they place their knees upon the floor or ground, and lean forward over something, raised about two feet high. It is seldom more than a quarter or half an hour before the child is born; and in a few days the mother is as active and vigorous as ever. The Indian women rarely ever die at this critical period. (Harmon 1820 cited in Gibbon and Mathewson 1947: 83).

And a final confirmation of the vigor of pregnant women is stated in an article by Van Wart (1948) on the Indians of the Maritime provinces. His information appears to be based upon descriptions recorded in the 17th and 18th century. He writes: "The indian women were well built, lived an outdoor life, were healthy, strong, very patient and bore children well, a very large proportion of whom were normal" (ibid 575).

A second theme which appears in two articles, describes the separation of the parturient woman from the community. In many societies, life crisis events demarcate major points of transition, which are critical both for the community and individuals. Childbirth is understood as dangerous and therefore accompanied by rigorous rituals designed to bring about a healthy outcome for mother and child. This danger can be understood as both a "ritual danger" and a physical uncertainty. As a result, the process of birth, and in some cases including pregnancy, require special rituals. Pregnant women may be required to take daily baths, observe food taboos and perform only a few restricted household tasks. Yet, the dangers are usually associated with the

afterbirth. Both physical and ritual risks are attributed to evil spirits which in turn thrive upon vulnerable individuals during the crisis events. Eliade (1987: 93) states that in some cultures "mother and child are placed in seclusion for a period of time, then ritually welcomed into the larger community after rituals of cleansing have taken place."

Descriptions of the birthing activities among the Indians of Western and Lower Canada appear to imply that these peoples had some beliefs about ritual and physical dangers associated with childbirth.

D.W. Harmon in his "General Account of the Indians on the East Side of the Rocky Mountains" states:

The following ceremonies attend the birth of children. When the time of a woman approaches, she erects a small hut, at a distance from the tent in which she usually lives; and at the time of labour, she sends an invitation to several neighbouring women, to come to her assistance. As soon as the child is born, it is washed in water, that had been previously prepared, by boiling in it a sweet scented root. The mother then orders a feast to be prepared A woman after childbirth, remains in a separate dwelling which she had erected, for the space of about thirty days, during which no man would, on any account, enter the place of her residence (cited in Gibbon and Mathewson 1947: 83).

I would assume that although "no man" was allowed to enter the dwelling other women within the community would. Men were probably prohibited from entrance because of the beliefs surrounding the birthing fluids and their danger to men.

J.J. Heagerty, in his book *The Romance of Medicine in Canada* (1940)

quotes an "early writer" who confirms this separation of pregnant women from the community. His source lived in French Canada. As soon as a woman believed herself pregnant, she notified her husband who will not have contact with her again, (but this is not generally observed). When the wife is ready to give birth, she leaves the hut and goes away into the wood, some distance from it, with another woman to assist her and she soon gives birth. The woman delivered gives her assistant the knife which cut the navel string, and that is all her reward. The new-born babe is immediately washed, whether it be in winter or summer. The first nourishment it takes is the oil of some fish or melted tallow of some beast; the infant is made to swallow it, and after, it has nothing but the mother's milk (ibid 4).

The description of the act of birthing is the third theme found in the accounts. Women were assisted in childbirth usually by a women who was a member of the family (mother). However in some circumstances a parturient woman may have called upon her husband or the shaman. Van Wart's (1948) description of birthing among the Indians of the Maritimes is the most detailed.

She walked or stood up until the last stage of labour. Delivery took place while the woman was squatting on her knees or on her hands and knees or elbows, only occasionally lying down. She might hold on to an attendant, usually another woman, or a sash, strap or stick which was fastened nearby for the purpose. Pressure was made on the abdomen by kneading with the hands or with a binder. After

birth the perineum was washed. She rested one day and was up on the second day. No secrecy surrounded the delivery. In difficult cases the mystery man [shaman, usually a man but not always] attempted external manipulation. A binder was tied about the mother's and also the baby's abdomen after childbirth to facilitate healing and to prevent excessive bleeding. After childbirth a strong bitter decoction was given to the mother to cleanse her. This was made from the leaves of yellow ash (*Fraxinus Americana*). Confinements usually lasted about 2 hours. The new-born baby was given fish oil or melted animal tallow and made to swallow it before being given anything to drink or eat. The babies were breast-fed and slept most of the time. The mother was the only one permitted to nurse the baby. When food was started the mother chewed the meats etc. into small pieces and fed them to the baby (ibid 575).

The fourth and final theme found in descriptions of birthing among the native population prior to 1850 refers to the swaddling and carrying of the infants. Both Van Wart (1948) and Harmon (cited in Gibbon and Mathewson 1947) describe this activity. Harmon writes:

All Indian children, when young, are laced in a kind of bag. This bag is made of a piece of leather, about two feet square, by drawing a string inserted in the lower end, and lacing the two sides together. Some moss is placed in the bottom of this bag; the child is then laid into it, and the moss is inserted between its legs. The bag is then laced the foreside of the child as high as its neck. the bag is laid upon a board, to which it is fastened by means of a strip of leather, passing several times round the board and the bag. At the top of this board, a bow passes round from one side to the other, perpendicular to its surface, on which the Indians fasten small bells -or the claws of animals by way of ornament, and which rattle when the child is carried by its mother The women, who are particular in keeping their children clean, shift the moss which is put into these bags several times in a day; but others do it not more than twice. They often fix conductors so that their male children never wet the moss. The Carrier women will nurse their children, when thus suspended at their backs, either by throwing their breasts over their shoulder or under their arms. Their breasts are larger and longer than those of other tribes; but I am unable to assign any

cause for this peculiarity (ibid 82, 83).

As previously indicated, there is one account related to birthing by Mrs. Anna Jameson (1965) in her description of her travels in Upper Canada during the 1830's. She tells the story of an Indian husband who performed a Cesarean operation upon his wife while on a hunting expedition far from their camp. Since it is a story, rather than a description of birthing practices and is a highly unusual event, it adds little to the knowledge of birthing practices in general.

This information on birthing practices is not linked to any one tribal group nor is any date given, excepting that it appears to have been recorded prior to 1850. There are no descriptions of beliefs about birthing nor are there general accounts of the social and economic conditions. Therefore it is unwise to assert that a particular birthing culture existed among the indigenous people of Canada, something which was stated in the *Report Of The Task Force On The Implementation Of Midwifery In Ontario 1987*. What the information indicates is that there are several birthing cultures and that involved in the *habitus* of midwifery of these cultures are the following social factors:

(1) optimal social and economic conditions which contributed to healthy, vigorous women who experienced pregnancy and childbirth with relative ease;

(2) beliefs about the dangers associated with childbirth. Within some

communities rituals against these risks included baths as well as foods (or medication) ;

(3) the types of assistance during confinement which varied although a woman or women were usually present and;

(4) although not that widespread or universal, the use of a cradle board.

Midwifery in English Canada 1788-1850

According to Bourdieu (1965), it is necessary to interpret the subjective events of midwifery in relation to the social conditions. At this time the 'root ideology' is based on reciprocal exchange in the market place. The economy has primacy. "Capitalism is based on markets which are necessarily mechanisms that make exchanges fair and equal and that promise 'that exchange relations will be and are just owing to equivalence'" (Abercrombie et al. 1980:17). This is essential to recall before I proceed with a description of the social conditions in Canada from 1788 to 1850

In English-speaking Canada at this time, females' social and economic roles were subordinated to male economic roles, as the world of production was both created and dominated by men. Johnson (1974) describes the existence of three classes; lower, aristocratic and middle class, merchants, mill owners and the other various kinds of small capitalists. The basic economic unit was the lower class family which

was engaged in autonomous production within a toiler society. The development of this toiler society was as a result of the vast amount of cheap or free land made available by the government in England. By 1820 the great majority of Upper Canada's society was comprised of independent small land owners in isolated communities.

In a toiler society, every member of a family from a small child to the elderly grandparent labours from sun up to sun down in order to contribute to the family wealth. A certain amount of produce is exchanged for such things as iron ware, tin ware, hooks, clothing, tea, tobacco, fine cloth or alcohol, but for the most part the family produces for its own consumption. Craftsmanship is primitive and productivity low. Yet because the whole family works, it is possible to accumulate land, buildings, tools and livestock.

Within a toiler society, the role of women is crucial. Not only does she labour but produces children whose labour is essential for the economic success of the family. Women's work is clearly defined. While men work in the fields, woods or sell their labour to others, women and children work in the house, garden and other buildings. They care for the livestock, tend the gardens, pick and preserve fruits and vegetables, spin yarn, weave cloth, make clothing, prepare meals and perform the numerous tasks associated with family life. "In the toiler society,

therefore, the role of women was both integral to commodity production and central to economic organization" (ibid: 17). Although a few unmarried women found employment in Upper Canada as teachers, the accepted status of women was that of wife-mother-producer.

Because there is little specialization and productivity is low in a toiler society, commodity exchange is carried on primarily through debt relations. It is in this particular economic situation that Bourdieu's (1977: 177) general theory of economic practice has relevance. Economic calculation is extended to all goods, material and symbolic without distinction, to anything that presents itself as being rare or worthy of being sought after in a particular social formation. In this type of society where exchange is carried on primarily through debt relations, prestige and renown attached to a family and a name is a valuable form of accumulation. It is the prestige of a family which is readily converted into economic capital. Women, in a toiler society tended to deal in symbolic capital, a fact which is relevant to the understanding of midwifery within the toiler society during this historical period.

In a society, such as that of English speaking Canada 1788 to 1850, there was little specialization. As a result, women were the experts in treating most medical complaints. The services of a medical practitioner were rarely deemed as necessary. Amelia Harris in writing about her life

in 1788 states "We had no Doctors, no Lawyers, No stated Clergy, we had prayers at home and put our trust in Providence. An old woman in the next clearing was the Chief Phys[i]cian to the surrounding Country as it gradually settled" (Talman 1946: 355).

This theme of women as physicians is confirmed in other writings by Canadian pioneers. Herrington (1915) writes:

The mother or grandmother, as a rule, was the doctor, nurse and apothecary for the whole family. In the month of September, or perhaps October, when the phase of the moon was supposed to be favourable for the purpose, she organized an expedition to the woods in search of a supply of herbs to replenish her medicine chest. In some cases she dug in the ground for roots, in others the bark, leaves, or stems were sought, and in others still the fruit or seeds possessed the necessary medicinal properties. When she had gathered in her stores, she tied them up in bundles and hung them up in the attic, or stowed them away in some convenient nook until required. Her collection contained specifics for nearly every ache and pain. (ibid 96,97).

And "Canuck" of the fifth generation (1905) explains that "Our grandmothers always kept a collection of herbs on hand for treating the simple ailments of the family. These herbs were collected at certain times, tied into bundles and hung up to the rafters and walls of the house to dry." (ibid 96).

Women's knowledge of the common herbs and their medicinal properties was extensive. For coughs and colds a syrup was made from the roots of a plant called spignet or spike-nard. For an illness referred to as polypus, women dried and then grated the tuber of the blood-root

into a fine powder. This was then snuffed up the nostrils. Children suffering from a stomach-ache or sore throat were required to drink a tea made from catnip. Herrington (1905) attests to the vileness of this brew. "There are few, if any, of us who have not protested vehemently against having our mouths pried open to receive a spoonful of tea made from the leaves of this common weed" (ibid 98). A tansy tea was prescribed as a tonic; hop tea for indigestion; and cherry bark tea for regulating the blood.

Tubs of hot water and the open fire-places were sources of great anxiety to the mothers of young families. The frequency of severe scalds and burns demanded a soothing, healing salve. Black alder, lard, resin and beeswax was a favourite prescription. Smartweed soaked in vinegar was applied to bruises and swellings. It relieved pain and reduced swelling. A healing ointment for abrasions was also made from the leaves of ordinary garden bean. For lame feet and other troubles requiring a soothing poultice the leaves of plantain were used. The plantains were first allowed to wilt and then crushed by rolling between the hands.

Herrington, describes other remedies for the settler's many common illnesses; yet these examples illustrate the extensive medical knowledge retained by the women healers. Both Herrington and A "Canuck" (1905) stress the good health of the pioneers.

The healthfulness of the people in the early days was attested by their vigorous old age; many of them, not withstanding their life of

toil, living to ninety and one hundred years old. Their diet of fried pork and food fried in grease was apparently rendered harmless by their life of hard work in the open air. (ibid 98).

Based upon the oral histories he has heard, Herrington (1915) states that "in any event the mortality among the pioneers does not appear to have been any greater than it is to-day" (ibid 97). Herrington appears to be comparing mortality rates from his time (1915) to those prior to 1850. Demographic data on mortality rates prior to 1900 are limited. What is known is that mortality levels declined consistently throughout the century and "by 1867, the mortality level in the Catholic population, as measured by a crude death rate of 20.9 deaths per 1000 population, was just 50 percent of what it had been one hundred years earlier. By 1920, the crude death rate had fallen to 17.5..." (Kalbach and McVey 1979: 69). With reference to Herrington's statement, I would suggest that the difference in the mortality rates between 1915 and about 1850 would be about three to four percent. Because Herrington was listening to the oral histories of those people who lived in the rural areas (and it is possible that their rates may have been lower than for urban dwellers) the percentage decline may not have been significant enough for the people to notice.

The admiration and honour ascribed to these women healers is best illustrated through a description by Samuel Thompson (1884). In discussing his life in Barrie Ontario in 1835, Thompson writes:

Wherever there was trouble in the settlement, or mirth afoot, Flora was sure to be there, nursing the sick, cheering the unhappy, helping to provide the good things for the simple feast, – she was, in fact, the life of the somewhat dull, and overworked community Flora was ever on hand, at the head of all the other lassies, guiding and directing everything, and in so kindly and cheerful a way that none thought of disputing her behests or hesitating at their fulfilment (ibid 102).

In a similar manner, W.L. Smith (1923) in his book *The Pioneers of Old Ontario* confirms the community's admiration for women healers, in his tale of Grandmother Trull of Darlington Ontario.

'In that pot,' Jesse said, 'my grandmother mixed the herbs which served all the medicinal requirements of the first settlers. My grand-mother had rare skill in the preparation of these herbs and she was further fortified by a book of directions in midwifery and the healing of the sick. Her services were frequently called on over a wide stretch of country, and, as there were at that time no bridges across the numerous streams flowing towards the lake, she many times had to swim her horse through them when on her missions of mercy. On one occasion the grandfather of S. Caldwell, of Hamilton township, near Cobourg, called upon her to visit a member of his family who was dangerously ill. The two set out together and arrived at the river at Port Hope just as night was falling. Mr. Caldwell had nearly lost his life in crossing the stream in daylight and he feared to make a fresh venture in the gathering darkness. Not so Mrs Trull. She boldly drove her horse headlong into the water, breasted the swelling flood, and on arriving at the other side, lit a pine torch with the flint she carried. By the the fitful flame of the pitch pine, she followed the blazed trail in the woods for the rest of the journey all alone and arrived in time to save the life of her patient' (ibid 15, 16, 17).

A reading of the letters and narratives on pioneer life in Upper Canada indicates that in almost every instance where women were described as healers and midwives, their virtues were extolled. These narratives were

given by individuals in the toiler society. There is one exception. In a letter to England, and English women, a member of the upper class writes:

Physicians are very much wanting here and apothecaries still more. Ignorant persons act in the capacity, who scarcely know the names of drugs they sell. At Niagara that most necessary branch is solely conducted by a female, who compounds medicines and puddings, with equal confidence, but not with equal skill. (Radcliffe 1953: 61).

The previous lengthy quotation on grandmother Trull of Darlington Ontario points out the role that women played as healers, consolers of the sick, and midwives. The most common fact with regard to the description of women who were called to attend childbirth is that they were grandmothers. This would fit the description of the traditional birth attendant; elderly women, who have usually had children and who are called not necessarily because they are a relative, but because of their expertise.

The earliest description of a birthing event is by Amelia Harris.

One Bitter cold night in February, 1794, the Household were alarmed by the announcement of my Mother's illness, no assistance to be had nearer than three miles, no Horses, no Roads, only a track through the woods. Mr. Powel, who had just received a Lot near us volunteered to go in search of Granny McCall with the Ox team. After some weary hours watching, the 'Gee, Haw' was heard on the return in the woods, and Mrs McCall soon stood beside my Mother, very soon after the Birth of a daughter was announced. That Daughter is now making this record of the past (Talman 1946: 120).

It is interesting to note that Amelia Harris refers to pregnancy and childbirth as an "illness". This perception of parturition as pathological

is integral to contemporary birthing practices.

A "Canuck" writes that "many of the old women made excellent midwives, their services being often called into requisition in the absence of a qualified doctor or a trained nurse, either of which it was sometimes impossible to obtain" (1905: 96). In Canuck's (1905) writing, Smith's (1923), and Healy's (1923) work, as well as in the following passages taken from the work of E.S Dunlop (1902) who writes about her mother, there are references to midwives being called in the absence of any doctor or nurse. At the time that these authors published, midwives were becoming extinct because of the licensing laws. The prevailing ideology insisted that birthing was now under the jurisdiction of physicians and nurses were becoming the physician's assistants. Whether the women who are being written about really sought a physician or nurse is questionable, for in reality there was no occupation of home nursing care at that time. What is more probable is that the writers were basing their comments with regard to nurses and physicians on the beliefs which existed at the turn of this century rather on those of the women about whom they are writing.

In the book *Our Forest Home* (1902), E.S. Dunlop has compiled extracts from the correspondence of her mother Frances Stewart. The family lived in Peterborough and the events described occurred between

1823 and 1850 The journals and letters of Frances Stewart provide a good account of midwifery activity in this period.

On December 13th, 1823 another event of great interest occurred: a little daughter was born, as it almost seemed, to replace the precious baby just gone home [died]. This dear child was the first white baby born in Douro, and at once received the name of Bessy. Again the difficulty of procuring a doctor and nurse had to be surmounted. And again the faithful Donald came to our help. He walked nine miles down to Otonabee where his mother lived and she walked back with him. She was a small woman and when they came to fallen trees which occasionally barred the road Donald would lift her on the log till he climbed over and then lift her down on the other side. She was very tired and faint when they came in but we were only too thankful to have her. As late as the year 1867 my mother writes of this time: 'So soon after our sad trial our darling was replaced by another little daughter who still lives and is a comfort and a blessing to her aged mother' (ibid 47).

Mrs. Stewart continued to have children and at each childbirth sought the assistance of the same midwife. in 1825 another child was born

On the 31st July of this year a great event took place: -the birth of the first white male child in the township. A dear little son was born and the joy and welcome was great in the little colony. William Stewart, the name long laid out for the first son, was pronounced from one to the other; the dear new-born brother was our great object. The same old nurse was brought again, but she could only stay one day. How hard to think of the mother and new-born infant receiving one day's care (ibid 79).

The last description is of a son born in 1832. The author writes:

On the 8th of January of this year another son Charles Edward, was born. The event caused no little commotion, as neither doctor nor nurse were engaged. A suitable nurse could not be heard of. In this extremity a good and true friend, Mrs. Webster, sister to Doctor Hutchinsin, came and was a great help and comfort (ibid 130).

Descriptions of birthing in Manitoba coincide with those of women in Ontario. In a book written from the recollections of women surviving from the Red River era, Healy (1923) presents the oral histories of a number of women. One woman explained that "She was born on Christmas morning." "My father was away. He had to go to Fort Garry - by dog train, of course - and hoped to be home for Christmas, but a storm delayed him until a couple of days after I was born. Mrs. Isbister was with my mother" (ibid 176). A Mrs. William Logan born at Middlechurch recalls some of her activities. During a period when Canadians were immigrating to Manitoba, Mrs. Logan was called out to one of the tents. It was a stormy night and in the flimsy shelter, soon after she arrived, a child was born. After wrapping the baby, she placed it in a box and sent it to her house. Then with her husband's assistance she carried the mother in a blanket to the house where she cared for her for three weeks. That was the beginning of a long service for Mrs. Logan, as a practical nurse among the settlers (ibid 257).

In general the accounts of birthing and midwifery indicate that infant and maternal mortality were seen as low. In his reminiscences Neil McDougal of Kincardine states that there was no doctor within sixty miles and still he never knew of a death in childbirth (Smith 1923: 246). Likewise a Mrs McQuade of Prairie Grove Manitoba explained that she had

nine children and no doctor ever entered her home (Healy 1923: 255).

Nevertheless disaster did occasionally occur. In a previous quotation, Samuel Thompson (1884) discussed Flora the admired cheerful nurse of her community. Sadly Flora died in childbirth. Thompson writes:

There were experienced matrons enough in the settlement, but their skill deserted them, or the case was beyond their ability. And so poor Flora died, and her infant with her (ibid 103).

A more vivid description of the calamities which could occur during birthing was written by Anne Langton in her journals:

Friday April 17 [1846]. I have been just called down to a little girl, who had brought back some sewing she had done for us, and for whom we feel much interested. Her mother died in her confinement last year, leaving this poor girl of ten years of age with several younger brothers and sisters to take care of. My mother paid for a six months' nursing-out of the little delicate baby, and it is now a thriving, healthy child. Another woman died under the same circumstances, literally of cold, and the baby was, while in charge of another woman, found one morning outside the family group in bed, and frozen to death. This was one of our coldest nights this winter. (Langton 1950: 230).

Between a system of objective regularities and a system of observed behaviours is a mediator which is *habitus*. Midwifery as a practice and act of assisting women in childbirth is a system of highly complex objective regularities. According to Bourdieu (1977) this system in the dialectical relationship with the *habitus* causes the interiorization of the objectivity, which in this study is the subjective midwifery. In the toiler society of English Canada in 1788 to 1850 the

social conditions are described. There is little specialization, productivity is low and commodity exchange is carried on primarily through debt relations. Women are both integral to commodity production and have a central place in the economic organization.

This importance of women to the economic organization is reflected in the status accredited to women in the subjective accounts. In these immediate life experiences understood through the expressions which hide the objective meaning but also reveal it, women are perceived as knowledgeable about herbs, healing and midwifery, vigorous, courageous, faithful and admirable. In a society where there was little specialization and physicians rarely deemed as necessary, women were central to midwifery and the system of healing. Midwives were not called upon to assist women in childbirth because of a lack of physicians as "Canuck (1905), Dunlop (1902), Smith (1923), and Healy(1923) have insinuated, but because they were understood to be the most competent assistants for the task at hand. Midwives were recognized by members of the toiler society as a legitimate birth attendants. This then is the habitus, which in a dialectical relationship with the objective regularities, constitutes the subjective midwifery i.e. a system in which women who have usually had children were called upon in childbirth because of their expertise. Such women accumulated considerable symbolic capital which in a debt

society was highly valued.

In contrast to the clearly defined economic roles of the women in the lower class, the role of the aristocratic women was more subtle and complex. According to Johnson (1974), the origins of their power and wealth was not based in Canada but in their hereditary ties to the British aristocracy. High positions in Canada were acquired by appealing to kinship ties with the elite in England, individuals who wielded influence. Important kinship ties were acquired by men who made "good marriages" to the daughters of important personages.

Land and the capacity to pass it on to future generations was central to the aristocracy's power. Since it was society's acceptance of the legitimate heir which was important, the question of paternity was crucial. Therefore, in order to guarantee legitimacy of inheritance, absolute sexual purity was required of aristocratic women. This guaranteed purity was equally useful, when alliances were formed among members of the land owning class. Marriages were commonly arranged and daughters were married without regard to their interest. As with women of the toiler society, daughters who failed to marry quickly lost their economic and social value.

Johnson contends that the duties of aristocratic women were related to the social requirements of their husbands. They must produce

heirs and enhance their husbands' social and economic positions. Women oversaw the economic management of their households, managed and disciplined the servants and ensured that their households were ever ready to provide for their husbands' social needs. A wife was required to be both ornamental and charming. Yet, she must accomplish this without calling into question her state of guaranteed purity. And most importantly these women must manage the welfare system i.e. the private charitable and moral organizations. "Thus, charity was used to smooth over some of the harshest results of exploitation, and by placing charity in the hands of women, [although I would note that there were male philanthropists] men could avoid the serious questions raised by its necessity" (ibid 19).

Women of the bureaucracy followed the social norms of the aristocracy. Although they accepted their values and aped their manners they had little material basis in land estates or inherited offices. Nevertheless, the women were required to be sexually pure as the bureaucracies economic dependency upon the aristocracy required them to accept their social norms. Similarly, the growing stratum of middle class capitalists was dependent upon the aristocracy and therefore complied with the aristocracy's social behaviour and standards. While the wives of capitalists were never accepted as equals, there was little to

distinguish the roles and activities of these women from those of the aristocracy.

The outspoken author and traveller, Mrs. Jameson (1852) has provided an astute account of upper class women in Canada.

Here, as everywhere else, I find the women of the better class lamenting over the want of all society, except of the lowest grade in manners and morals. For those who have recently emigrated, and are settled more in the interior, there is absolutely no social intercourse whatever; it is quite out of the question. They seem to me perishing of *ennui*, or from the want of sympathy which they cannot obtain, and what is worse, which they cannot feel: for being in general unfitted for out-door occupations, unable to comprehend or enter into the interests around them, and all their earliest prejudices and ideas of fitness of things continually outraged in a manner exceedingly unpleasant, they may be said to live in a perpetual state of inward passive discord and fretful endurance In women, as now educated, there is a strength of local habits and attachment, a want of cheerful self-dependence, a cherished physical delicacy, a weakness of temperament, - deemed and falsely deemed, in deference to the pride of man, essential to feminine grace and refinement, - altogether unfitting them for a life which were otherwise delightful: - the active out-of-door life in which she must share and sympathise, and the in-door occupations which in England are considered servile; for a woman who cannot perform for herself and others all household offices, has no business here. But when I hear some men declare that they cannot endure to see women eat, and others speak of brilliant health and strength in young girls as being crude and vulgar, with various notions of the same kind too grossly absurd and perverted even for ridicule, I cannot wonder at any nonsensical affectations I meet with in my own sex; nor can I do otherwise than pity the mistakes and deficiencies of those who are sagely brought up with one end and aim - to get married (ibid 87,88).

Since the primary function of an aristocratic woman was to produce an heir (Johnson 1974), birthing took on added importance. Among women

of this class in England, birthing with the assistance of physician was accepted practice and such ideas were beginning to filter down to the bureaucratic and emerging middle classes. Women who immigrated to Canada brought with them these ideas with regard to birthing and therefore sought medical assistance. Three case studies, those of Letitia Hargrave, Mary O'Brien and Susannah Moodie provide details of the similarity yet diversity in birthing practices among women of this class.

Letitia Hargrave was born in Edinburgh to a well-to-do family. Her father, a lawyer was appointed court judge of the county. Letitia received an education suited to women of her position and her latter years were spent in a ladies' finishing school. In 1840 she married James Hargrave, the chief trader at York Factory on Hudson Bay. Letitia and her husband lived there for ten years. Her letters written at York Factory describe a woman's life in the fur trade from 1838 to 1857.

Although as Letitia stated: "The ladies here never have a doctor, nor do they go to their bed but sit on their knees" she insisted on a physician and was forever grateful to him. Comments such as; "he is zealous and well versed in his profession"; "I have good reason to be grateful to him"; and "I wd. [would] have died had he not been there" indicate her belief in her own frailness and her dependency upon the physician. However, it is her vivid description of a second birth which is

of value to this analysis. Letitia's letter to her mother is the most detailed account of a birthing experience as yet obtained for this historical period. I would note that like Amelia Harris (Talman 1946:120), Letitia Hargrave refers to childbirth as becoming "ill". It would appear that it was a cultural phenomenon to link parturition with sickness. The rather lengthy account is as follows:

York Factory 1st April 1843

My dear Mama

When I closed my letter on the 9[th] Decem altho' anxious & uneasy, I had little idea of the pain I now feel in writing to you again. Hargrave wrote papa the moment that my poor baby was born, w[ch] was about 2 on the 10[th], & died on the 27[th] - I will try & tell you its sad history. Altho I think of it constantly I will never be able to write with composure. I became ill about midnight but was not regularly so till 8 in the morning, and till 12, was no worse than I had expected. After that, the suffering was fearful & almost continuous till after what seemed to me some difficulty on the D[rs] part, the child was born. The delay had been caused by the navel cord being twisted round his neck, & when I looked the D[r] was working with him & he was blue & had not breathed. When I saw the little chest move, I never as completely forgot myself, nor felt any thing like the gladness I did. It was very large & strong, much more so than Joseph was. I fear that my trials began with myself for my breasts got so sore that the irritation brought on a feverish attack & we had to get a nurse for awhile, for he drank so constantly that I c[d] not get them properly treated. The girl had a thriving baby of her own w[ch] she left with her sister. I was nervous about it, but they assured me there was no danger. After the 2[nd] day I nursed him at night myself but from having been ill & leaving off had not enough of milk & kept her. He continued well till the 24[th] when he kept wailing all day. The D[r] thought there was nothing the matter as his pulse was good & he drank as usual. Next day he was better till night when I found that there was something fearfully wrong. The D[r] came & said it was rupture. He reduced it easily & comforted me by saying that it was not dangerous in an infant. He said shortly after that there seemed to be a little inflammation &

after a little hesitation put 2 leeches on his hand, he remained watching all day till 5 when he said the pulse was much calmer, breathing better, & bid me offer him a drink in a little, & call him if there was any change as he was tired from being up all night & w[d] take a rest. Willie came in & assured me that the complaint was so rapid that he must be recovering & told me that it was very common here that Munroes whole family were born with hernia & that men & boys of them were strong. He left me along with Hargrave quite satisfied that danger was over. The child on my knee, Marg[t] lay down to hush Joseph & they fell asleep together - I felt babys hands rather cold about 9 & rose from the stove to get some more to put round him when shortly after he gave a sharp cry & Marg[t] awoke. It was the first time he had cried for 8 hours & was so peculiar that she ran for Harg[ve] & the D[r]. I soon found that there was no hope. They took it from me & I only recollect thinking of every thing in the world but it till I saw Willie carry him out of the room, I dont know when. I asked the D[r] next day if I had been too late of sending for him but he said no, he had done all he could, & hoped from several symptoms particularly by its bowels being very open, that it would have recovered. Poor Hargrave was terrible distressed, but he soon got well again. I thought I never [would]. (Hargrave 1947: 136, 137).

The second study is that of Mary O'Brien. She was born Mary Gapper, the daughter of Reverend Edmund Gapper of Charlton England. On a visit to Canada she met and married Edward O'Brien and together they raised six children. The O'Brien's were referred to as "gentle folk". They were supporters of the family compact and acquainted with influential government officials. As members of polite society there were guests of the lieutenant governor of Upper Canada. They resided firstly in Thornhill and later in Shanty Bay, Simcoe. Mary had one brother and a brother-in-law who were doctors. It is *The Journals of Mary O'Brien 1828-1838* (1968) which has provided this information.

True to the practices of her class, Mary O'Brien sought medical assistance for birthing. However, because of the particular social conditions i.e. the isolation of settlements, the physician frequently missed the births, due to the distance he had to travel. A nurse usually assisted the doctor and remained with the mother and infant for some time after the birth. In the event that the doctor was late, it was the family who assisted at birth. In her journals Mary writes:

August 15-...to strange and ominous sensations.
Edward set to work to get the stove up and I lay as quiet as I could on the sofa to wait till they had finished their work.
After dinner I went into Mama's room to get out of their way and from thence I did not very immediately return, for a few minutes made me the mother of another son. The nurse had not arrived, but Mama was so completely taken by surprise that she had no time to be alarmed. With Edward's [her husband] assistance and Flora's ministrations she did all that was requisite for me and the baby.....
Dr. O'Brien and Mary arrived in the evening not much disappointed to find themselves too late. (ibid 197).

Having given birth with only assistance from members of her family, Mary appeared to gain in confidence in her own abilities. With the onset of labour in her next pregnancy (1834), Mary sent for a doctor and nurse, but also set about cheerfully to prepare for the birth with only her husband's assistance.

October 26 -The baby which is now sleeping in my lap must plead my excuse for a few days' neglect of my journal.
It was with more of cheerfulness than awe that, with occasional interruptions and the assistance of the damsel, I arranged my bed like an expert pupil of Mr. Toogood. I was secretly rejoicing in the probability of being beforehand with the doctor. I then

methodically, with Edward's assistance, undressed and prepared myself. I placed everything likely to be wanted within reach. This was just accomplished when it became, we thought, advisable to call in his assistant. In about ten minutes after, and almost as soon as I became assured that the crisis of my complaint was actually coming on, the little damsel was in her father's hands, audibly existent. In two minutes more she was lying snugly in my arms till the conclusion of our operations should give us leisure to attend to her further needs.

We had more than an hour to wait, and I began to be a little alarmed and to wish for the doctor. Baby meanwhile amused herself with what has been the solace of most of her waking hours ever since. We had just completed the whole of this business when the doctor arrived to congratulate us, eat his supper, and go to bed.....

In the afternoon Mrs. Fraser came to see me, and with her assistance I managed to rewash my baby and to get her partly dressed, supplying the place of the outer garments by a piece of flannel with a hole for her head to go through. This I find so convenient that I have adopted it as her night clothing since. (ibid 231, 232).

Despite the fact Mary completed two childbirths without a doctor and without any untoward effects she continued to seek assistance of a physician and a women helper for future birthing events (ibid 279). Mary does not provide a reason for reverting to physicians for childbirth but it may be assumed that she was remaining faithful to her class practices.

It was the aristocratic woman who performed the important function of managing the welfare system. Routine day-to-day charity was placed in the hands of women, although as previously mentioned men were not absent from the charity system. Confident, because of her own achievements in childbirth, Mary O'Brien fulfilled her role as a charitable aristocrat by assisting lower class women through birthing. She describes these activities in her journal. For example Mary writes:

November 15-A fine day. I was arranging to pay a visit to the shanties when I was sent for to the assistance of one of our labourers' wives at the wharf. I packed up my baby in the arms of my damsel whom I needed as interpreter and, leaving the other two with Edward, I hastened away. I arrived just in time to do the needful for a fine little girl. This is the second time I have cheated the doctor within four weeks. The said doctor arrived just after the work was done to look very foolish and go home with me to dine (said doctor not being the same whom I cheated before). He is a young Scotchman lately come out. Doctors have no chance at such work here. We make so light of it.

These charitable acts carried with them an attitude which is best illustrated through the writings of Edward, Mary's husband. He writes in Mary's journal:

Mary is nurse or Hoodie or grannie or whatever else you may please to call her to all at Shanty Bay. 'Tis well for the doctor that she does not try to supplant him. The stupid people would not send for the doctor till the last moment and before he could come the husband came about eleven at night to entreat Mary to go down. So off she trudged in a pair of long boots through the mud and in some places through water up to her knees. In the morning, she returned before the ox cart (her carriage) got down. She then went to bed and with the chicks round her had breakfast, but could not sleep. She was much rested, however, and has not suffered from her exertions, but just now has dropped fast asleep in her easy chair looking particularly comfortable and snoring most awfully. (ibid 250).

The final birthing events of relevance are those described by Susannah Moodie (1974) in her book *Roughing it in the Bush*. Mrs Moodie's description of two events are of interest as they contrast the difference in birthing assistants and express a subtle attitude which can be related to social class. For her own child birth, Mrs. Moodie hired "old Dolly

Rowe my Cornish nurse" (ibid 211). From this statement, it can be assumed that Dolly Rowe was a professional midwife from England who had received some form of formal training. Contrast, this to her description of the birth of her American neighbour's child.

The middle of May at length arrived, and, by the number of long, lean women, with handkerchiefs of all colours tied over their heads, who passed my door, and swarmed into Mrs. Joe's house, I rightly concluded that another young one had been added to the tribe; and, shortly after, Uncle Joe himself announced the important fact, by putting his jolly red face in at the door, and telling me that his missus had got a chopping boy; and he was right glad of it, for he was tired of so many gals, and that he should move in a fortnight, if his woman did kindly." (ibid 203).

These three illustrations of midwifery practices among the upper classes reveal the diversity and yet this diversity can be understood as a part of the greater homogeneity. Women among the upper classes; (1) were socialized into a dependency upon a male medical profession (excepting Susannah Moodie who was dependent upon a trained midwife) for birthing; and (2) they assumed a condescending attitude towards the birthing practices of the lower class.

Who then were these men-midwives, physicians to the women of the aristocracy? Based upon material found in the museum of the Academy of Medicine in Toronto, M.C. Watson (1939) has profiled one such physician, Dr. W.H. Burritt of Smith Falls, Ontario. Born in 1809 to Daniel Burritt, a United Empire Loyalist who raised and commanded a company of

volunteers at Prescott and later at the taking of Ogdensburg in the War of 1812, Walter Burritt attended school in Brockville and as was the custom in Upper Canada at that time studied medicine under an established medical practitioner Basil P. Church of Merrickville. Sometime later he attended Fairfield Medical College in New York State. It may be assumed that Burritt used two texts in his studies; one written by Dr Dewees who was adjunct professor of midwifery at the University of Pennsylvania and the other by John Burns of Glasgow called *The Principles of Midwifery*.

In 1835 Dr. Burritt recorded his inclination to specialize in obstetrics. He commissioned Rufus Collins, a blacksmith in Smith Falls, to fashion a pair of obstetrical forceps. This was his one technological aid as anaesthetics were not in use yet. Practitioners at this time gained their reputation as much by their strict attention to "delicacy" as by their professional skill. The doctor did not dare to subject his patient to unnecessary pain, nor was he allowed to expose the patient in order to observe the perineal area. Therefore, he had to work under cover. This included not only the initial examination but the subsequent delivery and the application of forceps. Great care had to be taken to ensure that no portion of the mother was included in the locking forceps' blade. Dr. Dewees cites a case in which a woman lost considerable portion of her right labium because of its inclusion in the joints of the forceps. Dr.

Burritt's practice extended over a great distance. Since there were no roads he travelled on horseback, foot, and canoe to visit his patients.

According to Watson (1939) archival material he used indicates that Dr. Burritt, in his fifty-one years of practice from September 19, 1835 to June 9, 1866, assisted at 1,828 obstetrical cases. (I do not know whether Dr Burritt did following the calculations or the work is that of Watson.

In *The Canadian Journal of Medical Science* of 1877 a Dr R. Zimmerman analysed data in a manner similar to Dr Burritts statistics). Although the data cover sixteen years outside the specified period (1788 to 1850), I will review it in this chapter because it is the only case study of a physician's practice that I was able to locate which made reference to the period prior to 1850. Of those 1,828 cases, he delivered 1854 infants had three maternal deaths (1.64 per 1000 cases) and 93 fetal deaths (48 per 1,000 cases). He used the forceps on 104 occasions, an incidence of 5.6 percent and beginning on March 21, 1835 and through the remainder of his practice administered ergot in only 67 of his 1828 cases (36 per 1000 cases). The indications for his use of ergot were 'deficiency of pains' and 'tedious labour'. He first used chloroform on march 27, 1877 and his records indicate that he questioned its action. He suggested that it may have been a factor in the death of a newborn infant. Of his 1828 patients, 10 showed symptoms of advanced toxemia. The accepted treatment for

toxemia was blood letting from the veins, and an opening of the bowels with a clyster (enema) followed with the administration of a purgative. For headache and oedema the patient was prescribed a diuretic. Mild laxatives and a light diet were the preventive measures taken for toxemia. Dr. Burritt had 16 cases of antepartum haemorrhage (probably related to placenta praevia) and 15 cases of postpartum haemorrhage. There is no indication of the number of patients who suffered or died from puerperal sepsis. However Watson believes that the fact that the population was not concentrated in his district, prevented an outbreak of this contagious disease among women in childbirth (ibid 188). This then is a brief outline of the activities of one male-midwife who practiced in Upper Canada between 1835 and 1866.

Bourdieu (1977) has argued that between the objective and the subjective system (in this study the system is that of midwifery) is a mediator which is the *habitus*. As Johnson (1974) has observed, the objective social conditions among aristocratic women of English speaking Canada were wealth and power based upon hereditary ties; land central to power; and women as appendages. Their functions were to produce heirs and enhance their husband's social and economic powers.

The subordinate, dependent position of women in the economic organization is reflected in the status accredited to women in the

subjective accounts. In these immediate life experiences understood through expression which hides the objective meaning but at the same time reveals it, women are perceived as frail, compliant, dependent, passive, and emotional. This then is the *habitus*, which according to Bourdieu's argument, is in a dialectical relationship with the objective system of midwifery producing a subjective midwifery in which, in this particular case, women were attended by men-midwives. Physicians who acted as birth attendants accumulated both economic capital (approximately three dollars per year per patient) (Stewart 1902: 33) and symbolic capital as they were esteemed by the women and families who sought their services.

Midwifery in French Canada Prior to 1850

Midwifery in the region of Quebec has been documented by Hlne Laforce (1985) in her book *Histoire De La Sage-Femme Dans La Rgion De Qubec*. It is not the intent of this analysis to duplicate this material but to indicate the major difference in midwifery between rural Quebec and rural English speaking-Canada. This difference was largely due to the role of the Church in the traditional society in Quebec, a position it occupied well into the twentieth century. Traditional societies are legitimated by a central world-view, typically religion. Habermas argues that legitimation is found in this belief. "The expression 'traditional

society' refers to the circumstances that the institutional framework is grounded in the unquestionable underpinning of legitimation constituted by mythical, religious or metaphysical interpretations of reality-cosmic as well as social-as a whole (Habermas 1971: 95)).

That religion played a prominent role in defining the birthing practices in Quebec is shown by the fact that one of first tasks of the midwife was to carry the newborn, accompanied by the father to the church to be baptized. In a case where the child was stillborn the midwife took it upon herself to baptize the child immediately. Prior to 1719 midwives also were required to transmit information to the clergy concerning the legitimacy of a child. If a child was illegitimate and the father was known, pressure could be exercised to bring about a marriage.

In Quebec city, eighty percent of the midwives were members of the fraternities of Sainte-Anne and Sainte-Famille. The function of these societies was to promote high moral standards in the city. On the other hand, reports indicate that midwives sheltered unwed pregnant mothers and after the birth arranged adoption of the infant outside parish boundaries. Babies were sometimes passed to Indian women (Laforce 1985: 172-173).

The church was concerned with limiting the number of midwives in a parish to a single midwife, who would be assigned by the parish priest.

According to Laforce having only one midwife meant the parish priest could have a clearer knowledge of all the births and baptisms. Also, he would have an easier time overseeing all this woman's activities.

A newly appointed midwife took an oath to the parish priest and promised:

- 1) that she would day and night assist women in labor, be they rich or poor and that she would do her best to avoid any accident to mother or child;
- 2) that she would call a doctor or surgeon in case of difficulties;
- 3) that she would not reveal any family secrets and that she would not use any superstitious methods, nor would she take vengeance on anyone;
- 4) that she would not consent to destroy the foetus or induce the delivery prematurely through extraordinary means against nature; and
- 5) as a good Catholic, she would take all precautions necessary for the bodily and spiritual welfare of mother and child and may God help me.

(Book of Rituals Rouen France (no date) cited in Laforce 1985: 158).

Although no exact date is given, it may be assumed from Laforce's work that the Rituals of Rouen France were written for village parish life sometime in the sixteen hundreds. It appears to be similar to a professional oath and articles of ethics.

It was the policy of the King of France to subsidize hospitals,

doctors and midwives in the colonies. In 1750 the French government provided the American colonies with four midwives; one in Quebec (since 1722); one in Ile-Royale (since 1740); one in Louisiana (since 1721); and one in Montreal (since 1730). These midwives were graduates from l'Hôtel-Dieu in Paris, which in 1631 had established the first education program for female midwives. Their salaries were the same as in France, if not higher. At that time the collaboration between surgeons and midwives was good. It was Sarrazin, a surgeon and medical doctor, who in 1714 asked the King to provide the widow Gauvereau, a midwife, with a salary. The initial request was denied, but a second request in 1722 brought a favourable response (ibid 82).

Catherine Jérémie dit Lamontagne, is one of the few midwives of this period whose history has been recorded, and her fame is due more to her work as a botanizer than a midwife, although work as a botanizer is related to skills in herbal medicine. Born January 25th 1681 to a trader, she was married at age sixteen to Jacques Aubuchin near Trois-Rivières. With this husband she had one daughter. On November 3rd 1688 she married once again, this time to Michel Lepailleur de Laferté at Batiscau. They had ten or eleven children. In 1690 they lived in Quebec and in the Autumn of 1702 they settled in Montreal where Lepailleur received a commission as a royal notary. It was in Montreal, that Catherine Jérémie

practised her profession as a midwife and established herself as a botanizer.

In the 18th century naturalists in New France were trying to discover the medicinal and practical properties of flora in Canada. Every year the naturalists collected plants and dispatched both living and dried specimens to France on the King's vessels. Catherine Jrmie although not as well known as other amateur botanists, did distinguish herself not only in collecting plants, but particularly in attaching to her shipments notes in which she explained the properties and effects of the medicinal herbs. Her goal was to discover the secrets of Indian medicine. Catherine Jrmie was widowed in 1733 and died in Montreal in 1744. (Forton-Morisset 1974: 314, 315).

With the takeover of New France by the British in the 1760's, gradual changes occurred in midwifery. State intervention (the bill to regulate midwifery in Canada of 1788) was accompanied by the arrival of English physicians and surgeons. They brought with them a new form of science which was applied to obstetrics. Yet in the rural areas (outside of Montreal, Quebec City, and Three Rivers) the midwives continued to practise under the patronage of the parish organization. Although English doctors attempted to diminish their importance through the development of professional institutions and licensing laws which restricted the work

of midwives , Roman Catholicism influenced birthing practices and the role of the midwife in rural French Canada until the early twentieth century.

The first lying-in hospital was established in Montreal in 1841 by Dr. MacNider. Initially it was successful. However, because of a refusal to allow students from the University of McGill College access to practical training (Dr. MacNider was then a lecturer at the Montreal School of Medicine) professors at the University of McGill College established a new lying-in hospital which fell under their jurisdiction. Shortly after Dr. MacNider's death in 1846 the original lying-in hospital was closed.

The faculty of medicine of McGill College opened the second lying-in hospital in November of 1843. Although the facilities were used by charity cases, its main function was to provide medical students with practical instruction. It was supported by voluntary donations, an annual grant from the legislature and paying patients. A Mrs. Hope was the matron and resident midwife. She had been "thoroughly instructed in midwifery and has received the license of the College of Physicians and Surgery" (Hall: 1860: 50). With the closure of the original hospital of Dr. MacNider, another lying-in hospital, the Hospital de St. Pelagie, a Roman Catholic institution under the management of the Sisters of St. Pelagie

was opened in order to provide an opportunity for practical instruction for the students of the Montreal School of Medicine. Dr. Hall (1860) indicates that the prime motive for establishing lying-in hospitals in Montreal was to secure access to women in labour for the benefit of the medical students. In the article written by Dr. Hall and published in 1860, only seventeen years after the founding of the original lying-in hospital associated with McGill College, there is no mention of any other motive for the hospital other than that of providing patients for medical students. This would suggest that the first lying-in hospital in Canada was established not primarily to assist women in childbirth but to assist physicians in their appropriation of midwifery.

In a letter to the editor of the *Montreal Medical Gazette* of 1844 a reader writes:

The ostensible object in establishing this second *maternité*, was the practical instruction of Medical Students in the important department of Obstetrics, and the education of Midwives. Strange it is that the pressing want of such an establishment had not been felt for upward of twenty years; yet, perhaps, not so, for we *know* that *three* of the members of the original Montreal Medical School did not approve of patients being under the charge of Midwives(ibid 223).

Of interest is the fact that the writer is stating that the facility was for the "practical instruction of medical students" and " *the education of midwives*." This statement indicates that the institution was

contemplating educating not only medical students but midwives. It is the only article I have found in which mention is made of educating women (I assume) as midwives. In the article, the statement "we *know* that *three* of the members of the original Montreal Medical School did not approve of patients being under the charge of Midwives" supports this conclusion. Although this is an unsigned letter to the *Montreal Medical Gazette* (1844) and the writer(s) does not give evidence for this assertion, it is of interest because it indicates that some form of controversy existed around the issue of educating midwives. Since it was in this time period that the medical profession was taking its first step in the appropriation of midwifery, it is logical to expect that members of the medical profession would protest having midwives in control of patients.

The Habitus of Medicine

Medicine is defined as the act or practice of restoring or preserving health; *habitus*, as outlined by Bourdieu (1977), as a system of durable, transposable dispositions, structures which are predisposed to function with objective regularity without in fact being a product of obedience to rules. As such, it is not a wilful arrangement. The *habitus* as it relates to medicine is the system of durable, transposable dispositions surrounding the act and practice of restoring or preserving health, which

are inclined to be similar or regular. Nevertheless they are not the result of a conscious obedience to any rules. They adapt to goals without a conscious aiming at these goals.

A description of the *habitus* of medicine will follow a similar pattern to that of midwifery. Involved in the scientific methodology are three steps. First, there is the analysis of the objective meaning and social conditions of medicine. Second, there is expression of the immediate life opinions through the use of subjective accounts. And third the subjective events are linked to the objective conditions in order to comprehend the *habitus*. The subjective act and practice of restoring and preserving health, is constituted in the dialectical relationship between the *habitus* on the one hand the objective event, medicine on the other.

Medicine in Canada Prior to 1850

In Canada as well as United States medicine took on an unregulated, open-market character. Individuals could secure treatment for medical conditions from people who sold diagnostic skills and treatment, or palliation for a price. According to Berliner (1982: 165) the physician and other healers who performed this service were acting as petty commodity producers working individually with little capital and virtually no overhead. This petty-commodity mode of production lagged behind the dominant social formation. It grew in strength only as the

general economy began to move into its industrial-capitalist phase at a larger level.

The basic law of the market place influenced the elaboration of petty-commodity medicine. As with other commodities value for money had to be demonstrated before it could be accepted. One group, the empiric practitioners moved from the rural to the urban areas and tried to perform their same role. They constituted one set of commodity producers. However they were rapidly marginalized. Much more successful were those trained as physicians, individuals who had an education or at least a university degree. Allopathic and homeopathic physicians fall into this category.

The empiric practitioners, called quacks by the orthodox educated doctors, were healers who declared themselves able to treat all manner of illnesses and often advertised their successes. They offered herbal remedies and/or psychological comfort to their patients. Orthodox physicians objected to their trial and error methods as no reference was ever made to academic theories about the origins and treatment of disease. Wertz and Wertz (1977: 48) have pointed out that these educated physicians prior to the development of bacteriology in the 1870's had little to offer that was practically superior to empiricism. There did not exist any convincing authoritative scientific nucleus of medicine and

doctors often had trouble translating their academic knowledge into practical treatment. In reality, the regular doctor practiced largely ineffective therapies, but they were convinced that their therapies were better than the empirics because they were educated men. Both the regular physicians and the empiric practitioners treated patients rather than diseases, and looked for different symptoms in different social classes. In the early nineteenth century the empiric physicians enjoyed considerable popular support as their therapies were often successful, and certainly less strenuous than those of allopathic physicians. It was this competition from the uneducated empiric practitioners which was most objectionable to the regular physicians.

As indicated by the biography of Dr. W.H. Burritt of Smith Falls, the educated or "regular" doctors were of the upper and middle classes. These doctors can be roughly divided into two groups; those who apprenticed under an established physician in their community, and the elite who attended the better medical schools in Great Britain or United States. In 1822 a Dr. Stephenson obtained permission to offer lectures in anatomy, surgery and physiology at the Montreal General Hospital. Then in 1824, Lord Dalhousie authorized the foundation of a medical school called the Montreal Medical Institute. It was subsequently absorbed by the medical faculty at McGill University. The second medical school to be established

was in Upper Canada in 1843 by physician, politician and member of the bar, John Rolph. After that several medical schools appeared in a quick succession.

Although there is little indication of the course curricula other than the subjects of anatomy, surgery, physiology, botany, chemistry and "classic learning" there appears to be little relationship between these academic pursuits and the actual practice of medicine. The objective of allopathy was to produce severe and intense physiological reaction. This was accomplished through the use of heavy doses of drugs. Basic techniques included massive blood letting; the use of drugs to encourage vomiting, diarrhea or constipation; leeches to draw out blood; and the indiscriminate use of foul-smelling or foul tasting potions. This regimen was rationalised as a means of jolting the body back to a normal state. "The intense reaction which allopathic medicine produced was a clear and ample sign that your money got you a major result...that it was well spent" (Berliner 1982: 166).

A very different type of medicine and popular among the upper classes was homeopathy, a system of healing based upon the theories of Samuel Hahnemann, a German physician. It was introduced into North America between 1825 and 1840. In opposition to the rationale of allopathy, homeopathy prescribed small dosages of drugs, down to the

ten-thousandth dilution. Small dosages were believed to stimulate the recovery from disease. Fresh air, bed rest, proper diet, washing and public sanitation were other measures used in the treatment of illness, and these practices were employed in homeopathy, long before they became popular within regular medicine. Because homeopathy attracted the upper classes, its physicians were accorded more respect by the regular doctors than were those of other sects.

In writing about sickness and healing in this period A "Canuck" (1905) states:

Vaccination, blood-letting and cupping were commonly practised, there generally being some one in the neighbourhood with skill in performing these operations, to whom the neighbors would go when requiring such treatment. Blood-letting was at the time the great panacea among the people in doctoring. People were bled for nearly every ill....

We said the progress was wonderful; might we not add, as still more to be wondered at, that so many patients survived the medical treatment in vogue half a century ago! Many a man who has had the lancet applied to his arm and the life-blood taken away from him, succumbed to the operation, who otherwise and with proper treatment might have lived a long and useful life. Cold water was strictly forbidden anyone suffering from a fever, it being stupidly supposed that it would cause immediate death. The doors and windows were kept securely closed to prevent any cold air from coming into contact with the patient. During the cholera times, men who were supposed to be dead and had been removed to outhouses, were brought back to consciousness and recovered by the invigorating action of the pure cold air (ibid 96, 97).

Bloodletting was a popular therapy for many symptoms of pregnant women. If such a woman seemed florid or perspiring the doctor placed

her in a chair, opened a vein in the arm and allowed her to bleed until she fainted. In some instances doctors bled women in labour to unconsciousness in order to counter delivery pains. A distended abdomen after delivery might be treated through the application of twelve leeches; for a headache, six on a temple; and vaginal pain merited seven. Calomel was also used; it is a chloride of mercury which when ingested irritates the intestine and purges it. A woman with puerperal fever was often treated with extended doses of calomel in order to reduce swelling by purging her of her bodily contents. If the calomel caused a too violent reaction, opium was administered to retard it. Emetics to induce vomiting were given to expectant women with convulsions. The doctors speculated that the emetics were specific for the treatment of hysteria or other nervous diseases causing convulsions. Any expectant or labouring woman could be subjected to a battery of such agents as doctors sought to restore her symptoms to a normal balance (Wertz and Wertz 1977: 68).

Criticism of the medical practices has been clearly outlined by Canniff (1894) in his book *The Medical Profession In Upper Canada 1783-1850*. It is interesting to note that although the criticism appears to be directed at the quacks, i.e. the empiric practitioners, the treatments criticized are those used by the regular physicians. In the *Kingston*

Gazette of March 3rd, 1812 a Jeremiah Freedling complained about a doctor who, having no one to practise on induced one of his daughters to be inoculated for small-pox and in the process devastated the neighbourhood.

In response to this letter Reverend (afterwards Bishop) Strachan wrote most vehemently of medical practices:

The Province is overrun with self-made physicians who have no pretensions to knowledge of any kind, and yet there is no profession that requires more extensive information (ibid 26).

After a lengthy discourse on the need for a classic education and legislation to license medical practitioners, Reverend Strachan continues:

They cure all diseases with two specifics, opium and mercury. Is a patient in great pain, he must swallow a large pill of opium. Is a practitioner in doubt about his disease, a dose of calomel is the remedy. I was lately visiting a young woman ill of a fever. The Doctor came in, felt her pulse with much gravity, pronounced her near a *crisis*. 'She must take this dose' said the gentleman, pouring out as much calomel on a piece of paper as would kill two ploughmen. 'Pray what is this?' said I. Doctor: 'A *febrifuger*!' 'Is it not calomel?' 'Yes' 'You mean to divide this into several doses?' 'Not at all' 'But the patient is weak.' 'No matter, I like to scour well.' 'Do you not weigh carefully' so powerful a medicine before you give it?' 'No sir I knows exactly.' As the woman was evidently getting better, I threw the calomel out of the window after his departure and sent her some bark [cinchona bark which is quinine] and wine (ibid 27).

Reverend Strachan continued his article by outlining two further cases to prove his point and then concludes with:

Let the law check this growing evil and do justice to regular

practitioners who have gone through the course of studies in order to qualify themselves for this arduous profession. At present they are elbowed out of their practice by men who can neither read nor write so as to be understood. (ibid 28).

The author Canniff supports the regular physicians with more letters from the *Kingston Gazette* of 1815; letters which he refers to as being written by the "more intelligent public" (ibid 29). In quoting one such letter he states "Then follows an earnest appeal to the public and Parliament against quacks, their danger, 'without one ray of science' who 'presume to thrust the created into the presence of the Creator'" (ibid 29).

Based upon our present knowledge of medicine, the practices of the empiric practitioners i.e. the use of herbs and charms was less destructive to the patient than those of the regular doctors. Many empiric physicians had a "reputation of being quite skillful" (A "Canuck" 1905: 96). Although Reverend Strachan lashes out at the lack of education of the empiric practitioners, the body of his criticism is leveled at the practices of the regular doctors. There is an inconsistency to his argument.

According to Bourdieu's concept, the practice of medicine in Canada was constituted in the dialectical relationship between the *habitus* on one hand and the objective event on the other. An analysis of the objective meaning and social conditions indicates that the empiric system arose in the rural areas among the lower classes and spread to the

cities where it was soon marginalized. Allopathy was the system of healing associated with the upper class and later the bureaucratic and new middle class. Practitioners of allopathy were from upper-middle-class families.

An examination of the immediate life experiences understood through the expressions which hide the objective meaning while also revealing it, presents a confused picture. On the one hand, the practices of the regular physicians are criticized. On the other, it is assumed that only regular physicians who have received an education should be allowed to practice. In the rationale of the critics, there is no link made between; (a) the classical education and the actual practice; and (b) the educated physician and the much despised practices. The major problem with the previously mentioned critics' evaluation of medical treatments is that same problem which has plagued medicine until the late 1970's; that is the "failure to assess explicitly the degree of validity and sufficiency of the evidence linking care structures and processes to outcomes of care in general and to health outcomes in particular" (Williamson 1978: 5).

Physicians, such as Williamson (1978), have researched extensively the lack of evidence linking care processes to outcomes and from their work identified areas of potential improvement in contemporary quality assurance.

From the evidence presented, it is possible to conclude, that it was not the issue of practices which was the major factor in the appropriation of power, but class and education. The dispositions and situations which combine synchronically in the subjective event(i.e. medicine within the Canadian context), were engendered "in the last analysis by the economic basis of the social formation in question" (Bourdieu 1977: 83).

The First Efforts At Appropriating Midwifery by the Medical Profession

In the next section and the following two chapters, I will be examining the various statutes which are related to the licensing of midwives throughout Canada. Although other authors who have written about midwifery in Canada have made reference to the legislation, none has articulated within their works the actual clauses on midwifery. I will be examining each clause which is directly related to midwifery, as the wording becomes important in future court challenges. It would be of interest to research the pre-legislation hearings and documents relating to each piece of legislation but that is another study in its self.

The first statute of Upper Canada which called for the licensing of midwives was passed in Westminster in 1795. This act stipulates:

That no person who shall or may have come into this Province since the passing of the above mentioned Act, and before the passing of this Act, nor any person who shall or may hereafter come into this

Province, shall be permitted to vend, sell or distribute medicines by retail, or prescribe for sick persons, or practise physic, surgery or midwifery, within the Province, for profit, until such person or persons shall be duly examined and approved of, by a board of surgeons who shall be constituted and appointed (as herein after mentioned) with full powers to grant licences for the practice of physic, surgery and midwifery with in the Province, and has received a licence under the hands and seals of the president of the said board and such members thereof as may be present at his or their examination (*The Statutes of His Majesty's Province Of Upper Canada*. Chap. 1, 1795).

Such an act was found to be irrelevant for the times. Few men were eligible to take the examination and no university education was available within the country. The absence of any record of an Examining Board suggests that it was not enforced. Settlements were isolated and rarely visited by medical men. Furthermore, the statute was seen as being particularly unfair to women since it prevented them from practising. A statement by a Robert Gourlay is indicative of the antagonism felt towards this particular law:

How absurd, how cruel, how meddling that a poor woman in labour could not have assistance from a handy, sagacious neighbour without this neighbour being liable to be informed upon and fined (Biggs 1983: 22).

By the time of the statute of 1815, the unfairness of the law towards female midwives was rectified and a two-tier system set in place. Although men were required to have a license to practise midwifery, women were exempted. The clause states:

Provided always, That nothing in this act contained shall extend or

be construed to extend to prevent any female from practising midwifery in any part of this Province, or to require such female to take out such a licence as aforesaid (*The Imperial Acts Applying To Upper Canada and Ordinances of Quebec* 1774-1819 Chapter X 1815)

With the statute of 1818, a medical board with the power to examine and license practitioners was established as well as a penalty of one hundred pounds for those caught practising without a license.

Nevertheless, clause II of this act contained the same exemption for females practising midwifery as was outlined in the statute of 1815. A further act of 1819, clarified the composition of the examining board, the frequency of meetings for examinations and the fee to be paid for the examination and license ten shillings (*The Imperial Acts Applying To Upper Canada And Ordinances Of Quebec* 1774-1819, Chapter XIII, 1818 and Chapter II 1819).

Despite the legislation and the importance of female midwives, not all citizens favoured the practice of female midwifery. An anonymous letter in the *Kingston Gazette* states that:

An unfortunate female accoucheur from ignorance or trepidation, separated the funis [umbilical cord] from the placenta, leaving the latter within the patient causing her death....The vigilance of the magistrates, the contempt of the public, the scorn of all good men must root out these pretenders and make them feel if they cannot see (cited in Biggs 1983: 22).

This letter in turn prompted several replies.

One subscriber said that without female accoucheurs 'those who live in the back settlements...would be in a very distressing situation

since the closest medical man was thirty or forty miles away.' Another letter from a 'female accoucheur' expressed alarm that this critic 'would shake the Province from a one end to the other' and suggested that if it were not for midwives the writer may not have been born (ibid: 22).

The next piece of legislation of interest to midwives was that passed in 1846-1847. In *The British American Journal Vol. II* of 1846-1847 there appeared a rough draft of a proposed bill to incorporate the profession of Upper Canada. Clause XIV states:

That from and after the passing of this act, it shall not be lawful for any female to practise midwifery for hire in any town where there are resident licensed practitioners in actual practice, nor in any township where there are licensed practitioners in actual practice, unless such female shall first have obtained a license so to do, under seal of the college, for which license she shall pay (pounds) currency (ibid 193).

In the same journal the "Bill An Act to incorporate a College of Physicians and Surgeons in Upper Canada" makes no mention of the clause which was outlined in the draft bill. Instead, in clause IV it states:

Provided that nothing in this Act contained shall be construed to prevent or prohibit any female from practising Midwifery in Upper Canada, or to require such female to take out such License as aforesaid (ibid 57).

It appears, that the clause in the original rough draft was too contentious to be passed by parliament. Therefore, female midwives in Upper Canada were free to practise for a few more years without the fear of legal harassment, and medicine had established its first major professional organization, The College of Physicians and Surgeons of Upper Canada.

Licensing of midwives in Lower Canada followed a different pattern. The original statute of 1788 required all midwives within the Towns of Quebec and Montreal to be licensed. A medical board examined each candidate as to his/her proficiency and upon the passing of such examinations issued licenses. Within the rural districts the *sages femmes* remained unregulated in the formal sense, although they retained their association with the local priest. It was not until 1846-1847 that a second act to regulate the study and practice of medicine, surgery and midwifery within the province was passed. This bill allowed for the establishment of a medical board with the power to set standards of education for the practice of medicine, surgery and midwifery, the licensing of practitioners in the previously mentioned fields, the cost of examination and licensing, punishment for the offense of practising without a license, and the composition and power of the medical board. With this bill midwives not only in Quebec and Montreal must be licensed but also those in Three Rivers. And the act also provided a two-tier system of licensing. Those women within the towns would be licensed by the medical board, those in the rural areas by individual physicians and surgeons. Clause IX of the Bill states:

And be it enacted, That nothing in this Act contained shall extend, or be construed to extend, to prevent women from practising as Midwives within this Province; Provided always, that after the

expiration of two years from the passing of this Act, no woman shall practise for gain or hope of gain in any shape as a Midwife, unless she shall have presented herself before some Medical Board to be appointed and nominated as herein after mentioned and obtained therefrom a Certificate as to her qualification and competency to practise: Provided also, that in country places too far removed from Medical Boards, any woman may at the expiration of two years after the passing of this Act, obtain a License to practise as a Midwife in the especial District in which she resides, on submitting to an examination before, and obtaining a Certificate of qualification from any two regularly licensed Physicians or Surgeons practising in the same District (*The British American Journal* Vol. II 1846-1847 27).

It is interesting to note the phrase " shall practise for gain or hope of gain". In a future court hearing, the Queen v Whelan (Tremear 1901: 277), described in chapter four , the issue of practice for gain is central to the case.

This then is the first significant effort to appropriate midwifery by the medical profession. It heralded the beginning of direct domination of persons (Bourdieu 1977) rather than of institutions. The first attempt at institutional to institutional domination will occur at the end of the nineteenth century when the medical profession will try to prevent the formation of the Victorian Order of Nurses. They will be only partially successful in this endeavor, but will have much greater success in the 20th century when they gain institutional to institutional control over related health care occupations.

In this period, there is regulation of individual midwives by both the

medical institutions and by individual physicians. This is the only known instance where individual physicians were given the legal right of authority over individual midwives. A comment in the *British American Journal* (1862) suggested the possible consequences. The statement suggests that corrupt licensing practices may have existed.

however much this is to be regretted at the present moment as opening the road to a flood of midwives in the cities whose ignorance may be shielded by favouritism, (although we can scarcely think it possible that any two members of the college would thus prostitute their position)...(ibid 151).

Nevertheless, the Act appears to have had the desired effect. In the *British American Journal of Medical and Physical Science of 1849-1950* there are the names of nineteen women who were registered and were licensed as midwives. The number appears low for the province of Quebec. This may be due to the fact that most women did not register, or to poor records, or to a combination of both reasons. Although names do not ultimately specify the origins of the women, they do give some indication of the ethnic background. Of the nineteen names mentioned, eleven were French and nine English.

The British American Journal of 1848-1849 provides a broader description four women who were registered and legally qualified to practice midwifery:

Mrs. Christine Stewart with a Diploma obtained in Edinburgh, and

signed by Professor James Hamilton in 1811; also with a Provincial License, dated 1817.

Mrs. Jane Buchanan, with a Diploma obtained in Edinburgh, and signed by Dr. Thatcher, Lecturer on Midwifery, dated 1824.

Mrs. Christian Sutherland, with a Diploma, also obtained in Edinburgh, and signed by Dr. Thatcher, dated 1831; and

Madame Marie Barbie Tavernier, dit Sanspitié who submitted to an examination as to her obstetric acquirements (ibid 193).

This short list suggests that those women with diplomas, the British immigrants, were not required to take further examination; those without diplomas, the local French, were. It is probable that the medical boards were composed of British physicians and surgeons. Since links with the establishment were necessary for government appointments, the individual physicians who examined the midwives would also be English. This resulted in a system of licensing in which the male medical establishment composed of Englishmen examined and licensed female midwives of French Canadian origin. Involved is domination according to gender, profession and ethnicity. It is difficult to envisage a worse scenario for midwives.

The Social Conditions Relating to Midwifery, 1788 to 1850

In an analysis of the social conditions which were instrumental in the construction of midwifery between 1788 and 1850, it is difficult to separate gender attitude from the economic status of women. Within the toiler society, women were crucial not only because they were central to economic production but because the children they produced provided

labour which was essential for the economic success of the family. Oral histories provide evidence of the fact that these women were esteemed for their intelligence, their strength of character, and vigor. This attitude was not only accepted by society but internalized by the women. It resulted in parturient women from this class seeking the assistance of traditional birth attendants. I would contend that these women were called upon, not because there were no physicians available as suggested by "Canuck" (1905), Dunlop (1902), Smith (1923), and Healy (1923), but because of their expertise as birth assistants. Midwifery was recognized as a legitimate occupation and the women who practised it were rewarded more with symbolic than economic capital.

In contrast with the clearly defined economic role of women in the toiler society, upper class women were valued for their ability to produce heirs and to enhance their husbands' social economic positions. In general these women viewed themselves and were viewed by others of their class as frail and dependent. This resulted in a system of birthing where pregnant women were assisted by physicians. As payment for their services, physicians received economic capital. They too were esteemed by their clients.

At this time, there existed several medical sects, empiric allopathic and homeopathic medicine, to mention only those more widely

known. The empiric practitioners, uneducated doctors from the rural areas, offered herbal remedies and psychological comfort to their patients. Within urban communities they were seen as quacks. Homeopathy found favour with some members of the elite, although allopathy was in general the accepted system of healing among the upper classes. These physicians were esteemed more for their social class and education than for their actual medical practices. Favourite treatments were blood letting, the use of leeches, emetics, and purgatives. Because of the rather questionable quality of the medical treatments, the women within the toiler society, tended to collect and dry herbs for their routine family illnesses

It was only in about 1847 that physicians began to organize professional institutions. In Upper Canada the society was the College of Physicians and Surgeons: in Lower Canada, a medical board. Torrance (1981) writes:

In Upper and Lower Canada from 1795 onwards, there were repeated attempts to pass legislation licensing practitioners and suppressing irregulars healers. Boards of examiners were appointed from among the well-trained physicians. For most of the century these laws were only partially effective...(ibid14).

It would appear that at this time there was little conflict and tension between physicians and midwives. Oral histories appear to suggest that these two types of birth attendants existed side by side in

relative harmony. I would contend that this was due to three factors; the respect that the traditional birth attendant had with in the community; the conflicts among the various practitioners; and the problems associated with the medical treatments. This resulted in a system of midwifery where women chose their birthing attendant according to cultural, social, and economic conditions.

State intervention into health care began in Upper Canada in 1795. This first statute regulated the licensing of midwives. Such a regulation was found to be inappropriate by the settlers of Ontario and the clause to regulate the licensing of midwives was repealed. Successive health acts in 1815, 1818 and 1846-1847 contained clauses which allowed females to practise midwifery without a license in Upper Canada.

In Lower Canada, the first statute which regulated midwifery was passed in 1788. With this legislation midwives were licensed in the towns of Montreal and Quebec. A second major piece of legislation was passed in 1846-1847. With this statute medical boards were given the authority to license midwives in Montreal, Quebec, and Three Rivers. Two regularly licensed physicians or surgeons would have this same responsibility in the rural areas. The question to be asked is "why did the local women of Upper Canada escaped such licensing, while those in Lower Canada were forced to submit to examination?"

There are three plausible explanations. First, there is a history in Lower Canada of having formally trained midwives, since the appointments of midwives by the Kings of France. The extension of licensing to cover all midwives may have appeared as a natural upgrading of the law. Second, Montreal was developing as a centre of medicine in Canada. The first medical school was established in 1824 and the first lying-in hospital in 1841. Because of the importance of these institutions, physicians may have achieved more authority and respect. Finally, it was the British physicians and surgeons who sought to regulate midwifery in Lower Canada. As members of the ruling elite, they would have more power and authority over a colonized people (i.e. local French midwives) than they may have had over midwives of their own ethnic group. It is probable that all three of these factors contributed to the licensing of the midwives.

Nevertheless, although midwives in English Canada escaped such regulations, their freedom to practise without a license was limited. Within the next fifty years the medical profession would concentrate all its efforts on legitimating male-midwifery by excluding females from the profession. By 1900 they will have achieved officially their desired goal. Yet, it will take the first part of the 20th century to transform the medical professions' official jurisdiction over midwifery into one in

which they are accepted by society as the valued authority on birthing.

Chapter 4

The Second Phase Of Appropriation: 1850 To 1900

The second phase of appropriation (1850-1900) is marked by several major transitions: the social conditions associated with the construction of midwifery. Within the toiler society, agriculture specialization due to the development of the cash economy, as well as compulsory education which removed children from home production, resulted in farm women losing their status as leaders of economic production. The role of women in the upper classes remained about the same although there was a demand for higher education for women. The gender attitude, which prevailed among the upper classes, gained wider acceptance because of its promotion by physicians who legitimated the view through reference to anatomy, physiology, and pathology

Medicine itself was improving as physicians sought to unite allopathy with a science based on chemistry and molecular biology. In all the provinces and the territory, physicians established professional institutions, and the state intervened into the health care system granting physicians the authority to license midwives. As was outlined in chapter two, the regular physicians, in an effort to gain greater economic and symbolic capital sought to broaden their control of medicine and other health related activities. Through parliamentary legislation, they

were able to set up decision-making bureaucracies which had the authority to license physicians, surgeons, and midwives. Nevertheless, although the politicians had seen it fit to grant the regular physicians the jurisdiction over medicine and midwifery, such powers had to be translated into reality. Through the use of "coercion" as well as "persuasion", (Abercrombie, Hill, and Turner 1980) allopathic physicians set out to extend their right over midwifery as well as the other medical sects. As a result of this increased activity, there was considerable tension and conflict between midwives and physicians. By the end of this period the medical profession had gained formal jurisdiction over midwifery, and the number of traditional birth attendants was greatly diminished.

However, at this time they lacked a standardized system of licensing and education, thus the objective mechanism with which to ensure and perpetuate their groups' interests. According to Bourdieu (1977) the greater the extent to which the task of reproducing relations of domination is governed by objective mechanisms which serve the interest of the controlling group, the more indirect and impersonal become the strategies orientated toward its reproduction. Once the system has been constituted and is capable of ensuring the reproduction of the established order, the group which occupies the commanding

position only has to let the system over which it exerts authority take its own course in order to exercise control. Until such a system exists individuals must work constantly to reproduce conditions of domination.

In the process of the appropriation of midwifery, individual physicians and surgeons, with the act of Lower Canada (1846-1847) were allowed legally to regulate individual midwives through the granting of licenses. With the legislation, which was passed between 1865 and 1906, individual to individual control was replaced by a mechanism which allowed for institutional domination of individuals (i.e. the fining of midwives for practising without a license). As a result, in this period there existed "direct domination" (Bourdieu 1977) of persons rather than of institutions. It was a time in which physicians used various means to corrode the confidence of women in the capabilities of the midwife. By the turn of the century, medical profession had partially achieved its first instance of institutional to institutional domination. Through a highly organized campaign and with the support of the media, the medical profession was able to persuade the federal government to cancel a previously promised grant to the Victorian Order of Nurses, money which they required to set up a home care program which included midwifery.

Midwifery 1850-1900

Between 1850 and 1900, the economic and social makeup of Ontario

differed from the earlier period which was described in the last chapter. The triumph of the British capitalist class over the aristocracy changed the nature of Britain's interest in Canada. Because of the need for cheap food for the labourers, England's interest in a secure source of grain waned in favor of commercial alliances with central European governments. In Canada, the Corn Laws, and the Navigation Acts, the granting of Responsible Government and the creation of reciprocity between Canada and United States in 1854 signalled the shift in power from the aristocratic to the emerging capitalist class (Johnson 1974: 22).

By this time the toiler farmers had accumulated extensive capital in the form of cleared lands, buildings, livestock and machinery. As machinery replaced hand labour, farmers became much more deeply involved in production for capital exchange

The British government, by the 1820's, had decided as a matter of policy to force the creation of a proletarian working class in Canada. They did so, by ending a policy of land grants to immigrants while still encouraging them to migrate to Canada. By 1840 there was a growing scarcity of cheap land, and a flood of immigrant Irish labourers. This resulted in a significant pool of labourers, in the 1850's, in cities such as Quebec, Montreal, Kingston, Toronto, and Hamilton (Johnson 1974: 23).

As the nature of the various classes in mid-century changed, so did

the role of women. According to Johnson, there were two developments which had a deep affect upon the lives of rural women. The first was the increased agriculture specialization due to the development of the cash economy and the increased use of farm machinery. This resulted in a new cash economy in which more and more goods for the home were purchased while fewer were manufactured. "Thus, while the making of clothing and preparation of food remained as farm household tasks, the care of the livestock (now a specialized field in itself), gardening and even such traditional female tasks as carding, spinning and weaving were gradually abandoned" (ibid 24). The second was the fact that compulsory education removed children from the home production team. Because of this, their economic value was greatly reduced, and by the end of the century children were regarded as consumers of wealth rather than producers. These two developments resulted in the farm woman losing her status as leader of the production team. Her labour was reduced to activities similar to those of a servant in a wealthier household. As the farm woman's economic status was narrowed and weakened, her subservient status was greatly reinforced.

The roles of the bourgeois women and aristocracy remained fundamentally the same. Female sexual purity was a central issue. Emphasis was placed on providing legitimate heirs and the organization of

charity and maintenance of social "morality" were central issues for both the wives of the capitalist and aristocratic classes. However capitalist wives faced a more complex world. They responded not by making greater demands for themselves, but by pushing for better education and greater equality for their daughters.

There were two other groups which require consideration. The first is the independent, highly skilled master craftsmen. These journeymen were well paid and were the elite of the working class. Skilled workers generally received high wages and frequently owned their own homes. With the development of manufacturing, the craft workers were replaced by proletarian labourers. They were poorly paid and usually lived in tenements or rented squalid cottages on or close to the manufacturing grounds. The capitalists constantly tried to reduce costs of production by employing semi-skilled workers in place of skilled master craftsmen. There was rivalry and antagonism between the two groups of workers.

As Johnson (1974) has outlined, the lives of the workers reflected this division. In order to retain her "respectable" position in society, the mechanic's wife aped the lifestyle of the bourgeoisie. She did this in order to maintain her distinction from the labouring class. In contrast, the working-class women usually had large families, and often worked as washer women, charrs, piece workers in the sweat system (women worked

on manufacturing goods in their homes on their own time) or other forms of menial labour. Inadequate diet, back-breaking toil, child bearing and disease reduced their productivity. Children often ended up working the streets i.e. begging or engaging in petty crime. The failure to achieve a standard set by the higher classes was often attributed to their personal inadequacy.

At the same time as land was becoming scarce in the east, several million square miles of virgin prairie in the Canadian west was available to anyone who wanted it. This offer of free land precipitated the great human migration to Western Canada. In 1869 the Canadian government purchased from the Hudson's Bay Company the North West Territories for 300 000 pounds. This land was wilderness, inhabited by a few thousand Indians, settlements of Métis buffalo hunters, fur traders and the agriculture colony at Red River. To incorporate this territory into the nation, Canada built the Pacific Railway. Since the railway needed settlers, the Homestead Act was passed in 1882 to encourage immigrants to settle in the North-West. On the condition, that settlers would break the sod, erect a shelter and live on the property for at least six months of the year for a period of three years, an adult male could acquire one hundred and sixty acres of farm land for ten dollars. He had the option of purchasing the adjoining one hundred and sixty acres for another ten

dollars. This offer resulted in a land rush as well as frantic speculation. Thus, immigration was haphazard and sporadic for the ten years following the building of the railway. In 1896, the Laurier's government, realizing the economic prosperity of the country relied upon the prairie farmers' agriculture production, initiated a planned aggressive policy of immigration to the west.

As territory in Western Canada was opening to new immigrants, British Columbia was also becoming settled. Due to the lack of a route through the Rockies, the majority of migrants were required to make the long treacherous journey from England to British Columbia around South America. Such a voyage required six months. It took three months to pass Cape Horn and another month before the ship made a landing in Peru. Two months latter, the passengers docked in British Columbia. These voyages were plagued with food shortages, stormy weather and discontented crews. A few of the more hardy individuals trekked across the plains of United States and through the passes of the Rockies. Women brought their babies in the saddle bags of the horses or strapped to their backs. The economic and social conditions in Western Canada at this time were similar to those of the toiler society in Eastern Canada prior to 1850. Women also had similar roles.

With this wide variation in economic and social conditions, it is

possible to assume that midwifery reflected this diversity. In areas where the role of women was both integrated to commodity production and central to the economic organization women were highly esteemed as both healers and midwives. Among women of the new capitalist class and other classes which conformed to the role model of the upper class healing and midwifery was delegated to the male physician. The poor never could afford the regular physician's fee. Therefore they looked to the traditional birth attendant and empiric practitioners in their times of need. With the increased specialization and the development of a cash economy midwifery itself became a more specialized profession both for the female-accoucheur and the male-midwife.

In the book *The Pioneer Women of Vancouver Island 1843 - 1866*, N. de Bertrand Lugin (1928) discusses at length the contribution made by women to the development of Vancouver Island. The author, using first hand accounts, relates in detail the hardships as well as the pleasures of pioneer life. In speaking about her family life, a Mary Porter described their living conditions in a one room log cabin in Skinner's Cove. There was no furniture, excepting a bed in each corner and a table, and the home was heated by a stone fireplace that had been built just outside the door yet close enough to let some heat in.

'And in this place my mother was confined, and little Mary, that's

myself, was born. Old Mrs. Francis was supposed to come to help her, but she was late. Doctor Helmcken was there. He got impatient, and when the baby had arrived and there was no one to wash and dress it, he took it in a towel in his lap and bathed and tended it himself. That's the kind of fine doctor he was, the gentlest friend of old and young. Many's the time afterwards he's said to me, 'And don't you talk back to me, Mary Porter, I was the first one to wash your little face.' A year after my birth my sister was born, and only a short time later my poor mother died. Her funeral is my earliest memory' (ibid 130, 131).

If the Porters had Dr. Helmcken to assist at the birth of their daughters, other settlers chose the traditional birth attendant. In Comox, Mrs Robb a healthy, hearty happy woman was of incalculable value to the community because of her knowledge of nursing. "Many miles, in all kinds of weather, she would journey to the help of the sick, or to mothers expecting their babies" (ibid 159). In Ladysmith and district, on Vancouver Island, women assisted other women in childbirth. Mary (Hocevar) Niehaus, on writing about her mother explained that she helped with the sick and assisted as midwife (Johnson-Cull 1980: 167). In these same chronicles other references are made to midwives, who were usually women with big families and who took maternity cases in the mother's own home. They acted as housekeepers as well as nurses.

Then there are the tales of those brave women who journeyed overland and through the treacherous Rocky Mountain passes. One such story is of a Mrs. Schulbert. She and her husband travelled by raft down the Thompson River. Food was low, and for nearly a week they had nothing

to eat but some potatoes they had found in a deserted Indian village. The inhabitants had been killed by smallpox.

The morning of the last day Mrs Schubert said to her husband, 'If we do not reach a village before night-fall, I shall have to stop by the way and rest.'

Weary, hungry, ill as they were, the men made a gallant effort to hasten the rafts, and in the afternoon they sighted the stockades of Fort Kamloops.

The brave mother was helped ashore, a tent was run up, and an Indian woman from the fort hurried to the scene. Here, two hours later, the first white girl in the interior of British Columbia was born (de Bertrand Lugin 1928: 262).

Although in most of the remote settlements there were women to attend other women in childbirth, on some occasions even this help was not available. In her memoirs, Mrs. George Black (1938), the second woman to become a member of parliament (member for Yukon) and the wife of George Black, the seventh commissioner of the Yukon, member of parliament and Speaker of the House, describes the arrival of her third child. At the time of her confinement she had problems with her finances. Father Judge (head of the Roman Catholic mission and hospital) explained that hospital and doctor's expenses would be a thousand dollars (probably gold rush prices). He offered to let her wait until spring to pay her debt. Yet, Mrs. Black abhorred debts and because she felt confident in herself due to two previous births, she decided to go through it alone

The baby came ahead of time. I was alone, and it was over quickly, an incredible easy birth - Mother Nature's gift to women who live a

natural out-of-door life such as I had done. And weren't the menfolk surprised, when they returned from work at night, to find, wrapped in red flannel - a fine, healthy boy! My brother nearly passed out when he had to give him his first bath. They called him the little 'Chechako' but I immediately named him 'Lyman' after Grandfather Munger (ibid 130).

Throughout the prairies and in Eastern Canada, there is evidence of the more traditional practices of midwifery. Members of the family often were delegated to assist in childbirth. Fourteen year old Mary Anne Caswell of Saskatchewan in a letter to her grandparents in Ontario expresses her feelings at her mother's absence for one such event.

In rather an angry sunset we hastened the cattle home after what seemed an endless anxious day. Mother had been summoned to sickbed. Martha was sure mother would return to Palmerston. But where was the money coming from for the railway fare from Moose Jaw and how would she get to the railway; one cannot fly without a feather! Tired, hungry and very desolate we did our belated chores. Presently mother came home to tell us we had another cousin; we did not enthuse much or care so long as we had dear mother to ourselves again (Caswell 1964).

The philosophy of these parturient women is best explained by Anna Leveridge of Hastings County Ontario in a letter to her family in England.

We should go to see Mrs. Peacock on Sunday. She has asked me so many times that I feel quite ashamed, and they are busy every day but Sunday. She is expecting another increase. I asked her how she did, as there is no doctor nearer than Madoc, a distance of over 20 miles. She said she has never had a doctor. They get a woman who is good at such times and do the best they can. She says you must make up your mind that if you are to live, you'll live; and if you die, you die: a comfortable sort of feeling (Tiuy 1972: 26).

That this tradition existed in the East coast is evident in the

writings of Sir Andrew MacPhail of Prince Edward Island. In a book about his mother he states:

The doctor had no part in the life of the community. The women were their own doctors, and she had an intuitive skill which she developed by experience Ten children had been born in the house before a doctor was known to enter, save once for the rite of vaccination and upon one other occasion beyond memory (MacPhail 1939: 192-194).

Eastern Canada was in a time of transition. With the new dominance of capitalism and the need for cheap labour, there was an increase in migration as well as the development of ghetto areas within the urban centres. This in turn resulted in new socio-economic conditions. The case of Mrs. Letitia Munson illustrates not only the role of the midwife within this particular social milieu, but it also throws light upon the lives of women who existed in the margins of society

Mrs. Munson was born a slave on a North Carolina plantation. She was sent by her master "to learn the healing art, so as to be useful...among the hands" (Richardson 1982: 629). According to Mrs. Munson, she spent five years with doctors and two with Indians, learning all she could of practical medicine and herbal remedies. About 1861, after gaining her freedom she settled in Woodstock Ontario. By 1870, she had established herself as a herbalist, fortune teller and midwife. She purchased two farm houses; one in which she lived with her husband, son

and daughter, the second in which she boarded pregnant women seeking privacy. As a confidante of women with unwanted pregnancies, she both advised them to go to the poor houses of United States for anonymity and assisted them in their needs in her private home.

In about 1878, Ellen Weingardner who had once been employed in a Woodstock hotel, became pregnant following an affair with one of the men working there. She took refuge in Mrs. Munson's house and in 1879 gave birth to a girl. She left Woodstock but returned in 1882 accompanied by a man named John Camp from Tillsonburg Ontario. Once again pregnant, she along with Mr. Camp made arrangements for her to board with Mrs. Munson. On the morning of September 16, 1882 Ellen Weingardner was found dead on a blood soaked mattress. She was the victim of an abortion in the eighth month of her pregnancy.

At the inquest which followed, the doctors questioned were of the opinion that there must have been an accomplice. The people of Woodstock were quick to remember the stories of alleged horrors connected with the Munson family. Mrs. Munson became the incarnation of untold villainy. The fair amount of circumstantial evidence as well as the fact that she made contradictory statements resulted in charges against her for conducting or assisting in an abortion. "The chief constable told the inquest that prostitutes had informed him 'girls

went...[to Mrs. Munson] to get rid of their incumbrances" (ibid 630).

Mrs. Munson was arraigned in November before the Oxford assizes. Although the jury was convinced of her 'moral guilt', they acquitted her of the charge. The case of Mrs. Letitia Munson illustrates the problems encountered by women because of their particular social and economic conditions. Unmarried mothers had a difficult time. Because orphanages did not accept illegitimate offspring, children were abandoned to the streets of Toronto or boarded in "baby farms" where they died of neglect or overdoses of laudanum. For women such as Ellen Weingardner there were limited options. That the solution they chose often ended in death is a grim indication of the social conditions they were forced to endure.

Although the work of the traditional birth attendants is mentioned frequently in letters and oral histories, actual biographical material is limited. Thus, the work of J.E. Kennedy (1982) on Jane Soley Hamilton, midwife is of particular value. Mrs. Hamilton kept a small almanac in which she listed every birth she attended with the date, name of mother and sex of child. Through the use of this book Kennedy was able to trace and record much of the activity of Mrs. Hamilton.

Kennedy writes that Jane Soley who was born in 1805 to William and Mary Soley of Lower Truro, Nova Scotia. As far as it is known, she grew up in Lower Truro and in 1825 married Robert Hamilton of

Brookfield, Colchester County. Over the next sixteen years she gave birth to seven children, two of whom died in infancy. Up until this time, she lived a life no different from other women in her community.

In 1851, Jane was called upon to assist at a birth, where she attended Elizabeth Hamilton (probably a relative) in the birth of her son. This was Jane's first case. It started a career which would span forty-two years and in which time she would assist at the birth of seven hundred and seventy-six children. She was forty-six years old, an age at which cross-culturally traditional birth attendants often begin their practice. There is no record of a doctor ever being in attendance, although it is probable that she sought available medical assistance for difficult cases.

In her small tattered almanac, Jane kept her records. It was nine months after the first delivery before she attended her second birth. Then in 1852, she delivered eight babies. Over the next few years, she made an average entry of twenty births per year. In 1867, her bonanza year, she recorded the births of thirty-two infants. Although there is no evidence that she was paid for her work, one descendant remembers hearing that she received fifty cents a delivery, if the family could afford it.

Stories of Jane's experiences have been passed down to her present

day descendants. A horse was kept in the barn to enable her to reach women in labour in record time. Often she saw bears in the woods and in winter, travel was almost impossible. "Many summons came via the father-to-be, who escorted Jane along a path through the woods, and when the snow was deep and they came to a steep hill, it was common for the man to sit down and slide down the hill with Jane sitting on his coattails" (ibid 7).

It was normal practice for midwives to remain with the mother and new born for one or two weeks or until the mother was capable of resuming her normal activities. That Mrs Hamilton did so is not evident. Since her almanac shows that she assisted at more than one birth on the same day, it can be assumed that she remained only for the labour and delivery before returning home or attending other cases

If babies were born to unwed mothers Jane recorded them as such. She noted infants that were still born (only four such entries) and is reported never to have lost a mother. She was middle-aged when she began her career, in her sixties at the height of it and eighty-eight when she retired. In 1893 at this age, Jane delivered Mrs Sinclair Hamilton of a daughter. As an appropriate ending to her long career she assisted at the birth of her great-granddaughter. In October of 1897, at age ninety-two Mrs. Jane Hamilton died.

The author, Kennedy, was able to question someone who actually remembered Jane. In 1977 Mr. Suther Fisher, then one hundred years old described when his younger brother was born. His father brought Mrs. Hamilton to the house where she remained all night until the baby was born. He remembered a 'little old wizened-up woman of about ninety pounds'. Jane's almanac reveals that she assisted Mr. Suther Fisher's mother on Sept. 12th, 1887 Mrs. Hamilton would have been eighty-two and Mr Fisher a ten-year-old boy.

Mrs Hamilton's death was recorded in four newspapers of the area. In her obituary, the community paid tribute to Jane or "Aunt Jenny" as they called her

This venerable lady was one of the best known and most respected woman in the place Ever ready to respond to the call of duty, she faced the most inclement weather at all hours and braved dangers that well might have tried the courage of strong men...wherever sickness and trouble were, she was ever ready to lend a helping hand and in her quiet, cheerful way, did all that lay in her power to soothe the suffering Her's was a truly unselfish, Christian life, entirely devoted to the welfare of others (ibid 11).

With the increased specialization and the development of a cash economy, midwifery developed as a special field in which professional midwives both men and women could earn a wage. The female accoucheurs were women who had received some form of formal training. Since no institutions in Canada offered this education, these midwives

were usually immigrants from Great Britain and Europe.

From about the middle of the nineteenth century to 1885, midwives played an important role in the development of the University Lying-In Hospital attached to the Medical Faculty of McGill College. They were in charge of nursing and the domestic affairs of the hospital. In the absence of the physician-accoucheur, they were consulted on difficult and abnormal cases and they taught the students a large part of their clinical routine. This continued until 1886 when the Faculty of Medicine deemed it necessary to appoint a resident physician for the hospital. Dr. H.I. Grant was the first appointee (Barrett and Fraser 1943: 24)

During the period between 1843 and 1885 eight midwives served successively as Matrons of the Hospital. The By-Laws, Rules and Regulations states:

that there should always be a permanent nurse in the hospital and if found necessary should be paid \$4.00 (four dollars) a month (ibid 33).

A midwife, who assumed the duties as matron, was usually trained in Edinburgh and designated as "a licensed midwife". In 1885 Mrs. Redmond was appointed as matron and it is not known whether she was a midwife. However in the year 1886, when Dr. Y.H. Grant was made the physician-accoucheur, Mrs. A.R. Rideout, a non-midwife was assigned as matron. It is evident that the newly appointed resident male-accoucheur was firmly

in charge as no knowledgeable midwife retained powers within the hospital setting.

Competition between the formally trained midwives and the physician-accoucheur existed within private practices, especially in the ever-growing urban centres. Midwives from Europe (particularly Great Britain) upon their arrival in Canada succeeded in developing their own practices. Again, little is known about these women. Yet, a casebook of a Mrs. J.A. Parks provides insight as to their knowledge and the birthing conditions of women of that period.

On microfilm at the Osler Library, McGill University is a hand written notebook of maternity cases attended by Mrs. Parks in Montreal from March 1888 to June 1888. During these three months, she attended thirty-cases. At the end of this period the case book was certified by a physician that Mrs. Parks had indeed assisted at the previously mentioned childbirths. Because there is a fairly lengthy reference to a Dr. Cameron's lectures, it can be assumed that Mrs. Parks was a trained midwife from Great Britain who kept this particular record for licensing purposes.

Her nursing notes are of unusual interest. They demonstrate the extensive knowledge of the trained midwives and the accepted causes of problems related to childbirth. Case #1 states:

1. March 4. Pate O'Grady House patient. Membranes ruptured 4.10

A.M. Hour of delivery 4.55 A.M. Labor rapid and very easy. Os fully dilated quite soft and head well down in pelvis. Vertex presentation in second position. Baby long. Administer castor oil third day, liquorice powder fifth & di. [ditto] seventh. Temperature up to present (Parks 1888).

This case is representative of a normal birth. Other cases were not quite so successful. The following is case #24.

24. Mrs. Phillip May 14. House patient. Labor commenced 5 A.M. Os thick & dilation just commencing. At 7 A.M. os rather larger than 5¢ piece pains getting more strong & frequent. Membranes ruptured simultaneously with expulsion of child. Delivered 10:20. Labor normal. Perineum ruptured to second degree. Vertex presentation in first position. F. [foetal] heart is in fast frequency 136 Had catheta [sic] passed up to third day. Temperature up to 104 ... [two words not clear] Skin hot and dry occasional slight chills Pulse rapid and irregular. Two tablespoons of castor oil caused some actions. Patient rather emotional. This cause for high temp. not ascertained. Has had tablespoon of aconite every four hours [two words not clear] had dessert spoonful brandy every two hours On ninth day found suffering from pneumonia. Pulse rapid 148, Temp high 103 4/5 eyes staring countenance blank, delirious since fifth day. Bowels distended, surface dry, tongue hard and cracked no evacuation. Died 22nd May 5 P.M. Infant fed from bottle Cause of death mental trouble deranged brain pneumonia - cause of death puerperal-mania. sex of child male. weight of child 8.3. Length of child 20 in. Length of cord 33" Weight of placenta 1 lb

A third birthing history is of interest, as it provides insight into the relationship of the socio-economic conditions of the parturient woman to the birthing outcome.

26. Sadie Jordan May 17 Sheltering home care. Admitted 12.30 A.M. in first stage of labor. Foetal heart nor head could not be found Diagnosis very difficult owing to weak state of patient. Exact position could not be determined. At 5 and 6.30 P.M. had hot water douche lasting ten and fifteen minutes. Stopped hemorrhage and facilitated labor. Labor slow and... [one word not clear] Membranes

ruptured 6:40. Delivered 7:40 Still born. Vertex presentation position not ascertained. Patient in a very weak condition when admitted. At the time there was slight-hemorrhage which continued until the membranes ruptured. Os dilated to size of penny and placenta attached beyond reach of finger of examiner. During the afternoon brandy was given hypodermically[!] twice and by the mouth once but was not retained thus. Delivery of child was almost immediately followed by that placental delivery with a large quantity of blood about the size of a cricket ball followed the placenta. Teaspoonful of ergot was given with brandy twice hypodermically. Foetus had seemingly been dead some days. Placenta very small and almost a placenta previa shown by the shortness of some of the cord and the length of the others [At this point Mrs Parks through diagrams as well as notes describes a lecture on placentas given by Dr. Cameron. Five note pages later she concludes with:] Patient died May 22 from heart disease. Unconscious for two days. Temperature 102 3/5 Pulse rapid 140. Died 6:30 A.M.

These then are three examples of Mrs Park's nursing notes. They suggest that by 1888 trained midwives had considerable knowledge as it relates to the physiology of birthing. However, as medical journals of this period indicate, there is a general lack of understanding of the causes of postpartum complications.

Just as the female-accoucheurs were establishing private practices so too were men-midwives. The descriptions of their practices differ considerably from those of the midwives. Whereas women kept notebooks with the names of the patients and the sex of the babies or notes on actual cases, the physicians classified their information according to specific criteria. Midwives dealt with the subjective patient; physicians with objective information. This, then, was the beginning of the

scientific approach towards midwifery.

In *The Canadian Journal of Medical Science* of 1877, Dr. R.

Zimmerman analysed four thousand seven hundred and four cases of midwifery attended by James Ross M.D. of Toronto from 1852 to 1877. He noted the ages of the mothers in 3839 cases. The youngest was fifteen years old, the oldest fifty and the most common was age thirty with 445 pregnancies. Maternal mortality rate was 1 in 213 9/11 cases (22 mothers died) and infant mortality in 1 in 16 1/2 (nearly) (287 children were lost). The majority of deaths of mothers was from puerperal fever (4) and 3 died from puerperal peritonitis. Of the 287 infant deaths, 193 were full term and 94 not full term. The latter ranged from the fifth to the eighth month. Dr. Ross recorded the births according to six different categories of presentations (head, breech, foot etc) and even had one category called unclassified presentations. He delivered 76 sets of twins, 136 of whom were saved 18 who died, used the forceps in 173 cases (1 in 27) all with favourable results; and had 5 cases of puerperal convulsion. Finally, he had 13 cases of placenta praevia. Of these 12 mothers survived and 1 died; 2 children lived and 11 died (ibid 138, 139)

This is a brief summary of an extensively detailed account of one physician's practice.

From 1850 to 1900 there existed in Canada a wide variation in

midwifery practices. With the increased specialization and a cash economy, midwifery practices were gradually evolving, thus reflecting the particular configuration of economic cultural and social conditions. It resulted in the male medical profession determining the need to capture greater economic and symbolic capital as it related to childbirth. To achieve such objectives, it was necessary to establish medical hegemony over birthing practices

The concept of hegemony expresses the idea of leadership which is as much ideological as political or repressive. In Gramsci's terms, it is the fusing of all the elements of leadership together, particularly control through repression with control by ideological persuasion. He insists on the notion of both intellectual and moral leadership. "Hegemony, then, critically involves ideological domination." (Abercrombie et al. 1980: 12). There is a balance between coercion and consent in the exercise of hegemony. Although it varies historically, there is generally consent by the weaker, repression by the stronger.

Nevertheless, constraint cannot be taken for granted. Obedience is not automatic but must be reproduced. Therefore it is necessary to analyse the machinery by which ideological domination is effected. Gramsci, in distinguishing between civil society and the state structures, understands civil society as the engineering of consent, while the state

represents the apparatus of repression. It is better "to reserve the term hegemony for the leadership of one group based on a fusion of repression and consent, even if the balance between these two varies" (ibid 13). To understand the process by which the medical profession gained authority over midwifery, it is necessary to examine both elements; medical hegemony through persuasion and consent and medical hegemony through coercion.

Medical Hegemony: Domination Through Persuasion And Consent

Based upon their belief in a midwifery rooted in the new ideology of science, the medical profession resolved to control the practice through ideological persuasion. By establishing their medical practices in a science which was based on chemistry and physics, physicians believed that they could persuade the public of the efficacy of their system of health care and as a result achieve the required consent necessary to establish their authority over birthing. As a part of this process, physicians perceived the need for a new title. The terms "man-midwife", "male-midwife" or "physician-man-midwife" were too clumsy, as well as being reminiscent of the female title. They did not reflect the new science or new skills. "Accoucheur" sounded better, but in England it was rejected because it was French. In 1828, an English doctor suggested the term "obstetrician" as an appropriate title. It is derived from the Latin

meaning "to stand before". Its advantage is that it sound more like an honourable profession, one which is related to the new ideology of controlling nature. It was not until about the 1880's that the Canadian medical journals replaced the term "midwifery" with that of "obstetrics".

This process of transforming midwifery into a science began during the 17th century. The French had achieved much knowledge because they organized their observations of birth around the idea that natural processes were machine-like. The surgeons and midwives spoke of the womb and birth canal as through they formed a mechanical pump with the capacity to expel the foetus (Wertz and Wertz 1977: 32). By defining birth as a natural process, the French reduced its potentially awesome aspects and removed birthing from the constrictions of traditional, magical, and religious explanations. The French achievement was primarily in its natural science understanding of the birthing process.

Midwifery in England had a different beginning, in that physicians here discovered new techniques with which to aid birthing. It began with the medical empirics and barber-surgeons struggling to save the life of the mother by extracting the foetus with whatever tools they could devise. They used instruments such as blunt hooks to bring down the thighs in a breech delivery, sharp hooks and knives, and perforators to puncture the foetus's head when it was impacted or dead, and a speculum

to dilate the vagina. In the early seventeenth century Peter Chamberlen invented the forceps. This was an improvement over other instruments as it freed the foetus without killing it. Since it was the custom of the surgeons to regard the tools as their own property, the Chamberlen family kept the forceps a family secret for more than a century. Gradually within the field of midwifery there was a fusing of the two traditions of French science and English forceps. These two elements in midwifery care became the basis for a system of birthing which the physicians believed would be efficacious for parturient women. All they needed to do was to persuade women of the effectiveness of their medical assistance.

Initially the surgeons limited their attendance to abnormal cases. This meant that the midwives could continue to deliver the normal cases that constituted the majority of practice. However, by the second half of the eighteenth century, men-midwives began to attend the normal cases, thereby posing a serious threat to the women's domain. It is at this time that figures such as William Smellie revolutionized obstetrics.

Smellie was determined to investigate scientifically the mechanical process that constituted normal childbirth. He was the first to make careful precise measurements of the normal female pelvis; to investigate its shape and dimensions. He studied the external shape of foetal head and with this information arrived at an accurate explanation

of the manner in which the head passes through the pelvic basin in normal childbirth. Once this was accomplished, Smellie studied the various types of malformed pelvises among women. Then he alerted men-midwives "to the necessity of acquiring 'an accurate knowledge of the figure, shape, and dimensions of the *Pelvis* together with the shape, size and position of the child's head'. This information would then enable them to proceed correctly with delivery." (Donegan 1978: 62). Along with his contribution to the knowledge of midwifery, Smellie became England's leading midwifery instructor.

A second physician, William Hunter, one of London's most fashionable midwifery practitioners and a former student of Smellie's contributed to the understanding of the gravid uterus. In 1774, he culminated twenty years of work with the publication of *The Anatomy of the Human Gravid Uterus*. Upon until this time, knowledge of the human uterus was based upon what was known of lower animals. Hunter's knowledge was obtained through the dissection of a pregnant woman who had died suddenly. He later acquired two other bodies which caused him to amend his original design.

Taken together, the works of these two figures were primarily responsible for affecting the revolution which produced the "new obstetrics". As midwifery continued its transformation into science, it

was brought into medicine and legitimized as a practice for men. At this time the medical profession was ready to establish medical hegemony over birthing practices. Further developments in technology only served to enhance medicine as the ideal authority over midwifery, and the medical profession set out to persuade the public of this fact.

In 1847, Dr. Worthington of Sherbrooke used an anaesthetic for the first time in Canada. He performed an amputation. Dr. Worthington was pleased with the results and suggested the use of ether by the accoucheur. Dr. A. F. Holmes was the first to use anaesthetic in a case of midwifery.

On January 25th 1848 the patient inhaled the drug and

'fell into what appeared a heavy slumber. The labour pains were evidently retarded, the interval between them being much increased, but they came on, although all the usual appearances of strong action were manifested, she continued to sleep and did not complain. The inhalation was continued for some time, but finding no advance of the head, I resolved to apply the forceps hoping she might remain under the soporific influence of the medicine, and was quite *conscious* during the application of the instrument which was made with great ease' (Heagerty 1928: 307).

A second major development in obstetrics in Canada was the application of Lister's antiseptic methods in 1877. Physicians Roddick, Stewart, Grassett, and Malloch brought with them from England the apparatus and carbolic solutions then in use by Lister. The introduction of rubber gloves by Halsted of The Johns Hopkins Hospitals was a second valuable aid. These techniques laid the foundation for more extensive

examination during labour and the development of appropriate operation procedures such as the Cesarean section. They therefore had a profound influence on the whole trend in obstetrics and the appropriation of birthing by the medical profession.

The following description of the state of the development of obstetrics is detailed. In retrospect one could dismiss maternity care in the 1880s' as primitive. Nevertheless, it should be remembered that in relation to the development of medicine in general, these achievements in obstetrics were significant. At this time operative procedures in childbirth became more successful, and as a result, technological intervention in childbirth gained in momentum. The purpose of describing the profession of medicine's account of the practices which they deemed as important to obstetrics is to provide a picture of the maternity care upon which the medical profession built its case for medical hegemony over birthing practices. It is through the practices that are described that physicians hoped to persuade women of validity of their claim as the rightful authority over childbirth.

In the article entitled "Report On Obstetrics" found in the 1881 edition of the *Canada Medical And Surgical Journal*, Dr. W.M. Gardner (1881) a professor at McGill University provides insight into the state of obstetrics. After stating the principal books and papers in obstetrics and

gynecology, Dr. Gardner examines the latest obstetrical techniques. Based upon the work of Professor Stadtfeldt of the Copenhagen Lying-In Hospital, he outlines a method for antiseptic midwifery: systematic syringing of the vagina before labour, the use of carbolic steam spray during labour, and intra-uterine injections after labour.

A second technique discussed was basilysis (crushing the foetal head while the mother is in labour). Professor Simpson in a paper read before the Edinburgh Obstetrical Society proposed replacing cranioclasm (the crushing of the foetal skull with an instrument called a cranioclast) with a simpler instrument, "a trephine of peculiar construction" which would break up the base of the skull by dilaceration.

Early use of forceps was another area of interest. In the discussion of 1879 of the Obstetrical Society of London, Dr. Barnes introduced the topic of early use of forceps. "The great majority advocated the earlier and more frequent use of forceps under circumstances and in conditions of the parts in which the older obstetricians would not have dreamed of applying them" (ibid 150). This suggests increased technological intervention, something many physicians believed was necessary if they were to persuade parturient women of their right to regulate midwifery.

For one hundred years prior to 1876, every woman who had received a Cesarean section died. Then on the 21st of May of that year, Professor

Eduardo Porro of the University of Pavia performed surgery later referred to as the Porro operation (removal of pregnant uterus, the ovaries and tubes through an incision in the abdominal wall). For the first time in the history of this type of operation the woman lived. Within the next four years, fifty Porro operations were performed in various European countries and in United States. The record shows that 20 of the fifty women recovered. This is in contrast with the 62 operations old Cesarean style in which all but 3 died. With the Porro operation 1 in 7 lived; old style 1 in 21. Successful Cesarean operations provided proof to the physicians of the effectiveness of their new approach to midwifery. It was an important achievement in their quest for control over midwifery activity.

There is a second surgical technique, that of Laparo-Elytrotomy (Laparo-operation through abdominal wall; Elytrotomy-incision of vaginal wall). By 1870 only 8 such operations had been performed. Of these 8 cases, 5 mothers survived as did 6 children. This appears to have been a less popular operation. In commenting upon these two surgical techniques, Dr. Gardner stated that no Caesarean operations had been performed in Canada. However "when necessity for operative interference does arise, the question, it seems to me, will lie as between the Porro operation and Thomas's Laparo-Elytrotomy" (ibid 153).

For puerperal convulsions, Dr. Clarke of Oswego advocated injecting the patient with 1 1/2 grains of morphia by weight and asserted that he had great success with this treatment. He believed that morphia should be used not only for the developed disease but as a preventive measure. For symptoms such as headache, mental dullness, ataxia, affections of vision etc. opium varying from 1 to 3 grains per diem should be given.

Professor Nunn of the Savannah Medical College developed a new method for checking the hemorrhage in placenta praevia. A speculum was introduced into the vagina and by means of a swab the solution of perchloride, or sub-sulphate of iron was applied directly to the bleeding point. This treatment was to be repeated as often as may be necessary for subsequent bleeding from successive portions of placenta. The solution must always be applied directly to the bleeding point.

Another postpartum complication was that of puerperal malarial fever. Dr. Fordyce Barker of New York studied 17 cases occurring in his own practice and that of other medical men in New York and vicinity. Approximately 21 to 24 days after childbirth the patient developed malaise, severe chills and a very high temperature. A day after such "a violent explosion" there was a remarkable remission. Two to three days later the symptoms returned. The treatment was the same as that of malarial fevers occurring under other circumstances. When tolerated,

Warburger's Tincture was deemed to be more effective and faster in controlling the disease, than quinine in the largest doses. As indicated by this description, the increased use of medication played an important part in the development of the "new" obstetrics. Since only physicians can prescribe medication, it would follow that only these practitioners can rightfully administer the activities surrounding childbirth. This is a persuasive claim in a debate which seeks to transfer authority over childbirth from a lay midwifery to a profession of physicians.

Intra-uterine injections were the accepted treatment in cases of septicemia. Two physicians, Dr. Jenks of Chicago and Dr. Cadwick of Boston recorded the number of cases by their particular methods and conclusively demonstrated the advantages of their treatment. Dr. Jenks used both carbolic acid and potassium permanganate; Dr. Chadwicks potassium permanganate only "which has advantages in that it is so readily soluble, that it is not irritant in solutions of moderate strength, and that by the color of the returning liquid we know when the disinfectants has no longer any work to do" (ibid 155). Dr. Goodell stated that he did not approve of the use of intra-uterine injections as a preventive measure because of "the danger of conveyance of infection, seeing that they must be administered by the physicians, whose fingers are thus soiled by infectious discharges; in the developed disease he

thought them a reliable remedy" (ibid 156). The treatment of infections associated with childbirth became an important area of research during this time. Such research fell under the jurisdiction of physicians, a fact which reinforced their authority over birthing. It should be noted, however, that in their zeal to find cures for these infections the scientists overlooked the more basic problem; that of the role of hospitalization of pregnant women in the development of puerperal infections. In other words it was an iatrogenic disease, something which went unrecognized.

At a conference at Cork in 1879 members of the obstetric section of the British Medical Association presented a number of treatments for postpartum hemorrhage. They are as follows:

- 1) Preventive measures during labor; (a) rupture of membranes during the first stage, stimulating enemata of strong infusion of ergot and hypodermic injection of ergotine in the second stage; constant firm pressure on the fundus uteri after the appearance of the child's head; and avoidance of the least traction on the cord,
2. Injection of water at a temperature of 110 degrees to 120 degrees ;
3. Injection of water at a temperature of 105 to 110 degrees.,
4. Cold douche to abdomen;
5. Continuous flapping of the abdomen with a towel dipped in cold water,

6. Injection of hypodermic ergotine; and
7. Perchloride of iron injections.

At this time researchers were examining possible solutions for transfusion. The three mentioned substances were; a weak solution of common salt; cow's milk; and blood or serum of other animals. Of interest was Mr Schafer's work in which he injected rabbits with small quantities of boiled milk. The rabbits invariably died within twenty-four hours. He concluded that any solutions must be either normal or defibrinated human blood. Transfusions would consist in connecting directly with a short flexible tube with glass canulas at each end, the vein of the donor with that of the recipient. The amount to be given from veins would require 3 or 4 minutes; from artery a 1/2 to 1 minute.

This then is a summary of obstetrics in the 1880's as outlined by Dr Gardner. It indicates that doctors viewed childbirth as risky. Therefore, it was best to prepare for the worst eventualities. Treatments were becoming more precise. Physicians were in search of effective manipulations and interventions both to cure and to prevent disease. All of this necessitated the transferring of birthing from the hands of a lay midwifery to those of a profession of physicians. Such arguments were persuasive in a society which was entering into an era in which science was assuming a new importance. Physicians believed that

the activities, which have just been described, would serve as the foundation for a "new" obstetrics, one which would fall under their authority. They were gaining momentum in their drive to capture greater symbolic capital, which in turn would eventually lead to medical hegemony over birthing.

Dr. Goodell's reference to physicians whose fingers are soiled by infectious discharges is indicative of an attitude which was beginning to develop. Physicians assumed that disease might originate in the hospital environment. As a result they had wards aired and washed with carbolic acid at regular intervals. Nurses were required to change their uniforms and bathe on schedule. It was also assumed that the patients themselves were carriers of disease. Women were treated as though they harbored germs which could kill them. Upon entry into the hospital, clothing was removed and the patient's hair was cleansed or shaved. The enema, an ancient practice was routine as doctors thought that accidental bowel movements might cause the fever. "Cleaning, shaving, and purging the patient were not merely training in cleanliness, they constituted preventive treatment, a broad prophylactic program to eliminate disease" (Wertz and Wertz 1977: 137).

In an article in *Medical Surgical Science* of 1875, Dr. Goodell, Professor of Diseases of Women at the University of Pennsylvania

provides a detailed account of the procedures developed for the management of parturient women in hospital. Wards were used in rotation, one always left vacant for two or three weeks. Once the ward was emptied the doors and windows were kept constantly open until it was once again used. Walls, beds, furniture and floors were scrubbed with carbolic soap, followed with a weak solution of carbolic acid. No water was allowed to be used on the floors until the ward was emptied again. Nurses, who worked on the ward went off duty for a week in which time they passed through a system of purification. The beds of straw were changed with each patient and bed clothes and blankets were boiled in water and a small quantity of carbolic acid. Bolsters, pillows etc. were baked once a year.

Women were required to take a bath once a week. Poor health was treated with quinine and porphoren acid; headaches and sleeplessness with warm baths and large doses of bromide of potassium. The bowels were kept relaxed and purged. Once labour began, the woman was placed in a warm bath. The membranes were ruptured artificially and the second stage was never allowed to be prolonged. The placenta was removed as quickly as possible, the cord cut, and stripped of blood and gelatin. The infants umbilical cord was allowed to dry naturally.

A day after the delivery, women were encouraged to get out of bed.

Morphia was given every hour for after pains. If this was not helpful then grains of quinine was given every six hours until the ears rang. No bed pans were used although vaginal injections were employed. Every woman washed herself daily with carbolic soap and a pad of fine oakum. No nurse was ever allowed to wash the woman's perineum. Vaginal injections were used for foul lochia.

It was Goodell's belief that these routines for cleansing and manipulating birth made delivery safer than home delivery.

Dr. Goodell believes that one of the reasons why the statistics of lying-in hospitals can never compete with private practise is, that the former are reliable, the latter not. His experience closely corresponds with Dr. Mathew Duncan's, and with that of all who have taken the trouble to investigate the matter thoroughly. It cannot be too strongly urged that the mortality of child-bed is much higher than what is generally stated, and that ailments arising from it are of a more serious nature, and more frequent than most medical practitioners suppose (Medicine Surgical Science 1875).

Thus, the belief of the efficacy of hospital births over home births was initiated by the medical profession. For the next one hundred years, in spite of contradictory data from Canada (Oppenheimer 1983) and United States (Brickman 1983), the medical profession continued to perpetuate this belief. The fact that medicine found its legitimation in science did not in any way deter the medical profession from rejecting all scientific data which contradicted their assertions. In the latest research in 1986, the Legislature Research Service of the Ontario Government concluded

that given that narrowly defined concept of safety by the medical profession home births are as safe as hospital births. If an alternative view, which sees safety in a much broader context including emotional, psychological and long-term child development factors is considered then home births are in fact safer than hospital ones. In the conclusion the report states.

Although opponents cite statistics and studies to support their rejection of home births, they are frequently flawed by serious methodological and analytical problems. The best available research does not support the view that home birth is inherently and inevitably less safe than in hospital (Legislative Research Service 1986: 21).

From the description of the emerging medical practices as they related to obstetrics, it can be concluded that physicians sought to establish hegemony over childbirth through the engineering of consent. They believed that once parturient women became aware of the new developments within obstetrical practice, they would be persuaded as to their efficacy. To a certain extent their assumptions were correct, in that some women believed that the new medical model of obstetrics was indeed the way of the future. Nevertheless, not all women were ready to commit themselves to this approach to maternity care. Control of birthing practices required ideological persuasion. If the medical profession could not persuade all woman that birthing in hospitals with

the assistance of a physician was the only safe option available, they, by necessity, must revert to the second element in medical hegemony, that of coercion.

Medical Hegemony: Domination Through Coercion

The concept of hegemony expresses the idea of leadership of one group based upon a fusion of persuasion and coercion. In the preceding section, I discussed the medical profession's use of persuasion in their struggle to appropriate midwifery. In this part, I will examine their use of coercion in their quest for legitimate authority over birthing. There were two ways in which physicians coerced women and midwives. The first was socio-political coercion. By linking physiology to feminine nature, physicians reinforced a perception of women as frail and dependent (Ehrenreich and English 1973, Schiebinger 1987, and Lewis 1983). Once this gender attitude was internalized by a greater cross-section of women, it had the effect of creating a mistrust in the abilities of the female birth attendants, and a need for male physicians. Their second coercive measure was through licensing procedures. In each province and the territory, the governments granted the medical profession the right to license midwives. Traditional birth attendant who were caught assisting women in childbirth, were charged, brought to court, and forced to stop their activities. Although the majority of these

cases have been lost to history, three precedent setting ones can be found in the court records. They are: *The Queen v Whelan*; *The King v Rondeau*; and *The King v Roffenberg*. These will be described later in this section.

In their article on American midwifery, Wertz and Wertz (1981) state that the choice of medical attendants was the responsibility of women upon whom devolved the care of their families' health. "Women were free to choose whom they wished" (ibid 168). This assertion, although questionable even for the United States is certainly not true for Canada. As of the first legislation on the subject in Ontario in 1865 through to the last statutes of Alberta in 1906, women were restricted to employing birth attendants who had been duly registered and licensed by the college of Physicians and Surgeons within their particular provincial jurisdiction. Women who assisted other women in childbirth were deemed to be practising midwifery without a license and subject to heavy fines. Appropriation of birthing practices by the medical profession required not only control by ideological persuasion but also by coercion. It was the state upon whom the medical profession relied to provide the machinery necessary for jurisdiction over antagonistic groups. In pre-modern societies, through state apparatus, responsibility for licensing midwives was handed over to the ecclesiastical authorities (Forbes 1966); in late nineteenth century Canada it was given to the

medical profession.

For Gramsci (Abercrombie et al 1980) there is no such thing as an autonomous intellectual stratum. All intellectuals and in this sense physicians are attached to a social class and perform the function of articulating the view of the world which is appropriate to their class. As far as the medical profession is concerned it is an intellectual stratum which refines and presents its world-view, therefore a part of the apparatus which preserves and transmits the ideological component of the ruling class. From the eighteenth century on, physicians assisted the women of the upper classes in childbirth. As of 1865, they proposed to extend their authority over women of all classes within Canadian society. Yet coercion involved more than just control of birthing procedures through the state intervention. If all women were to participate in the medical model of birthing, they must believe not only in the male obstetrician's competence but also in their own frailty. Thus, the belief in the frailty of women and their dependency upon men was extended to include women of the middle classes, although women of the lowest class were to assume a different role. It was a period of socio-political coercion.

According to Lewis (1983) one of the most influential writers of this time was Herbert Spencer. In his work, Spencer presented an

argument which justified the position of the upper and middle class Victorian women. He contended that sex roles were a product of mankind's successful adaptation to social survival. The sexual division of labour was indicative of social progress and a reflection of organic law. By arresting women's individual development, energy is conserved for the development of their reproductive systems. According to Spencer, the more highly developed the society, the more differentiated would be the sex roles, and the more capable women would be in producing better children. He therefore condemned any attempt to change women's position in society as well as opposing state intervention to safeguard the position of the poor and weak (ibid 11).

Lewis (1983) states that based upon Herbert Spencer's ideas physicians wrote of the importance of adolescent girls conserving their limited energies for development of their reproductive organs. It was women's duty to sacrifice, particularly with respect to education in order to ensure the continuation of the race. The time of sacrifice began at menstruation. At this point in their lives, according to the physicians, young women must make an important psychological change by shifting the emphasis from self-centredness to consideration of others. The successful accomplishment of this transition assured a normal, well adjusted adult both sexually and socially (Mitchinson 1979: 18). It was

women's bodies which imposed the service role on women, not society. Therefore should women choose to expand their activities in society, they were working against their very own physical being. Such activity was doomed to failure.

Authors such as Lewis (1983), Mitchinson (1979) Ehrenreich and English (1973) and Schiebinger (1987) have outlined the arguments in which "researchers" have sought to link women's social inferiority to their supposed biological inferiority. Schiebinger (1987: 325) believes that scientists in the twentieth century have given their prejudices a modern dress through research "based on hormonal research ... brain lateralization ... and sociobiology".

Based upon her research of medical journals, Mitchinson (1979) outlined the view of women which permeated medicine in the nineteenth century. The articles revealed that physicians believed that men and women were mentally equal until puberty. After puberty women did not keep pace with their male counterparts. Their mental growth became slower and more limited until after menopause when their mental qualities became more male like. Since after puberty the reproductive functions "dominated" women, it was necessary to educate the sexes differently. To educate women with men was to weaken their nervous system. Women were required to let their bodies develop, to prepare for

maternal function. This they could not do if they studied. (Ehrenreich and English (1973) have also discussed this at length). Education influenced the development of gynecological diseases. Physicians argued that too great assiduity in study in the early youth concentrated the nerve-energy on the brain, thus depriving the uterus and ovaries of their share at a time when these organs were undergoing an enormous development in preparing for motherhood. Such activity could lead to disease (painful menstruation) and even sterility (Mitchinson 1979: 20). Such arguments provided the opponents of higher education for women with ample ammunition (Ehrenreich and English 1973). It should be pointed out that physicians were not against all education for women. They supported that type of training which would prepare women for their domestic roles within society.

That physicians encouraged their female patients to think of themselves as frail has been discussed by several writers (Lewis (1983), Mitchinson (1979), Ehrenreich and English (1973), and Schiebinger (1987). As one nineteenth century practitioner put it, it meant that womens' constitutions were believed to be inherently unstable throughout the life cycle (Lewis 1983: 14).

While researching the medical journals, I found this article which appeared in *The Canada Medical Record* of 1887 (239). I would suggest

that it illustrates well this perception of women's physical frailty. Its title is of interest also. It is called "Girl Doctors".

On the much vexed question as to whether women should be allowed to compete with men for the practice of the medical profession, we have always held the opinion that no obstacle should be thrown in the way of their having a chance. If it is an easy way of making a handsome living, by all means we say women have as much right to it as men. At the same time on the question as to whether such women, whose mental endowments are such as to fit them for a physician's duties, are likely to have the necessary physical strength, is a question upon which we have always had our doubts. As the editor of the *Medical Times*, Philadelphia, says: "There are certain responsibilities which the physician, - man, or woman, - must assume. In no walk of life is a shirk more out of place. Office work and attendance on the wealthy make no serious calls upon one's strength, and as long as ladies' work is limited to these easy tasks, she may do very well." We commend the following case to which he refers to the attention of any lady who is thinking of entering our profession. A young girl of his acquaintance started out in her professional life, precisely as a young man must do. She had no means, and she began with the poor - "the alley folks." She took a poor district; turned out of her bed at night in all sorts of weather to visit the filthy denizens of the seventeen family house, and similar places; was cheated most unmercifully by those she served; and, in a word, did just what any young male physician in similar circumstances must do to get a start. He noticed her when she graduated as a bright, pretty girl, with so much intelligence that one could not help sympathizing with her desire to make of herself something more than ordinary. It was five years later when he saw her again. The struggle for existence had told heavily upon her; she had aged greatly, and her fresh, youthful beauty was gone, and hard lines on her face told of the severity of the struggle. She was disheartened and weary, and in less than six months more she was dead. He felt satisfied that she had died in the hopeless endeavor to show that women can fill men's place in the world.

Many physicians were environmental eugenicists, who, while still adhering to a belief in the importance of better breeding, felt that social

reform had an important role to play. They were concerned with the quality of motherhood and infant mortality. Their attention therefore fell upon lower class women who were condemned for their child rearing habits. The solution was believed to lie in educating lower class women on the care of infants and children. While ignoring the material conditions, society offered the poor pre-natal and childrearing education. There is a paradox in the physicians' position. Whereas middle class girls and women were seen to need protection and encouraged not to take their health into their own hands, working class women were encouraged to take on the guardianship of the health of the whole family. "The consistent strand was the denial of autonomy, something that also permeated the movement of childbirth from home to hospital and the curtailment of female midwifery and the prohibition of female lay attendants" (Lewis 1983: 14, 15).

Within Canadian society and particularly in the West, where the settling of the land required a vigor and hardiness in women which was apparent in the East prior to the late nineteenth century, not all women accepted this prescribed notion of themselves. Of particular interest is Dr. Elizabeth Matheson, whose contribution to her community and role as a liberated woman is most admirable, even by today's standards. In her relationship with midwives she set an example which could be emulated

today Dr. Matheson's life provides evidence of the restraints imposed upon women by the social conditions of the time.

Elizabeth Matheson was born in Manitoba in 1866. In 1887 she was enrolled in the Women's Medical College and registered at Queens University, Kingston. Every woman who enrolled was aware of the strong opposition there to women in the field of medicine. The faculty at Queens had been established in 1854 and was reorganized in 1866 as the Royal College of Physicians and Surgeons. It was affiliated with Queens, a proud distinction it retained in 1891 when it resumed its former status.

In the summer of 1880 a course of lectures for women only was established. Then in 1881-82 six women were admitted with a separate dissecting room, and a classroom adjacent to the general one where they might take jurisprudence, obstetrics, anatomy and physiology separately. The following year the male students sent their ultimatum to the faculty; if the women were to continue at the College, the men would go en masse to the University of Trinity College in Toronto.

Of the small group of women who were then in their third year of studies, and who experienced the full force of that unjust and deliberately instigated revolt, two became instructors in the Women's Medical College - a College that seemed the best solution to a troubled situation though a similar one for women was opened at the same time in Toronto (Buck 1974: 24).

From then on, although students attended Queens for classes in chemistry

and botany, all classes in medicine were conducted in the rooms at city hall.

Elizabeth, while living with her brother Tom, completed her first year of medical school. In the summer she enrolled in a second-year chemistry and botany completing both classes successfully. The following year, Elizabeth left for India under the auspices of the Presbyterian Board of Missions in Toronto. Upon her return from India, she did not resume her medical education but married an old childhood friend John "Grace" Matheson. John Grace, who was eighteen years older than Elizabeth was born in Kildonan on the Red River. At age fifteen he taught school and did farm work. In his early twenties he became a trader and buffalo hunter while living with the Indians and Metis. He spoke both French and Cree. After his marriage to Elizabeth, they moved to the Territories where they settled on the Indian Reserve in Onion Lake Saskatchewan. John was a teacher with the Anglican Mission in the Diocese of Saskatchewan.

Elizabeth settled into her role as wife and mother. The stories of her confinements illustrate the precarious situations which existed for parturient women. Of her first pregnancy, the author, Elizabeth's daughter writes:

She was buoyant with health and energy, not in the least worried as

her time approached. She had asked a white woman to attend her, the only other one except for the Sisters. It was a natural enough inclination, and John Grace said nothing to alarm her. The woman was capable - when she was sober. She was more likely to be drunk, however, if given the least excuse - and that was supplied by an Indian woman who came to the Mission on the morning that Elizabeth's labour pains began, and who carried the news promptly. When her help was sought, the intended midwife was quite incapable of giving any.

Matheson turned at once to run the mile to the Hudson's Bay Company post, most of the distance uphill. He appealed to Mrs. McKay, and then raced back again on foot to the Mission, while she waited for a horse to be harnessed. At four in the afternoon, the child was born, a healthy ten-pound girl. (ibid 58).

And for the second child the author writes.

An old Indian woman had thrust herself in, eager to assist; but Elizabeth had learned that it was usually their custom to cut the cord close, and then stop the bleeding with a paste of astringent herbs that they kept with them for such purpose. She was terrified for her baby, and her Cree was quite inadequate to make the old woman understand. John Grace settled the matter simply by putting her out of the room, and delivering the baby himself (ibid 67).

A few years later, it was decided that Elizabeth should return to medical school. Because of the numerous problems on the reserve there was a dire need for a physician. It was John Grace who believed that Elizabeth should fulfill her potential, by completing her education and by becoming the doctor for the area. With her two children, Elizabeth returned to Winnipeg where she lived with her husband's younger sister. She enrolled at the Medical College which was more than a mile from her sister-in-law's home. In all kinds of weather she walked across the open prairie to the lectures.

She was the only woman to attend that year, although two others had graduated from the College. She was accepted and received credit for her entire year at Kingston and the two courses she completed in the summer of 1888. However, Elizabeth did not graduate from the Medical College in Winnipeg but finished her education at the University of Trinity College in Toronto where she graduated in 1898 with the degree of Doctor of Medicine. Dr. Elizabeth Matheson then returned to Saskatchewan where she assumed her duties as physician on the Indian reserve. She practised medicine in the Territory of Saskatchewan from 1898 to 1918.

Dr. Matheson continued to combine her roles as wife, mother and physician. She had more children and each time was attended by midwives. At the birth of her fourth daughter two Indian women assisted her. For later births, she depended upon the "practiced" hands of Mrs. Slater, who herself had had five sons and three daughters. The seventh confinement was a difficult one. Again she was attended by Mrs. Slater. The labour was prolonged for five days. Yet Elizabeth recovered quickly and once more became involved in her duties as physician. Her daughter writes:

There were many obstetrical cases, though often Elizabeth was not called until delivery proved difficult. Her own confinement that summer went smoothly, with Mrs. Slater's cheerful assistance again (ibid 128).

The story of Elizabeth's life is of interest to this discussion. Not only did she accept childbirth as a natural phenomenon which could be handled successfully by a midwife, but her whole life style as an educated woman, physician and mother to a large family directly contradicted the widely held views of the medical profession on the physiology of women.

Dr. Matheson had other problems with the medical establishment. She was registered with the College of Physicians and Surgeons in Manitoba and when she returned to Onion Lake she once again requested registration in the Northwest Territories. As in a previous attempt at registration she was told once again to appear before the council in Calgary. Her husband John Matheson was annoyed, and wrote the cheque for fifty dollars. Her registration returned within the next mail.

She would never know why the decision had been altered. Perhaps her registration in the College of Manitoba had been confirmed, and was so recognized. That would seem the most logical reason; and yet she held to her own explanation, for she was well aware of the discrimination against women in Medicine. She was certain that her registration came because of John Matheson's signature on the cheque. Until then, she was simply some unknown woman in the territory of Saskatchewan who believed that she should be registered to practise Medicine without subscribing in every detail to the ruling of the College of Physicians and Surgeons (Buck 1974: 114).

As much as the medical profession aimed to gain control of birthing practices through socio-political coercion, it was the establishment of

laws by the state for licensing midwives which had the greatest impact. Through the use of parliamentary statutes, courts and police, the state provides the machinery necessary for one group to dominate another. One need only to examine the political figures of the day to understand within whose hands power lay. Dr. Tupper, a country physician, was Premier of Nova Scotia, Canada's High Commissioner to London, and Prime Minister of Canada. Sir Frederick Borden, who also practised medicine in Nova Scotia, was a cabinet minister in Laurier's government. Sir Thomas Roddick M.D. dedicated a great deal of time and energy in having the Roddick Act (the Canada Medical Act) of 1902 passed. These very strong alliances between the medical profession and the legislatures ensured the passing of statutes favourable to physicians. Such laws symbolically consecrated (by recording them in a form which renders them as both external and universal) the structure of the power relationship between the two groups (physicians and midwives). This objective mechanism (Bourdieu 1977) produced and guaranteed permanent relations of domination.

The first statute was passed in Ontario in 1865. From then until 1906, all the provinces passed a medical act which in one form or another established medical councils, powers to regulate admissions to medical programs and licensing, fines for practising without a license, and in some instances fees to be charged. An example of such a statute is The

Quebec Medical Act of 1877. First, it established The College of Physicians and Surgeons of the Province of Quebec. From the college, the members would establish a board of governors of forty members, each elected for three years. The act stipulates the representation on the board from each area i.e. nineteen members residing in Montreal etc. and from each university (two members). It then lays out the number of times the board must meet per year, plus the powers it retains with regard to the admissions of students to medical programs and licensing.

The Quebec Medical Act (but not all the Statutes) discusses the powers the council retains over tariffs.

It shall have power to make tariffs of rates to be charged in towns and country for medical, obstetrical or surgical advice, or for attendance - or for the performance of any operation or for any medicines which shall have been prescribed or supplied (*Medical And Surgical Journal* 1877. 331).

It also records the penalty to be given to those who practise without a license.

Any person ... [convicted in] this province, of having practised medicine, surgery or midwifery in the Province of Quebec, for hire, gain, or hope of reward shall, upon summary conviction before a sheriff, or district magistrate or recorder, or judge of the sessions of the peace be condemned to pay a fine of not less than \$25 nor exceeding \$100 (ibid 334- 335).

It is the clauses relating to the practise of midwifery which are of particular interest to this analysis. Such clauses vary with each

provincial medical act and not all regulate midwifery. For example, an Act Relating to Physicians and Surgeons (1871), of Prince Edward Island states "From and after the passing of this Act no person shall practice physic or surgery within this Island, ... unless he or she shall have been carefully examined by a board of Examiners (*Acts of the General Assembly of Prince Edward Island* 1871: 158). There is no mention of midwifery in this act, nor in one passed in 1874. Therefore, it can be assumed that midwives continued to practise in Prince Edward Island without fear of a legal penalty.

In New Brunswick the medical act was passed in 1881. It stipulated that no person shall practise physics, surgery or midwifery within province without being registered by the council of physicians and surgeons. Yet the final clause (45) states:

Chapter 93 of The Consolidated Statutes of New Brunswick, 'Physicians and Surgeons' is hereby repealed; provided nevertheless, that this Act shall not apply to or be construed to extend to Clairvoyant Physicians practising at the present time in the Province, or to Midwives (*Statutes of New Brunswick* 1881: 51).

Therefore, it is unclear whether midwives were free to practise or not. Perhaps as in a previous act in Ontario, male-midwives were required to register while female midwives could continue to practise without a license.

The medical act of Nova Scotia (1872) is interesting because its

reference is only to midwives in Halifax. It states:

Nothing in this Act shall prevent any competent female from practising midwifery in Nova Scotia; except that any such female must satisfy the Provincial Medical Board of her competency, and obtain a certificate from the Registrar to that effect, before she can lawfully practise as aforesaid in the City of Halifax (*Laws of Nova Scotia* 1872: 53).

This clause indicates that in Halifax only were midwives required to be licensed, leaving those in the rural areas free to continue their practices uninhibited by such restrictions.

The Quebec Medical Act of 1877 is explicit in its requirements. All physicians, surgeons and midwives must be licensed and licensing of midwives falls under the provincial medical board.

The Provincial Medical Board shall have the power to make rules and regulations respecting the admission of females to the practice of midwifery in this province (*The Medical and Surgical Journal* 1877: 333)

In Ontario, the Medical Act of Upper Canada (1865) limits its reference to midwives to one phrase "to practise midwifery". This phrase is of interest in a court case (The Queen v Whelan) held in 1900 in which Whelan is charged with practising midwifery. The act states:

... and by every other college or body in Upper Canada, by law authorized or hereafter to be authorized to grant Medical or Surgical Degrees or Certificates of qualifications to practise Medicine, Surgery and Midwifery (*Statutes of Upper Canada* 1865. 153).

The Medical Act of Manitoba, passed in 1871 contains a clause which

is similar to that of Ontario.

Subject to the exceptions hereinafter made, no person shall practice physic, or surgery, or midwifery in the Province of Manitoba, unless he has obtained a license from the said 'Provincial Medical Board' who are hereby authorised to issue such license; ... (*Statutes of the Province of Manitoba* 1871: 60).

The Medical Ordinance of the Northwest Territories of 1888 served both Alberta and Saskatchewan until 1906, when at that time both provinces passed their own Medical Profession Acts. In the Northwest Territories statute, only those who practised medicine and surgery were required to be registered. Midwives were free to practise unhindered by any legal precept. With the passing of the Alberta Medical Profession Act and the Saskatchewan Medical Profession Act both in 1906 the practise of midwifery required a license.

... those persons only whose names are inscribed in the register and who are not under suspension by the council shall be deemed to be qualified and licensed to practise medicine, surgery and midwifery in the province except as hereinafter provided and such register shall be at all times open and subject to inspection by any person (*Public Statutes of the Province of Saskatchewan* 1906: 231-232).

The clause within the Alberta Act is similar to that of Saskatchewan (*Statutes of the Province of Alberta* 1906: 268).

Finally in British Columbia, it appears that midwives were free to continue in their practices. The Medical Ordinance of 1867 refers only to the licensing of physicians, surgeons and practitioners of apothecary:

Any person who shall wilfully and falsely pretend to be or take the name or title of a Physician, Doctor of Medicine, Licentiate in Medicine and Surgery, Bachelor of Medicine, Surgeon, General Practitioner, or Apothecary, or any name, title, addition, or description implying that ... he is recognized by Law as a Physician, or Surgeon, or Licentiate in Medicine and Surgery, or a Practitioner in Medicine, or an Apothecary, shall upon, a summary conviction for any such offense, pay a sum not exceeding one hundred dollars (*Statutes of the Province of British Columbia* 1867: 260).

From this description it is evident that conformity in laws relating to the practice of midwifery did not exist within Canada prior to the Canada Medical Act of 1902. Each province sought to deal with the problem in its own particular way.

That women were charged with practising midwifery without a license is clear from a search of the medical journals and court records. In *The Canada Medical Record* of 1883-1884 (144), a detective officer C.E. de Lamorande in a letter to the journal states: "An unlicensed midwife by the name of Adeline Rivet, wife of A. Lafortune, of l'Assomption, has paid a fine, without costs, before the taking of the action against her, and promised to retire from practice".

There are three court cases, *The King v. Rondeau*, *The King v. Roffenberg* and *The Queen v. Whelan* which illustrate the effect the provincial medical acts had upon women in their practices of midwifery. The first case; that of *The Queen v. Whelan* occurred in 1900 at the Court of General Sessions, County of York, Ontario. Polly Whelan was convicted

by the police of the city of Toronto of illegally practising medicine for her gain, and hope of reward, within the space of a year between the 24th of October 1898 and 24th of October 1899, by prescribing for and attending and operating on Mrs. Rider and other women' (Tremear 1901, 277).

Witnesses produced at the hearing were a Mrs. Rutledge who told of being attended by Polly Whelan during her confinement and being nursed by her for two weeks for a fee of \$8. No date or month or year was stated by the witness as to when the services were rendered. Mrs. Harrison swore that in February 1899 she was attended by the defendant but paid nothing. A Mr. Darby stated that he had called upon Mrs. Whelan in August of 1899 and paid \$8 for her services. Mrs. Emily Rider swore that the defendant assisted her in her childbirth, seven months prior to the date she gave her evidence. There was no evidence that Mrs. Rider promised or gave any payment for the services. The last witness, a man called De Falio stated that the midwife attended his wife in July 1899 and he paid \$5 for the services. For the case, the information relied upon was that of the witness Emily Rider. There was not the slightest evidence to show that Mrs. Whelan was paid anything by Mrs. Rider or had she promised her anything for her services.

The conviction of the defendant depended upon the understanding of

the term "practising" within the meaning of the Medical Act. There must be more than one act to constitute "practising medicine" and the several acts constituting the offense must be specified. The crown felt that it was not shown clearly that Mrs. Whelan had practised frequently, customarily or habitually midwifery nor did she prescribe, attend, and operate for hire, gain and hope of reward. Therefore the conviction was quashed and there were no costs for the defendant.

A second case is that of the King v. Rondeau in which an application was made to quash a conviction under the Medical Profession Ordinance Edmonton, Oct 2, 1903. The defendant Sarah Rondeau was charged with practising medicine and surgery contrary to the ordinances by "attending and operating upon Mrs. Napoleon Ponton, on or about the 17th day of April 1903, and by attending and operating upon Mrs. Edmund L'Abbé on or about the 2nd day of March, 1903" (Tremear 1903: 524).

The evidence given was to the effect that the defendant in May attended Mrs. Ponton during her confinement, remaining with her for about a week. She was also present during the confinement of Mrs. L'Abbé in March, having been sent for the day before the child was born but reaching there only in time for the actual birth. There was no evidence that the defendant administered drugs or medicines or performed any operation. "It might be inferred that she was in attendance in the capacity of a

midwife, but there is no direct evidence that she acted in any way as such, or that she performed any duties other than those of nurse or attendant" (ibid 527).

The conviction was made under section 60 of the Medical Profession Ordinance which requires, as indicated previously the licensing of those who practise medicine or surgery. There is no reference to midwifery in the section. Therefore, unless midwifery could be included within medicine or surgery no penalty could be imposed. In referring to the Ontario Act, the crown concluded that "medicine" "surgery" and "midwifery" denote separate and distinct "branches" of medicine and there is nothing to indicate that the last mentioned "branch" is included in either of the others. It was the view of the crown that the omission of midwifery from section sixty of the Ordinances "points strongly to the conclusion that it was the intention that no penalty should be imposed for the practise of it by a unlicensed person" (ibid 528). Therefore the conviction was quashed and no costs were awarded

And third is the case of *The King v. Roffenberg* in Regina, Saskatchewan in November, December of 1909. (It should be noted that this occurred after the passing of "the Medical Profession Act of Saskatchewan" of 1906). The offense was that of practising medicine or midwifery contrary to The Medical Profession Act as the accused

attended one patient continually for two weeks. Mary Roffenberg, as a person not registered under the act was found to have practised midwifery on Mrs. Moore for hire, gain or hope of reward contrary to the provisions of section 64 of the act.

It was contended by the defense that the act was passed in the interest of the medical profession not in the interest of the public. The crown sided with the opposite view as it believed that such an act was in the public interest especially as it was included in the Revised Statutes of Saskatchewan. It was clear that Saskatchewan prohibited the practice of midwifery for gain by persons not registered under The Medical Profession Act of Saskatchewan. The concept of practice was also discussed and the judge concluded that a continuous attendance at the birth of Mrs. Rider's child and the absence of a lawful medical attendant constituted a practising within the meaning of the act. Miss Roffenberg had charged \$20. Therefore, she was convicted for practising midwifery for gain without being registered as required by law. She was required to pay \$10 to the Provincial College of Physicians and Surgeons and \$3.75 to the informant for his costs. Any default in payment would require that Mary Roffenberg be imprisoned for fourteen days (Tremear 1909: 295-299). These three cases illustrate the effect that medical statutes had upon the practice of midwifery.

Through the use of parliamentary acts, the courts and police, the medical profession was able to set into motion the objective machinery (Bourdieu 1977) which would allow them to dominate midwifery. Medicine as a profession had also achieved a status of legitimation not previously obtained in Canadian history. Through increased material rewards, recognition by institutions of parliamentary democracy, and the formation of professional organizations with the ability to exercise political decisions, medicine received its much sought after recognition.

According to Bourdieu (1977) The central purpose of the dominant group is to create the objective mechanisms which will reproduce the relations of domination, thereby serving their interests without any conscious effort on their part. The more indirect (and in a sense impersonal) the strategies become, the less the agents are required to create and restore relations of domination. Once the system has been constituted to reproduce the established order, the principal group has only to let the system take its own course in order to exercise their control. Elementary forms of domination are replaced by the objective system. Direct control of one person by another is replaced by institutional to institutional domination. However, The process of legitimating control proceeds in stages. By the end of the nineteenth century, as indicated by the passing of the medical acts and the resulting

court cases which challenged the right of midwives to practise without the consent of a College of Physicians and Surgeons, regulation was institutional to individual. In 1897 the medical profession attempted for the first time to exercise "institutional domination" (Bourdieu 1977). I refer to the Victorian Order of Nurses and the role of the medical establishment played in its development. The physicians were not completely successful because of dissension within their own ranks. Nevertheless, although they did not achieve their ultimate goal, the demise of the Victorian Order of Nurses (VON), they did manage to prevent women practicing midwifery, forced the government to renounce its original financial assistance and gained control of the organization through the Advisory Medical Committee.

Countess Ishbel Aberdeen, wife of the Governor General of Canada from 1894 to 1898, was the founder of the Victorian Order of Nurses. The idea of a home visiting nursing service was suggested to Lady Aberdeen in Vancouver in 1896 by two ladies organizing the Vancouver local Council of Women. They told her of the hardships suffered in the isolated settlements by the sick women and children. In an earlier trip to Kaslo on Kootenay Lake in 1895, the idea of a cottage hospital was suggested to her.

At the time, the federal government was initiating a program of

immigration to Western Canada. Settlers were pouring into the prairies with little preparation for their reception. Doctors and nurses were very scarce. Sir John A. MacDonald's national policy of protective tariffs had also resulted in a number of industrial communities along the railways (particularly in Ontario) where there was a need for hospitals and trained nurses. Nurses were even scarcer than doctors, and many of the ones who worked had little training beyond practical experience (Gibbon 1947: 2).

In Britain the Institute of Queen's Nurses had been established to commemorate the jubilee of Queen Victoria. With this in mind Lady Aberdeen suggested that the two Vancouver ladies (Mrs. Macaulay and Mrs. Gaven) write to her as president of the National Council of Women, urging that something be done to provide newcomers with medical and nursing aid. This they did and after receiving a sympathetic reply arranged to have papers read on the subject at the local Council of Women. In 1896, at the annual meeting of the National Council of Women in Halifax the organization made a similar request for a home nursing service. As a result, Lady Aberdeen was able to show that the demand for such a service was dominion-wide.

After consultation with some of the leading medical men, a public meeting was held in Ottawa under the presidency of the Governor General. The Honorable Wilfred Laurier, Prime Minister of Canada moved the

following resolution:

That this meeting heartily approves of the general character of the scheme described as the Victorian Order of Home Helpers, as a mode of commemoration by the Dominion of the Queen's Diamond Jubilee, and that a fund be opened for the carrying out thereof (Gibbon 1947: 6).

Prime Minister Laurier had already promised Lady Aberdeen a parliamentary grant.

In the initial proposal among a number of other aims for the new organization were the following prerequisites:

- 1 A practical knowledge of midwifery, sufficient to obtain a prescribed certificate;
- 2 A practical knowledge of First Aid to the Injured, and of Simple Nursing;
3. A general knowledge of homekeeping, simple home sanitation, with the ability of preparing suitable foods for invalids.

It is proposed that no person under twenty-eight or thirty years of age should be admitted to the Order, and, when admitted, an undertaking should be given to continue the work, provided health does not prevent it, for a period of at least three years (ibid 6).

A number of letters were written to Lady Aberdeen concerning the Order. One was from Mrs. N. Livingston, Superintendent of the Montreal General Hospital and a leader in the movement for training schools for nurses. She indicated that she believed that the Order should employ trained nurses and that the title "Home Helpers" was not applicable. "The word is misleading, for if the organization is to be a success, it must

stand for something definite, must express at least an approximate standard of attainment, or it will be chaotic and of limited influence" (ibid 7).

After considerable advice Lady Aberdeen proposed a second set of aims for the Order. The name would be changed to the Victorian Order of Nurses for Canada and only fully trained hospital nurses would be admitted to the order.

Although the preliminary committee contained no medical men or nurses an Advisory Medical Committee was formed which consisted of eight physicians, two lay men and no women. The advisory committee recommended that:

'the administration of the funds and affairs of the Order should be by a Central Board at Ottawa, to fix the standard of qualification of the nurses, to inspect the schools in which they are trained and the homes in and from which they work - to provide nurses for outlying districts - the nurses to be called 'Queen's Nurses' and the they be of the highest qualifications.... graduates of recognized training schools be permitted to volunteer, subject to passing prescribed examinations' (Gibbon 1947: 9-10).

Gone is all reference to midwives.

At this time the newspapers and medical associations were beginning to pick up the story. Various newspapers viewed the new organization in negative terms. The *Ottawa Citizen* of June 4th 1897 wrote:

'Lady Aberdeen's scheme to found the Victorian Order of Nurses, whose qualifications are that they must be women not less than 45 years of age, and well versed in the Bible, is being buffeted right and left. The Ontario Medical Association, in session today, passed a resolution expressing unqualified disapproval of the proposed Order' (ibid 12).

The *Halifax Herald* on May 25th suggested that the occupants of Rideau Hall were going beyond their jurisdiction, that the public refuses to supply the money and newspapers jeer at the scheme.

Toronto Globe and Mail dated May 28th carried a May 17th dispatch from Winnipeg in which the Medical Society stated:

'This meeting, representing the Medical Society of this City is unanimously of the opinion that though the object of Lady Aberdeen has in view in establishing the Victorian Order of Nurses is highly commendable, with our more perfect knowledge of the country in attending the sick, we feel that the scheme, at any rate so far as Manitoba and the North West is concerned, will prove an entire failure' (ibid: 11).

There were physicians who supported the establishment of the Order, especially those, such as Dr. O.C. Edwards who had lived on Qu'Appelle District of the N.W.T. and knew of the problems. He states "'I venture to say that the medical men who are actually in practice in the territories will in every instance welcome and warmly welcome the Nurses of the Victorian Order'" (Gibbon 1947: 13). Nevertheless the opposition from the medical establishment had political results.

According to Gibbon:

Sir Wilfred Laurier, the Prime Minister, had virtually promised a day

on which he would introduce a motion for giving a grant to establish the Victorian Order of District Nurses as a National Memorial, the leader of the Opposition, Sir George Foster, undertaking to second the proposal, but with the outspoken criticisms from the medical profession, members of parliament felt they could not work for the scheme, and so the idea of a National Memorial supported by Parliament fell through (ibid 15).

Although the Order did not receive government grants it did survive through private donations. Successive wives of Governor Generals took it upon themselves to raise finances through special drives. It was not until 1921 when Lady Byng assumed the role of honorary presidency that the Victorian Order of Nurses returned to its original objectives. They now devoted special attention to pre and postnatal care, provided field work for nurses enrolled in public health courses at universities, and worked in the prevention of conditions which lead to disease. As a public health organization, the Victorian Order of Nurses, reflected the prevailing ideology of the medical profession as to the role of women in the delivery of health care in Canada.

The Social Conditions Relating to Midwifery 1850 to 1900

Between 1850 and 1900, the economic and social makeup of Canada was in transition. Two developments deeply effected the lives of rural women. With increased agriculture specialization related to the development of a cash economy, and the increased use of farm machinery, women no longer played as central a role in economic production. At the

same time compulsory education removed children from the home production team. Because of these two factors, women's economic status was narrowed and weakened. The role of women in the upper classes remained fundamentally the same although there was a push for higher education for women.

The decrease in the economic status of women within the toiler society, was accompanied by an increase in the emphasis on women's frailty and dependency on men. Physicians through their linking of women's physiology to the feminine nature, offered to the public "scientifically" based evidence which reinforced the gender attitude articulated by the upper class. As a result of the physicians' intervention in the gender debate, the ideology of frailty and dependency gained in acceptance. However, women such as Elizabeth Matheson (Buck 1947) continued to function with the same intelligence, vigor, and strength of character which was prevalent in the toiler society. Because many women did not internalize the popular notion about themselves, a discrepancy existed between the ideology and the reality. This resulted in tensions and conflicts within society.

Medicine was quickly evolving from allopathy to biomedicine. Although far from our present system of maternity care, the improvement in quality was sufficient to encourage physicians in their belief that

technology would solve the many problems associated with pregnancy and childbirth. According to this reasoning, they would require sole authority over midwifery practices in order to accomplish the task at hand. Yet jurisdiction over birthing could only be achieved through state intervention on behalf of physicians. Between 1865 and 1900, provincial and territorial governments passed legislation which gave the physicians the right to establish professional organizations with the authority to license midwives. The physicians officially achieved their objectives and midwifery was appropriated by the medical profession.

At the time that physicians were seeking control of birthing, both formally trained midwives and traditional birth attendants were establishing thriving practices which were in competition with those of physicians. The fact that parturient women tended to favour midwives was also an important factor on the appropriation of midwifery. Through licensing, many traditional birth attendants were forced to stop practising. As a result, physicians gained in both economic and cultural capital. Midwives were charged by police, brought to court, fined, and forced to give up their occupation. This resulted in considerable conflict between midwives and physicians and a substantial decrease in the number of practising traditional birth attendants.

The importance of this period lies in the struggles of the medical

profession to gain control of the various medical specialties. The physicians of allopathy sought to create a professional homogeneity, therefore eliminating the multiplicity of practitioners, educational standards, and fee scales, all detrimental to professional prestige and practice. Because of their close economic, political, and social alliances with the members of parliament the regular physicians achieved their desired ends, (1) the formation of medical bureaucracies (The College of Physicians and Surgeons within each province) with decision making powers; (2) the power to make rules and regulations with respect to the admission of students to programs such as midwifery and the power to license (midwives); and (3) in some provinces the power to dictate the rates to be charged for medical, surgical and obstetrical advice.

According to Torrance (1981:15), the problem in creating a profession is that of weeding out the popular but irregular physicians in order to establish a homogeneous occupation. In the Canadian situation the major competition came from the healing sects such as homeopathy and eclectic medicine which had quite a following. The solution to the problem in Ontario was to absorb physicians from homeopathy and eclectic medicine into the mainstream by giving them representation on the Council of the College of Physicians and Surgeons. A representative of homeopathy continued to sit on this licensing body until 1960.

"Although in Upper and Lower Canada potentially strong licensing legislation to control entry was in place by 1870, medicine was still a loose conglomeration of conflicting segments until well into the twentieth century" (ibid15).

In contrast to the physicians, midwives were not able to form a homogeneous group. The immigrant midwife with some form of formal training, the farm wife of rural Upper Canada or rural Saskatchewan or the *sage-femme* from Quebec expressed a particular perception of birthing which can only be understood within each context. Unfortunately, it was those cultural, economic, social and language barriers as well as geographical separations which caused midwives to remain isolated from each other. Their loyalty was to their kin and local social groups. They functioned within an ideology of local self-help, one that continued to be very strong in pioneer Canada. Any suggestion of an allegiance to an abstract medical science or to an organized profession would have appeared as incongruous to these women. As a result they had no medium through which they could make their voices heard. Nor did they have the political alliances necessary for gaining power and control over the occupation they practised. Therefore, once the objective mechanisms i.e the statutes, courts and police, were in place, the medical profession needed only to let the system take its own course in order to exercise

their domination over midwives.

Although the objective mechanism was now in place, it did require a certain degree of "fine tuning". Standards of education varied from province to province as did the qualifications for licensing. Thus the need for the Canada Medical Act of 1902 and the Flexner Report of 1912. Perhaps more importantly, the early twentieth century saw science firmly entrenched as the dominant ideology in North American society. This final touch ensured lasting relations of domination. The system once constituted freed the medical practitioners from the endless task of creating and restoring symbolic and economic capital.

Chapter 5

The Final Phase Of Appropriation: 1900 To 1940

From 1900 to 1940 the basis for contemporary maternity care was established in Canada. Physicians became the respected authority on birthing; childbirth was transferred from the home to the hospital; and a new occupation of nurse midwives was established. The work of these women was under the authority of physicians. Women occupied a low economic status within society. Lower class women provided a source of cheap industrial labour; women of a higher social status occupied jobs which dealt with women's work. Both groups were paid low wages. The dominant gender attitude, that which understood women as dependent upon men, gained wider acceptance through out society. The quality of medicine improved to the point where women accepted hospital births, and the medical profession continued to receive strong support from the state, particularly in Ontario, where the provincial government was determined to place all maternity care under the jurisdiction of physicians. With the decrease in traditional birth attendants and an increased population a new kind of health care worker was required to assist women in childbirth. Nurse midwives took up the challenge. There appeared to be little tension and conflict between the nurses and physicians as these health care workers had internalized the ideology of

their dependency upon men.

In this period, three factors contributed to the successful completion of the process of appropriation of midwifery by medicine. First, there was a distinct difference in the 'root ideology' of the state. The acceptance of the ideology of technical solutions determined by the impersonal forces of science concided with the transition of allopathy into biomedicine. Second, there was increased state intervention in the market place. This intervention for the benefit of the medical profession began in the last quarter of the nineteenth century by provincial governments, but culminated with *The Canada Medical Act* of 1902. At this time the federal government granted the medical profession the powers to form a Medical Council of Canada whose prime purpose was to put into effect one system of qualifications for all physicians regardless of the province in which they resided. The profession of medicine, which previously had been fragmented because of the various provincial jurisdictions was now united under one central, powerful organization which could speak on behalf of all physicians. And third, the Flexner report appeared on the scene. It had the effect of standardizing medical education throughout the country. By extending the years of education, reducing the number of students allowed to enrol, and eliminating the number of medical schools in order that only the more prestigious schools

remained intact, the report also had the effect of establishing permanently, middle to upper class males as the dominant group in medicine.

With these final efforts, the objective mechanism for domination received the necessary "fine tuning" for its smooth functioning. Through legitimation by the federal government, the formation of medical bureaucracies (both federal and provincial) and standardized academic qualifications and licensing procedures, the objective institutionalized mechanisms were fully in place. This ensured the medical profession's jurisdiction over health care including that of midwifery. The end result was the complete appropriation of midwifery by an elite, predominantly male medical profession.

Appropriation Completed

According to Habermas, the sustaining of capitalism required increased intervention by the government into the economic system. Politics assumed a greater role in economics, and the institutional framework of society was repoliticized. As a result of this intervention, a new form of legitimation, upon which the state depends for justification was required. This new form by necessity took on an appearance similar to that needed in traditional societies where legitimation is direct and founded on an over-arching system of values

rather than arising from the economy. The state was required to intervene in the economy to preserve its capitalistic form. In stressing some of the features of a 'root ideology', Habermas states "What is needed to this end is latitude for manipulation by state intervention that, at the cost of limiting the institutions of private law, secure the private form of capital utilization *and bind the masses' loyalty to this form*" (Habermas 1971:102 original italics). Therefore, the form of legitimation which meets the need is a depoliticization of the mass of the population in order that the activities of the state which are of prime importance appear "not as political decisions between alternative courses of action but as *technical* solutions to agreed problems" (Abercrombie et al 1980: 18, original italics). For example, the legislation which empowered the medical profession in its pursuit of domination of midwifery is made to appear as a technical solution to problems related to birthing rather than as a political decision to expropriate the role of female midwives. This increased role of science and technology makes it appear as though the development of capitalist society is determined by impersonal forces of science, rather than by the subjective decisions, both political and economic, of men. Once the 'root ideology' is effectively integrated into society, those who are in authority can refer to the role of technology and science in order to explain and legitimate most aspects of life within

contemporary society.

Between about 1880 and 1920 progressive Canadians campaigned not only for scientific medicine but for the integration of science into all aspects of society; housekeeping, child raising, public administration, etc. The author G.N. Daniels in his book *Science in American Society: A Social History* portrays the excitement that gripped North America at the turn of the century. The changes wrought by technology were dramatic and impressive. He writes:

...nothing was more important to that era (Progressive Era) than 'science'. It was a word to conjure with; a word to sweep away all opposition by labeling it 'benighted', 'romantic' or 'obscurantist'; a word to legitimize any program no matter what fundamental reorientations it might entail or what sacrifices it might call upon particular groups to make. In the name of science, one might reorganize a city government, fundamentally alter the relations between labor and management [sic] revolutionize a school curriculum or consign whole races of men to genetic inferiority. If the 'science' involved in Progressivism seldom possessed the rigor of a Newtonian Law, few would notice; the name had a magic of its own which made questioning irrelevant(cited in Berliner 1982: 167)

After describing the "miracles" of technology (telephones, telegraphs, electric lights and airplanes) the author continues:

... When a justification for ... activities was sought, it was 'science' that was invoked in the late nineteenth century, as an earlier generation would have invoked religion, tradition or prescriptive right. Science was coming more and more to supply American social thought with its vocabulary and its supply of images. It served as a major source of metaphor and, like figures borrowed from any area, the analogies drawn from science variously suggested, explained and justified social categories and

values. This reflects the changing position of science in the hierarchy of American values; for since that time it has had a growing role as an absolute, able to justify and expected to motivate individual behavior (ibid 167).

In medicine, as within other scientific endeavors, the progressive leaders believed that the success of their discipline was based upon the known technique termed "scientific methodology". By the turn of the century, Canadian physicians generally agreed that the scientific method, which they sometimes simplistically presented as the adding up of 'facts' relevant to a problem, was the route to determining "truth". Biomedicine, which began distinguishing itself from the other systems of healing in the late nineteenth century was now identified with the new ideology, that of science. Physicians looked to science as the ultimate force which would project them above other systems of healing, including a midwifery founded on "superstition" and "ignorance", and establish them as the permanent legitimate protectors of birthing practices.

Their cause received an added impetus with the passing of The Canada Medical Act (or Roddick Act) of 1902. Sir Thomas Roddick M.D., a member of parliament, devoted his energy to the passing of this piece of federal legislation. The objective of the act was to establish a medical council, referred to as the Medical Council of Canada, whose major purpose was to create a standardized system of qualifications, and a medical register. This was to ensure recognition of Canadian

practitioners in Great Britain. A second act of 1906 established the qualifications in such a manner that a holder of a degree in medicine was accepted and eligible to practise in all provinces of Canada.

Clause two of The Canada Medical Act states:

In this Act, unless the context otherwise requires, - (a.) The expression 'medicine' shall be held to include surgery and obstetrics, and to exclude veterinary surgery, and the expression 'medical' shall be held to include 'surgical' and 'obstetrical' (*Acts of the Parliament Of The Dominion Of Canada* 1902 Vol 1: 125).

This clause is an indication that the the final stage in the process of assimilating midwifery into medicine was virtually complete. In the statutes of Ontario prior to 1850, midwifery was recognized as an endeavor under the control of women. Clause IX of An act to incorporate a college of Physicians and Surgeons in Upper Canada (*The British American Journal* 1846-1847: 57) states:

Provided that nothing in this Act contained shall be construed to prevent or prohibit any female from practising Midwifery in Upper Canada, or to require such female to take out such License as aforesaid.

The statute of 1846-1847 was followed by The Medical Act for Upper Canada (1865). In this piece of legislation, midwifery was removed from women and placed under a medical council whose members were chosen from the various universities. Yet, midwifery continued to exist as a separate sphere of practice. With The Canada Medical Act of 1902

midwifery has become obstetrics, and is no longer understood as a separate discipline. Midwifery is now part of medicine. The process of appropriation and assimilation is complete. Through parliamentary legislation and within a period of fifty-four years, the medical profession has been able to absorb midwifery officially.

One final step remained. Up until 1910 there was an overproduction of uneducated and poorly trained physicians. This overproduction of poorly qualified doctors was due to the existence of a large number of commercial schools, particularly in United States, whose primary function was to make money. In order to weed out the empirics and "non-scientific" practitioners, the AMA's (American Medical Association) Council on Medical Education, an elite committee composed of research-orientated physicians, approached the Carnegie Foundation to finance a study of medical education in both Canada and United States. A layman was to be hired to do the job; one Abraham Flexner, whose brother Simon Flexner M.D., was director of the Rockefeller Institute. The report presented by Flexner was used as a model for basic change in medical education for physicians in North America.

According to Flexner there were too many doctors that were too "low class". This perception is underlined in the "introduction" by Pritchett:

The existence of many of these unnecessary and inadequate medical schools have been defended by the argument that a poor medical school is justified in the interest of the poor boy. It is clear that the poor boy has no right to go into any profession for which he is not willing to obtain adequate preparation; but the facts set forth in this report make it evident that ... the excuse which has hitherto been put forward in the name of the poor boy is in reality an argument in [sic] behalf of the poor medical school (cited in Flexner 1972: XI).

According to Flexner, black physicians were needed, if only to check the spread of disease from black to white neighbourhoods. Of course their practices were to be limited to their own race. There was no need for women physicians as the demand was limited, and women themselves did not express a strong desire to enter the profession. Medicine itself should be controlled by the physicians of the new "scientific-medicine". There was little place within the health care system for other existing medical sects.

This led to a reduction in the number of medical schools, although there was no absolute decline in the number of physicians in Canada. Only the larger more prestigious schools remained intact. Flexner also set a minimum of two years of college education as a requirement for entrance into medical schools. At a time when university education was limited to a small portion of the population, this requirement ensured that almost only those individuals of upper and upper-middle classes could arrange enrolment.

Some would argue that these reforms were necessary. Many of the schools that were closed were too small, poorly equipped, and offered a poor education. "But there could have been an alternative strategy for reform—to spread out the wealth so that many more schools could be improved" (Ehrenreich and English 1979: 88). This move would have opened the system to a larger number of applicants. However, this is what the medical establishment wished to avoid. With the strategy, as offered by Flexner, medicine became permanently dominated by the elite white males of the middle and upper classes. The process of professionalization had taken on a new dimension. According to Torrance (1981: 17) the upgrading of qualifications had the effect of raising incomes through the creation of an artificial scarcity. High education had a further benefit, in that it consolidated the profession's position and enhanced their symbolic capital. Medical hegemony was complete. Medicine was now practised by an elite group of mostly men. The task of reproducing relations of domination was controlled by objective mechanisms which served the interests of the medical profession and which required no conscious effort on their part. Domination was indirect and in a sense impersonal. The medical profession need only to "let the system they dominated take its own course" in order to exercise their control.

Midwifery 1900 -1940

In the last quarter of the nineteenth century and in the early twentieth century major changes were occurring in the Canadian economy. United States was having a growing economic influence on Canada, and manufacturing was being replaced by the factory system of industrial capitalism. As a part of his national policy, Sir John A. Macdonald had created a protected market which attracted foreign investment. The Canadian market, thereby protected from foreign competition, absorbed the necessary volume of goods allowing for the efficient application of mass production techniques. The industrial revolution was well underway.

Central to the development of industrial capitalism were two key factors: the replacement of high-cost skilled labour with low-paid unskilled labor; and the replacement of muscle power with machine power. For lower class women this transformation created work which was different from that of a wife-mother or servant. It allowed them to become directly involved in economic competition with men. For the group of highly skilled craft workers, it directly attacked their livelihood. Mass production demanded a large pool of labourers. Industrialists therefore seized upon the poorly paid disadvantaged group

as a source of cheap labour.

Around 1885 there had occurred a massive flow of immigrants to North America; millions of Jews from eastern Europe, millions of Italians, Macedonians, Finns, Syrians, Mayyars, Galicians, Poles, Croats, Lithuanians, Slovaks, Greeks and Armenians. All were subjects of decrepit yet repressive regimes. By the time of the First World War, the cities both east and midwest reflected this onslaught of new people, although the configuration of each city's new population was due to the impact of local conditions and opportunities. In 1907, for example, about 4,500 Italian men legally entered Canada, accompanied by only about 400 women. Jewish immigration consisted of 2,000 men, 1,600 women and 1,900 children. The census of 1911 and 1921 indicate that many settled in Toronto. By 1911 there were about eighteen thousand Jews and more than three thousand Italian-born immigrants in the city. In addition, Toronto contained close-knit sizable communities of Chinese, and a lesser concentration of Syrians, Greeks, Poles, Croates, Ukranians, and Finns (Harney and Troper 1975: 1-3). These immigrants became the source of cheap labour, and encroached on the highly skilled craft workers' standard of living and status.

Johnson (1974) argues that initially the reaction of the male workers was to oppose equal wages for women and children. However,

they came the realization that if employers were required to pay equal wages for women and children and to provide high standards of factory conditions for them, the results would ultimately exclude women from the labour market. A second rationalization was to picture women as both physically weaker and morally more corruptible. The mixing of the sexes in the workplace would lead to the moral and spiritual breakdown among female workers. The capitalist employers discovered an ingenious solution. Johnson (1974) states that an apartheid system was developed within the workplace. Women were designated to certain jobs which became known as "women's work". For these tasks they were paid low wages. Therefore the main goals were achieved. The women still provided a source of cheap industrial labour, yet they were not in direct competition for the working-class men's work.

In Western Canada the policies of Laurier's government were bringing thousands of immigrants--Swedes, Germans, Ukrainians, English, Danes, and Jews, to settle the land. The people who came were the landless. They built their own sod shanties or log or frame shacks, broke their sod, and raised their own food. Success was measured by the their ability to survive. Each family lived alone, miles from the nearest neighbour, a day's drive from town, and in a constant struggle with the elements. They endured and survived in their creation of a new society.

Nevertheless, there were those who lost everything. Nature shattered their vision of prosperity through drought, pestilence, and frost. Those who controlled the means of wealth – grain merchants, machinery dealers, storekeepers, real estate salesmen and politicians – exploited them, and debt caused them to give up. With the outbreak of war in 1914, the boom collapsed. Many settlers responded with cynicism. Immigration was reversed, and the sacrifice many had made now seemed all for nothing.

Women of higher social status did not perceive wage labour as attractive but found an escape through education. Because of the gender attitudes of the times, these women were forced to occupy professions which dealt with women's work. They were segregated into occupations such as home economics, nursing, and teaching, jobs which dealt with women and children. Women who pursued these professions were also paid lower wages than their male counterparts.

The success of the medical profession in gaining control of midwifery created problems for the burgeoning Canadian population. As the population increased, the process of professionalization led to a decrease in the number of physicians. Restrictions on licensing of midwives resulted in a decrease in the number of birth attendants. However women continued to have babies and required assistance. The

medical profession found itself in a dilemma which was partially of its own making. At this time, what was needed was a dedicated group of employees to work in regions and among people where physicians did not wish to work, to accept wages which were in no way competitive with the doctor's salary, and most importantly to accept the authority of the male dominated medical profession. To answer this need, society looked to the newly developing occupation of nursing. Out of this context, there emerged the nurse midwife.

Fred J. Taussig, a physician from St. Louis Missouri ,introduced the term *nurse midwife*. In a presentation to the National Organization for Public Health Nursing in 1914, Taussig suggested that the solution to the "midwife question" lay in establishing schools of midwifery which would be limited to graduate nurses. He realized that midwives met the defined needs of women in society, and he believed that it was more practical to train the nurse to do midwifery than to teach the midwife to do some of the rudiments of nursing. Taussig concluded by saying that he thought that the nurse midwife would prove to be the most sympathetic, most economical, and most efficient agent in the case of normal confinements (Litoff 1978: 123).

In the next ten years few positive measures were undertaken to expand upon this proposal. However, such services were well underway

in the mountains of Kentucky. From 1919 to 1922 Mary Breckinridge observed the activities of midwives in France and England where she served with the Visiting Nurse Service of the American Committee for Devastated France. Upon her return to United States in 1922, she studied public health nursing at Columbia University. The next summer in 1923, Breckinridge conducted an extensive study in the three mountain counties of Kentucky. In interviews with fifty-three midwives, she discovered that midwifery practice had been thrust upon these women; only twelve women could read and write; a few had a little training; and there were only a few licensed physicians upon whom midwives could call.

Mary returned to England, where she received training as a nurse midwife, and in Scotland, where she observed nursing and maternal care programs. When she returned to United States she began preparations for establishing nurse midwifery programs in the Kentucky mountains. This eventually resulted in the establishment of nursing centers staffed by American nurse midwives trained in England. By 1927 the Kentucky centres were providing maternal and child health care to women and children throughout 250 square miles of rugged Kentucky terrain.

In Canada, public health and VON nurses tended to assume the role of nurse midwives. In the 1860's in England, Florence Nightingale established the occupation of nursing. She set the pattern which was

repeated in many countries including Canada. Victorian women, of the upper and middle classes, focused their energies upon charitable activities. Their works were directed into areas deemed as suitable for women. Led by Nightingale, reformers challenged the morals of the bourgeois family by demanding respectable careers for women of the middle and upper classes. They desired to become "mothers" to the destitute in the various charitable institutions as well as to those men fighting in the Crimean war.

Coburn (1981: 188) outlines the factors which worked against the integration of upper and middle class women into nursing. The daily tasks consisted of doing laundry; mending; changing bedding; making up bandages; supervising the kitchen and diets; preparing and administering medicine; keeping wards and equipment scrubbed; seeing to the toileting of patients; turning; feeding; and changing patients. Such menial tasks were accompanied by low pay. As a result, the actual nursing tasks fell to women who came from working and lower class homes. Women from middle and upper class families assumed the role of educators and nursing administrators. They had the financial and social positions which allowed them to receive the necessary qualifications.

Through nurses' training women from the lower classes were socialized into the social values of their upper class instructors. A very

important aspect of their education was the instilling of strict authoritarian values. The need for the complete subservience of the nursing sisters to the doctors was emphasized. Teachings defined not only the correct relations with the medical profession but also authority relations throughout the hospital hierarchy. Nurses were taught how to behave and were expected to stand if a doctor was present. Such values were transmitted to the student nurses even up until the 1960's when I took my "training". The perception of women and the values of the middle and upper classes from the Victorian era were integrated in to the developing occupation of nursing. Canadian nurses were socialized into a position of subservience, a fact which served the medical profession's interests.

Because of the minimal interest the Ontario government took in the field of health, communities were forced to take their own initiative. Women's groups within the communities arranged for public health services such as school nursing, "well baby" clinics, etc. In some towns the Women's Institutes petitioned for public health nurses to assist in meeting the immediate health problems and in educating mothers in self-help and preventive care. The equivalent organization called the Saskatchewan Homemakers was formed in the West. Public health nursing offered the nurse a new independence and the opportunity to develop close

relationships with the community.

By 1922, one thousand public-health nurses were in the field. These included the Victorian Order of Nurses, Red Cross nurses, public health care district nurses, hospital outpatient nurses, industrial nurses etc. Removed from the suffocating relationships of the hospital setting, the public health nurse could exert her independence. She often assumed isolated posts, traveled long distances by horse, sleigh, on foot, rode on a sectionman's railway jiggers, and rarely had access to a physician's advice. She lived a rugged life, and in her new-found freedom assumed a great deal of responsibility. Such independence of character was not easily tolerated by the medical profession.

Public health nurses became the nurse midwives for the many rural and isolated communities. In 1925, the VON hospitals and Red Cross Outpost Hospitals cared for 38, 634 births, while the VON assisted at 14,700 additional obstetric cases in the homes (Coburn 1981:194). Midwifery was incorporated into the public health nursing program, but in such a manner as to prevent intrusion into the physician's domain. The Alberta Nursing Act of 1919 eliminated all possible competition from the public health nurses. They could practise only in the designated portion of the province, where in the opinion of the minister, the services of a registered practitioner were not available.

Thus midwifery in Canada evolved into its modern form. In the process of becoming an elite professional organization, the medical profession appropriated midwifery. This was done on the pretext that only they had the knowledge necessary for such activities. Through provincial and federal legislation, they were given sole responsibility for licensing "midwives", which in reality meant "male physicians". As a part of this act of professionalization the number of physicians was reduced, at a time when Canada was experiencing a large influx of immigrants. The end result was that physicians could not meet the needs of parturient women.

The various provincial governments chose to deal with the problem in different ways. If the Alberta government allowed nurses to assist women in childbirth in areas where they did not intrude upon the physician's domain, it was the policy of the Ontario government to promote the physicians as having sole responsibility for both obstetrical and prenatal care. Initially, the child and maternal hygiene programs relied heavily on public health nurses. However, the 1927 report of *The Division of Maternal and Child Hygiene* reflected a change in emphasis away from nurses and foreshadowed the future whereby child and maternal care would be directly supervised by the medical profession. By 1929 the Department's position was clear. It openly supported the

physician's as primary care givers in maternity cases (rather than nurses) and left the final details to the obstetricians to work. The previous emphasis on programs with instruction in prenatal care gave way to ones on increased obstetrical care. The Department set about persuading both the medical profession and the public that maternity care was a problem for the physicians. The Department asserted that:

'the lessening of the morbidity and mortality associated with maternity is primarily a task for the medical profession. No other agency can willingly or otherwise, assume this responsibility. The interested woman can, however, materially lighten the load of the physician by consulting him at the earliest possible moment and by following his advice literally' (Oppenheimer 1983: 54).

Frustration with the Ontario government's policy was experienced at all levels i.e. by the physicians, public health nurses, and most importantly the public. In transcripts of interviews found in the Ontario Archives there is a record of a conversation between Mrs. Stevens and Mrs. H.I. Kert of Englehart and the provincial secretary, Mr. McPherson. Mr. Putnam, in his introduction of the women, explained that they had come to speak about the lack of proper care for parturient women. There were few medical practitioners and no trained nurses:

Mrs. Kert: There is no Doctor from New Liskeard to Swastika only one Dr. there, a distance of 280 miles and the surrounding district, there is Charlton, Heaslip, Tomstown, Eldon, Thornloe and many little towns and large settlements that have no assistance they all have to come to Englehart.

Mrs. Stevens: Supposing a woman wants attention and comes to

Englehart she has to be sent to New Liskeard. There is the Lady Minto Hospital at New Liskeard. One poor woman about to become a mother had to drive a long distance in a sleigh and did not reach the hospital in time. It would take some of them 3 or 4 days to reach the hospital. There are districts where there is no one available who could stay with a woman. The people are poor and the sanitary conditions are bad. Some of them are afraid to open the windows. There was another case where a woman needed assistance, she was suffering very much and the Doctor was willing to go but had other patients to attend to and got there too late (Transcripts 1917: 1).

The provincial secretary inquired as to the solution. Mrs. Stevens and Mrs. Kert suggested that since it was so difficult to get doctors as "so many of them [are] at the front" they would like a couple of nurses.

Mr. McPherson: Is it your idea that the nurse should be supported entirely at the Government's expense?

Mrs. Stevens: If it is possible to do so. The employers of labor and large farmers, can come to the city to spend their money. Only the poor people need assistance. If you travelled in Northern Ontario you will see that it takes one all their time to make a living (ibid 2).

Mrs. Stevens, at a later point in the conversation, pointed out that the poor classes "have absolutely no accommodation. There is no inducement for Doctors to go up there" (ibid 3).

The original transcript is dated May 10th 1917. Five days later the Chief Officer of Health Dr. J.W.S. McCullough replied to the request. In a memo to the provincial secretary, he wrote:

... I do not think it wise to have nurses appointed for the purpose of taking charge of such cases. What in my opinion should be done in obstetric cases or cases of severe illness would be, that provision be made in certain of the hospitals of the north country for the reception and care of such cases. The assistance nurses could give would no doubt be very useful but it is not medical assistance and

disastrous results might occur in some cases, for which the government, if it had followed a scheme of this kind, would be held responsible. (McCullough 1917).

It is clear from these transcripts that Ontario government policy, regarding maternity care, although not clearly articulated until about 1929, actually began several years prior. Such a policy resulted in a health care system which not only did not meet the needs of parturient women but left both the nurses and physicians angered and frustrated over the problems such a system imposed upon them. The official reports written by public health nurses in the early 1920's throw light upon this particular situation.

In 1917 the Ontario Provincial Board of Health sought funding from the legislature for a child welfare program with the objective of decreasing childhood mortality and morbidity in rural and northern parts of the province. The program was initiated in 1920, with the aim of stimulating local health boards or voluntary agencies to assume the work themselves once the Board's agent, the public health nurses, had demonstrated to them the efficacy of such a program. In October of 1920, nurses in pairs (one Red Cross nurse and one provincial nurse) were sent to eight districts. Their work was to educate through demonstrations. Only in cases of absolute emergency were they to carry out bedside nursing (Stuart: 1987). The reports of these women eloquently describe

the conditions of this period.

The correspondence of Marguerite Carr-Harris is perhaps the most revealing, particularly as it relates to the care given during confinement.

And October 28th 1920 she writes from Fort William:

Some time ago Mrs. Harrington was here at a meeting, which was rendered somewhat stormy by the class of feeling over the question of women dying in childbirth from lack of care. Mrs. Harrington feels that midwives could save many lives. The graduate nurses here opposed the idea and at the same time their attitude towards the VON who were here for a time formerly-was such that the other refused to stay and there are none here now. Therefore their attitude towards any intruder is decidedly on the defensive (Carr-Harris 1920 Oct 28th).

As part of her duties Carr-Harris traveled from community to community. From Kenora she wrote:

that care during confinement is much needed - and also instructors for mothers.....
I have asked and foresee that I will be required to furnish a solution as to whether a Public Health Nurse would go to maternity cases in cases where no nurse had been secured. I pointed out the difficulty of drawing the line where to stop - and said the committee would have to arrange where. If the nurse would not do these cases she would be useless here Mrs. Earngey said (ibid Nov. 2nd).

Return correspondence from head office did not appear to take issue with the problem. It must be remembered that this is official correspondence and therefore it is highly unlikely that Carr-Harris would express openly her feelings with regard to this matter. Nevertheless the following indicates some of her frustrations. She inquires:

...If the Government is going to do anything along the line of increasing the endowments to Hospitals. Everyone here speaks of the urgent need of care during confinement. I hope in fact our practise the Public Health Nurse will prove the paragon we paint her! (ibid Nov. 7th).

Carr-Harris did not approach again the subject of the public health nurse as primary care giver during confinement. Nevertheless, she continued to present the problems faced by local women during pregnancy and childbirth. From Sioux Lookout she explained:

I called on an expectant mother who lived about half a mile along the track in a log shack. She has already four children, one of 14 in the States.

The shack was well kept and the children were very nice looking and intelligent. Baby is expected any day now; there are two women who may be available, one has a family and can only come if the event takes place at night, and the other speaks no English (ibid 1921: May 4th).

And again from Kenora she outlined the problems:

A number of the women told me of very sad cases of loss of health and of life due to the lack of Prenatal Care or of Medical Care in time to save mother or child....

Two doctors at Emi and one at Stratton try to cover that whole territory, but in winter the travelling facilities are such that adequate medical attendance or supervision of Maternal Cases is not possible.

A nurse who could get in touch with such cases and keep the Doctor posted as to their conditions should be able to avert some cases of chronic ill-health or even death (ibid April 25th).

Other public health nurses faced the same dilemma. From St.

Joseph's Island, M. Bagshaw wrote:

Undoubtedly I believe they need a community nurse who would be obliged to include bedside nursing to a considerable extent in her

program. Hitherto they have women for all of the work. As a result there have been some very sad accidents and they have been doing without a doctor where possible because the MOH [Medical Officer of Health] is generally hated (Bagshaw 1920).

Laura Douglas in her work near Sudbury drew the following

conclusion:

The people in most cases avail themselves of doctor's services only in the instances of dire necessity - and midwifery is carried on extensively at all times by women living in the country (Douglas 1923).

Finally from Penetanguishene, A.L. Campbell states that she found that there were practically no trained nursing services available for maternity cases. "The Doctors are frequently not called at all and if called only at the last minute" (Campbell 1921).

Although government health policy at the political and bureaucratic level was influenced by the medical profession, physicians at the grass roots had considerable difficulty in dealing with the situations such policies provoked. Some of the more pragmatic doctors simply worked with the resources at hand. For example, in Thessalon six untrained women provided midwifery care for women with the consent of the doctors (Bagshaw 1920: Nov. 26). Other physicians chafed under the load they were expected to carry. Fort William doctors looked after about four-fifths of the rural work. On one of her trips to Fort William, Carr-Harris spoke with a number of the physicians concerning their

problems and expectations for health care in the community. The

following are the conversations as she recorded them:

Dr. McTavish - People will not call the doctor in confinements until they have to i.e. when they are in difficulties. Even when confinements cost only \$10, they do not pay in many cases. They are not fair to the doctor.

Suggests that municipalities should guarantee reasonable fees. Possibly the Municipalities and the Medical association might confer.

Dr. Gellespie - Thinks that fees should be assured. Obstetrical cases should be brought to town. Cited a case of call 30 miles by car and 15 miles on foot where he found an arrival that the placenta and one arm had been born, child dead for several hours and mother "blanched right out".

Dr. McCartney - Suggests women coming to town for confinements and for two weeks before.

Dr. Hardiman - Accommodation for waiting maternity cases near the local hospital. Dr. Spence suggests women coming into the cities for confinement. Says its impossible to treat them properly in the average settler's home (Carr-Harris 1921: Dec. 19).

Although it was official government policy, that the public health nurses were there to educate and to perform bedside nursing care only on the rarest occasions, there is evidence that one nurse, I.I. Grenville, did assist women in childbirth. In writing from Earleton she states that she attended two obstetrical cases, one alone, the other with a Red Cross nurse. The case was difficult since the mother had fallen down a long flight of stairs the month before. The woman chose to have her baby at the home of a practical nurse. However, when the case became difficult, they sent for help from Miss Grenville and Miss Lind (the Red Cross

Nurse). The infant was born dead, and it appeared as though it had been dead for some time. According to the author it was a large child, about ten pounds. Grenville was also called to another case at Keenaleik. She left on the speeder (the sectionman's jigger or patrol car) at midnight but found that, although the woman was having strong pains at the time, they subsided by morning. She stayed over night and returned home the next day by train (Grenville 1920).

As part of her doctoral research work, Meryn Stuart (1987) interviewed one of the nurses, Marjorie Heeley, from this special program. Like Grenville, Heeley was called to homes to assist women in childbirth. Although she felt inadequate for the task she did her best, because she realized that she was the only 'medical' person available.

Nurse Heeley in describing one of these incidents explained that:

she remembered a baby being born 'very prematurely' to a mother with five other children; by the time she had finished with the mother and looked at the baby, it had 'hemorrhaged' and died. She knew that she did not have the knowledge nor the equipment to save the child, and resolved her grief by doing the best she could and going on to the next case. However, the feeling that one had to be ready for 'anything' stayed with her (ibid 161).

Nurse Heeley's experience indicates the predicament in which nurses found themselves. They were assigned roles as health educators in areas where health care services for parturient women were in great demand. According to the objectives of the program, they were not to assist

women in childbirth, but to provide pre and postnatal education. Yet women required practical help and called upon the nurses. Realizing that any help they could give would be better than any other form of assistance presently available, the nurses complied with the requests. Nevertheless, they were aware that they lacked the knowledge and experience required for such a situation. As a result, the nurses lived in fear of the inevitable disaster and repercussions from their superiors. If they chose not to attend the births they created problems with the community; if they chose to attend the births they could have problems with their supervisors. It was a no-win situation for both the expectant mothers and nurses. The Ontario government's health policy neither served the needs of women in the remote or rural areas nor satisfied the local physicians or public health nurses who were required to put it into practise.

In contrast to the position assumed by the public health nurse in Ontario is that of the nurse practitioner in Alberta. The work of Alvine Cyr Gahagan illustrates well the difference in what was expected of nurses during this period. Alvine Cyr was born in Edmonton in 1910 to Vital and Felicit Cyr, French Canadians whose ancestors arrived in Quebec in the 1650's. She received her nursing education from The Sisters of Charity at the Edmonton General Hospital, graduating in 1932.

While working at the hospital, she was approached by the superior, Sister Mary, for work in Northern Alberta. A young priest, Father Loranger, had come from the remote French speaking area of northern Alberta to seek help for his parishioners. He and the people of Plamondon were alarmed at the numbers of women and babies who were dying in childbirth.

Therefore, he requested a French-speaking nurse to work in his impoverished backwoods parish. The plan offered to Alvine was that she would receive \$25.00 for medical supplies and \$10.00 a month as well as free room and board for the first two months. After that she would be expected to support herself on the income she would receive from her practice. Alvine Cyr accepted the offer and became the only medical practitioner in 265 square miles of sparsely populated territory. There was no doctor, hospital, or quick means of transportation available.

Gahagan in her book *Yes Father Pioneer Nursing in Alberta* (1979) describes in detail her first maternity case. After a long ride in a bob-sled pulled by horses she arrived at the farm house of the parturient woman. She was informed the mother's water had broken.

I encouraged her to walk around and have a cup of tea, as again her pains had ceased As the baby was low, it was difficult for her to walk, but she felt better, moving around. In the meantime I checked her bed. She had the oilcloth under the clean sheets that Trudi had just prepared with extra padding. Newspapers were a scarce item, often used for bed protection in homes. Then on, I would save the *Edmonton Journal* and *La Survivance* for this purpose.

I then sterilized my instruments, basins and gloves. Then I tried to prepare my patient, per hospital method - shaving soap suds, enema, bath - she was able to void, so I need not catheterize her. I also would try to keep aseptic technique....

By 11pm. her pains were q.15m. (every fifteen minutes). She continued with a slow progress. During all this time, I worked and talked with her, with encouragement. She was so apprehensive, remembering her past deliveries (ibid 79: 89).

Alvine continues her story by discussing the friendly interaction between the family and herself. Finally at about 4:30 AM after little progress had been made she made a decision.

I had been praying silently, as I tried to relax this very worried little family. Was it time to give my patient a hypodermic of Pituitrin? At 4:55 a.m. I gave her the injection. It soon took over; she was ready as a little girl was born at 5:10 a.m. She had the cord twice around her neck; my goodness, I thought, you poor baby - but she soon gave out with the great "cry of life" and awoke her mother. My records show the placenta was expelled at 5:40 a.m. (ibid 91).

At the end of the two months, the people of the area signed a petition requesting a grant from the government in order that Alvine could stay on. Many months rolled by with no word from the government. However, Alvine continued with her work. Her greatest expense was for medical supplies for maternity cases, accident dressings, and medicine. She charged \$10.00 for maternity cases, but out of this paid for anesthesia, sterile pads, navel and cord dressing, rubber gloves, masks, Pituitrin, ergot, boric acid, silver nitrate ampules, and green soap. Some maternity cases only paid \$2.00 and her records show that many did not

pay in full. Nevertheless this did not interfere with her care to her patients. "Money or no money, they all received the best service that I could give them, and they knew it" (ibid 99). She charged \$.50 for an office visit, and the same for a dressing. However if there were a number of visits it was only \$.25. For a home visit Alvine charged \$1.00 but often received \$.50. Distances were so great that often, it took a whole day to make one call. Since these visits were important to the families, she answered all calls, day and night.

As a nurse practitioner, Alvine Cyr was expected to handle the problems in a manner similar to any general practitioner. After a long cutter ride, in 65 degrees below zero weather, to a woman in labour, she encountered one of her most difficult cases.

As I examined her, I found the baby in good position. The head would soon crown - the perineum was thinning - time of delivery was close. The anesthesia was administered Soon a large baby boy is born - but he is limp - no cry comes from him. I now have a near-lifeless little human being in my hands. I pray to God for more knowledge. I feel great anxiety in these seemingly lifeless moments. The baby showed no signs of life. Mr. Chévigny was helping me - he had gone downstairs for the hot and cold water basins. At this time, Mrs. Chévigny was using her skill in covering for me, caring for her daughter. Both grandparents knew that we were in deep trouble.

I did the usual procedures, immediately, to get life into this baby, from removing the mucus from the mouth and nostrils, to up-ending the baby, holding him by his ankles, slapping between the shoulder blades. Still no cry. Mouth-to-nose resuscitation - Still no cry. I did a few bendings - head to feet - Still nothing. Then I immersed him (hitting the spine first) in the two warm and cool basins. All

this was done without response. I was working very fast as time was very precious and important.

God please help me - in great humility I beg Him for more knowledge. Just then another thought comes to me, of swinging the baby by holding him by the ankles (he is heavy). I think this might dislodge the mucus in the bronchioles ... or it may help his lungs distend and force the lungs to work. Oh! my God, as I am doing this ... he nearly slips out of my slippery hands.

All seemed to be hopeless by now - so much time had gone since I had cut his umbilical cord. Again I started with mouth-to-mouth resuscitation - nothing - again and again I tried. Finally it seemed like a century had gone by since his birth. Then a little sound was heard - then a faint cry - then all of a sudden the greatest loud cry ever came forth; at the same time his little arms stretched out, as if to cry, 'Here I am. What's all the fuss about?'

Well, the grandparents fell into each other's arms at the same time, saying 'Thank God'. His cry woke his mother; she said 'Oh, my baby'. I was so glad that she was still unaware of all the commotion that had gone on (ibid 111).

The writings of Alvine Cyr Gahagan are of interest, not only because of her discussion of the work of a nurse practitioner, but also because of her description of a French Canadian community in Northern Alberta. The people's strong religious beliefs and acceptance of God's will pervades much of her writing. Birthing, as understood by the women of this community, was not perceived as a medical event nor as simply a normal one, but carried with it spiritual connotations. There was a recognition of the vast array of problems that women and the new born could encounter. Nevertheless, there was also a belief that God is a part of this whole creative process and the community understood themselves as God's people. The story of Valérie is a good example of this perception.

Alvine assisted at the wedding of Valérie to Charles Daiglé. In fact, she helped the bride's sister, Cécile, in dressing her for the occasion.

"Seeing her small body [the bride's] of eighty-six pounds, I thought, oh no, if she becomes pregnant, what then. She was so tiny" (ibid 173).

Inevitably Valérie became pregnant. Alvine watched her over the next few months and advised her to go to Peace River for her delivery. During the pregnancy she continued to advise her to go but no amount of talking would change Valérie's mind. As expected one morning the father-to-be arrived at her door and Alvine went to attend her friend in child birth.

On arrival, I did the usual check - she was advancing very well; even the hot water bottle was in the crib. I cannot explain this exactly, but Val had the most serene calmness that I had ever seen in childbirth. Lo and behold, in a short while this beautiful baby boy was born, with the greatest of ease. I could hardly believe it - I was in a little shock of disbelief. So, before leaving, I fed petit Jean (Johnny) a little water and rocked him to sleep. He weighed in at all of five-and-a half pounds (ibid 173).

After Alvine had reflected upon this case, she went and discussed it with Valérie. She was told 'I prayed to the Sacred Heart of Jesus, during my labor'. The author comments "What faith - she called on the Greatest and He heard her" (ibid 173). Spirituality, appears to have been integrated into all aspects of life and was very much a part of this woman's birthing experience.

That nurses assumed the duties of midwives is supported by much

of the autobiographical material written by these women describing their roles in this particular period. I refer to the writings of Marjory Bellamy (1974), Amy Wilson (1965), Kate Colley (1970), and B.J. Banfill (1967), as well as that of Nan Shipley (1955) on the work of Anna Gaudin. There is another interesting facet to these stories, that of the work of the public health nurses with the Canadian Native population. Indians had their own midwives and would send for help only when they thought a woman was going to die. It was often the public health nurse who was called upon to assist with these difficult births. Amy Wilson (1965) recounts the occasion when she was asked to assist a critically ill Indian woman in labour, at a camp 12 miles out of Minto, a tiny settlement about 160 miles north of Whitehorse.

She arrived at a camp of about thirty-five to forty Indians, all living in tents and was taken to one tent, where a woman lay utterly exhausted on a heap of blankets and old clothing. The baby had arrived but not the placenta. The old women, who had assisted the mother during the night, were resting in their tents because of the previous night's ordeal.

When an Indian woman goes into labour, she calls upon her favourite midwife who is often her mother or mother-in-law. If there are no complications, she is the only person needed. However, should there be difficulties all the old women attend her. The woman in labour

sometimes stands or kneels over a pole put across the tent. She is then pummelled and squeezed or a blanket is tied around her tightly as two women pull on it. The belief is that such actions force the baby's birth.

When Amy Wilson arrived she found that the condition of the woman was not serious. She soon completed the delivery and then checked the infant, putting silver nitrate in the eyes. The Indians rarely tied the cord as they seldom had string. If no knife or scissors was available, it was not unusual for the mother to bite it off. The lengthy cord was then doubled back on itself and bound down to the baby's abdomen with cloth. Frequently there was bleeding from the cord, a not uncommon cause of death in a new-born infant.

Amy found that the cord had not been tied and was oozing fresh blood. After this was attended to, she proceeded to bathe the infant. Five or six women observed her and were delighted when she pulled a small scale out of her kit in order to weigh the baby - weight 9lbs, 4ozs. The mother had prepared for the arrival of the baby by assembling a few clothes which were not new but clean. The supply of diapers was limited to three washed flour sacks but a box, over half full of soft clean moss, was available. A bit of moss was tucked under the baby. It is very absorbent and when soaked thrown away. The author commented upon the fact that one seldom sees a baby with sore buttocks if muskeg moss has

been used in a diaper (ibid 47-49).

In a similar tale, nurse Kate Colley (1970) described her visit to Jennie, an Indian woman who was having a difficult labour. Kate found the woman, on her knees clinging with both hands to the centre lodge tent pole. When the nurse attempted to have Jennie lie down, she refused point blank and in no uncertain terms informed her that her mother had hung to the tent pole and she would do the same.

As time passed Jennie became exhausted. Kate called the husband, Joshua, and insisted that the tall Indian should stoop over his wife and hold her firmly under the armpits. She, herself dropped on her knees to assist the woman. "Jennie was bending and swaying to the storm like a Canada lodge-pole pine, yet refusing to loose her hold" (ibid 35). At last the ordeal was over and Jennie collapsed in Joshua's arms.

The nurse was then able to get Jennie into bed. Nevertheless, Jennie insisted upon sitting bolt upright and observing her every move. She proceeded to clean herself and observed Kate as she began to bathe the baby. As in Amy Wilson's description of birthing, Kate Colley found that the mother had prepared a bundle of baby clothing. Jennie dressed her new-born infant, placing the moss upon a small square of cotton which was used as a diaper. The baby was then laid in a softly tanned rabbit skin and finally in a moose hide moss bag (*waspisoan*) which was lined

with white caribou-hide and heavily decorated in beadwork. The bag was drawn securely, leaving only the baby's head exposed. "Then came the crowning glory, a white linen embroidered bonnet, with a faded ribbon to be tied under the baby's chin" (ibid 37). The baby now dressed and secure in her bag, was hung from a nail high up on the lodge pole.

The baby opened one eye, gave us an oblique and somewhat disdainful glance, but one in which the wisdom of the ages seem to appear. Then, blowing a few bubbles, from her rosebud mouth, May went to sleep! (ibid 38).

Description of nurses, such as Amy Wilson and Kate Colley, are useful because they provide information not only on the practices of public health nurses at this time but also on the birthing practices of the native population of Northern Alberta and the Yukon Territories.

Since it was the V.O.N. nurses who provide bedside nursing care within the homes, it could be assumed that when required, this particular group would take responsibility for assisting women in childbirth. Yet, the information is contradictory. Public health nurse A.L. Campbell in her official correspondence to her superiors in Toronto states "VON Nurses have been very busy all year. They handled 110 maternity case ..." (Campbell 1925: Feb 12). She was writing from the community of Kitchener Ontario.

However, in her autobiography *40 Years A nurse, Thirty Two a VON*

(1975) Mabel Louise Dublin is explicit in underlining the fact that VON nurses were not allowed to assist women in childbirth. She writes:

I then explained that the rule of the Victorian Order of Nurses was for the doctor to call the nurses. With the majority of confinements I attended, the doctors either fetched me, or were in the home when I arrived there (ibid 131).

In cases where the doctor had been delayed and Nurse Dublin arrived at the the home before him, she would assist the woman in childbirth, cover the baby "warmly" and wait for the doctor. Miss Dublin accepted this role throughout her career as a V.O.N. nurse in spite of the fact that she was trained as a midwife in England and had passed the examination of the Central Midwife's Board in 1911.

Local midwives continued to practice unhampered by organizational interference. Nurse Dublin wrote:

It was not long before I became acquainted with the midwives and their work. The three I recall had a fair size practice in the district, and although they were not professionals they would take cases without a doctor. Then, if anything went wrong, it was not easy for the patients to get a medical man. Sometimes I was called in, but I could do nothing until I had orders from a doctor, and then douches would be prescribed, - twice daily. Infection would send the mother's temperature as high as 104F degrees, and it would be days before it came down to normal. I worried a lot about these cases, but the midwives did not seem overly concerned (ibid 75-76).

The description of the V.O.N. work by A.L. Campbell and that by Miss Dublin are contradictory. Why would some V.O.N. nurses assist women in

childbirth while others assist the doctors? I would suggest that the role played by these nurses depended upon their location and the availability of physicians. Nurse Dublin practised in Sydney, Nova Scotia where there were at least two medical practitioners who could be called upon. Other V.O.N. nurses, who assisted women in childbirth, worked in areas where there were either no physicians or not sufficient numbers to meet the needs of the population. As the previous description of the development of the V.O.N. indicates, the Advisory Medical Committee ensured that the medical profession retained the powers to direct the activities of the organization. They could do this only in areas where there were sufficient numbers of physicians to reinforce the will of the dominant medical profession.

By the 1930's the major emphasis of governments was to shift birthing from the home to the hospital. Women had become socialized into accepting the physician as the only competent assistant in childbirth. Now these same physicians were insisting that the hospital was the only safe place for childbirth. The predicament in which women found themselves is aptly described by Nurse Dublin:

The new doctors in the city insisted that women who were expecting their first baby must plan to go to the hospital. Even some of the older doctors who had delivered hundreds of mothers in their own homes were making this rule.
I tried to explain to my patients that this was the modern way

although I was not very happy about it. For this new way was really frightening to some of these women. I am sure they would have been less worried if they had been given the opportunity to meet the nurses who were going to attend to them. I think it also good for nurses to know something about their maternity patients beforehand. For I found that pain can change a person's disposition so completely that she is not like the same person at all, especially if she has always enjoyed good health. (ibid 152-153)

On the subject of postnatal care, Nurse Dublin states:

The postnatal visits to mother and babies who had returned from hospital were also disappointing. The mothers were not breast feeding their babies - instead they brought home a formula for bottle feeding. These babies would not have the same protection from disease, and this later on could cause regret (ibid 153).

Modern obstetrics gained a foothold in the larger urban areas of Canada. From its inception, it demonstrated an impersonal technological orientation which present day critics denounce. As Nurse Dublin indicates, it was a system of birthing practices which some women feared but were forced into.

In Western Canada, because of its particular social and economic conditions, midwives continued to practise well into the twentieth century. In the book *The Soil Is Not Enough* (1938). M.J. Wilkins Campbell and the co-authors W.H. Wilkins describe the situation in South Qu'Appelle Saskatchewan between 1900 and 1940.

Hospitals and nursing homes had not come nearer to us with the advent of the next little Canadian, but there had come to our community a gaunt Scotswoman with a splendid reputation as a midwife. Mrs. McPherson had been trained in her native land, with that training which made her kind famous among *accoucheuses* of

that time. She hadn't been young for many a year, and she was verra, verra broad, and her six-foot bony frame lacked every semblance of beauty. But her hands were kind and firm and skilful, and her heart great, and her judgement of the wisest. Without fuss or comment she took capable charge of the mother and child, and managed the household with competent ease (ibid 233-234 original italics).

In much of the literature describing this period in the prairie provinces, three main themes permeate the writings. They are (1) the incredible hardships faced on a daily basis by these early settlers; (2) the fact that women were more and more socialized into accepting the male physician as the principal birth attendant; and (3) the lack of physicians available to attend women in childbirth. The article written by Edith Lazonby (1974: 56-57) illustrates well, these three problems.

Early in the next spring, I was expecting a child. Often I would run and bury myself in the deep prairie grass and weep for my mother. How were babies born, anyway? The present-day girl with her comprehensive knowledge of life was a far cry from my girlhood, where we were literally sheltered from that type of knowledge. Mother sent me two volumes from England, *Advice to a Wife* and *Advice to a Mother* and studying the illustrations I became more terror-stricken but I wouldn't have thought of showing that fact or of discussing it.

The nearest doctor lived at Humboldt, fifty miles away. My husband had notified him that we would need him around a certain date and one of the McCabe boys had promised to take a fast team and sleigh when we would put up a flag as a signal or a lantern at night, and go and get him. But we reckoned without the weather. For three days a wild blizzard raged and we seemed to be cut off in a white world of quietness. It was hardly safe for Duke to find his way the short distance to the stable. The path was entirely obliterated. When the storm first started, he piled hay and blocks of snow for the cattle, to last them for a few days. On the fourth day the sun shone bright and clear. The cattle were let out of the stables and floundered

around in the deep snow, their nostrils emitting steam-like breath on the frosty air. I muffled up in a fur coat and was glad to be outside too, and for fun helped Duke pitch hay into the stalls. I felt lighter, happier, as though some awful load were lifted and we were very gay at my laborious efforts. That night I awoke in an agony of pain. Arousing Duke, he lit the lamps and put on a huge tub of water to heat. It was snowing and so no use to put up the lantern. As I was wracked with agony, Duke held my hands and in between the knife-like pains, I would let out peals of laughter in a wild, excited way. Later, I remember Duke, seen through the haze of the lamp light with sleeves rolled up and perspiration rolling down his face, walking between the book *Advice to a Wife* which was propped up on the table as he followed the processes of birth in the book, and actually delivered the child, a perfect boy, who protested lustily at his entrance into the world.

Duke wrapped up the child and layed it beside me. He knelt down beside the bed and put both hands around my face as gently as a woman, saying, 'Christy, I don't have to tell you to be brave, for there is no one like you in the world, but I'll have to leave you to get someone to go for the doctor, for the rest is a doctor's work, though I'll have to take the risk if I can't get him.' He left me, going out into the early dawn on skis. I heard later that when he reached our neighbour's threshold, he fell across in a dead faint. He came back to me and we waited patiently for the doctor, who was also to bring a nurse. As the hours passed Duke came to me and said 'Christy, I'm afraid I'll have to take a chance and remove. . .'. Before he finished speaking we heard the faint tinkle of sleighbells and soon the doctor, nurse and the driver entered. The doctor had to thaw out before he could touch me and when he did it was far worse than the actual birth. Duke showed the strain as he almost sobbed, 'Thank God, Doctor, you arrived in time.' The doctor congratulated Duke on his skill. The memory of that night has never been erased from my mind. I know the meaning of the word 'man'.

It is these environmental, social and economic conditions which contributed to the special milieu of the prairies. Everyone shared in the hardships and out of this act of sharing and the need to survive, there arose a cooperation among peoples which may have been evident in

Eastern Canada during the early pioneer days but had given way, in the urban areas, to the competition of capitalism. There were few hard lines drawn between the physician, public-health nurse, and midwife. Well aware of the physical hardships, remoteness of the settlements, and the lack of physicians, these health care workers cooperated in a manner which displayed the respect they held for each other.

In the urban centres and the university settings, physicians carved out their specialties within medicine, surgery and obstetrics. The rank-and-file doctors, especially in the rural areas watched all of this with mixed feelings. By and large, they distrusted the elite doctors and the scientific medicine they crusaded for. There was a certain mistrust of the new theories which were being proposed and many physicians refused to listen.

On the other hand, the general practitioners liked the reform movement. The medical establishment was achieving through a precise and methodological campaign what the rank-and-file could never have achieved given their numbers and isolation from each other. The competing sects were gradually eliminated, thereby providing a more stable and higher income for the regular physicians. As a part of the achievements related to the transformation of allopathy into scientific medicine, licensing examinations and standards of education were brought

into line across Canada. The regular physicians gained a legal monopoly over health care and all this was achieved without a major crisis or conflict within the health care system. Therefore the general practitioners, in areas such as Western Canada, accepted with gratitude the improvements in their profession, while continuing to meet the demands of their particular situation in a realistic way.

Wilfred A. Bigelow M.D. F.A.C.S. is an example of such a physician.

Dr. Bigelow was born in Kingsport Nova Scotia and moved to Winnipeg in 1898. He entered medical school in 1899, graduating in 1903. After post graduate training he married and moved to Brandon in 1906. In 1913 he formed the first medical clinic in Canada. It was located in Brandon.

In his book entitled *forceps, fin and feather* (1969), Dr. Bigelow discusses his maternity cases and his relationship with midwives. At a time when he was just beginning his practice in Souris he describes one of his first cases. He had arrived at the house where there was quite a commotion going on. Dr. Bigelow writes:

There were two midwives present. They were wonderful women. We called them "gamps" but it would take a lot of nurses these days to do what these women could do in their practical way. These two had just what I wanted, a big wash boiler in the stove, as if they were going to scald a pig (ibid 53).

Dr. Bigelow proceeds with his story by describing the particular problems associated with the case, as the parturient woman was eclamptic (a form

of toxemia of pregnancy which is characterized by convulsions). Each midwife assumed various duties as did the doctor. The three, working together, were able to save the life of the mother. Dr. Bigelow finished describing the incident with this statement "The 'gamps' were great boosters of mine for the next two years of my practice there" (ibid 54).

A second incident, which occurred in 1908, not only illustrates the mutual respect which existed between the physician and midwife but offers a snapshot of rural life in Manitoba. Dr. Bigelow had just set up practice in Brandon and was called out on a maternity case between Nesbitt and Wawanesa. He writes:

As I entered the small, isolated farmhouse, I was immediately aware of an old midwife sitting on a chair, with her feet on the hearth of the stove, looking into the fire (the door of the stove was open), smoking a clay pipe.... She was quite elderly and as I entered, I said 'How long have the pains been on?' 'Started yesterday morning, Doc, and she is not getting anywhere' I asked her if the pains were coming very often, and she said, 'No, they are not. I think we will have to quill her.' I did not know what 'quilling' was; I had never heard of it before or since. I did not want to show my ignorance to her personally, so I said, 'Well, we will wait awhile, I hope we can get along without quilling' (ibid 51).

Doctor Bigelow observed the woman for some time and when labour did not proceed as it should have, he suggested to the midwife that she proceed with the 'quilling'.

She immediately got up from her chair and pulled down the wing of a goose which was hanging on a nail behind the stove. She got a nice long goose quill (a waive one it was) and cleaned the inside of the

quill, cutting off both ends. She went to the cupboard and dipped one end of the quill into a small package of cayenne pepper. I wondered what the devil was coming next, so I followed her into the bedroom. She took the quill and inserted it in to the nostril of the patient, then gave it one big blow, and away went the cayenne pepper into the poor woman's nasal cavity. I knew what was liable to happen. She began to sneeze immediately. With the sneezing the midwife said, 'Doc, you'd better get ready' (ibid 51-52).

By the time Dr. Bigelow had taken a look at things, the perineum was bulging and with another "few sneezes", the baby was born.

If Dr. Bigelow's writing provides evidence of the cooperation which existed between the medical personnel so too does that of Nurse H.E. Gerry. Nurse Gerry, a graduate from the Training School of the Royal Alexandra Hospital at Edmonton worked for five years as a travelling nurse in the Indian Service. She took a public health course at the University of Toronto and then returned as a travelling nurse to the Vancouver-New Westminster District.

In writing of her personal experiences Nurse Gerry describes the multitude of activities which occupied her on a day to day basis. She states:

And here we are at another door. Oh, isn't that nice, a clean, tidy midwife meets you and you hear that this baby is four hours old. So questions and answers and the baby's eyes treated, and mother visited upstairs - and away we go. That midwife is good - wise in the ways of her art as learned from her mother (Gibbon and Mathewson 1947: 449-450).

It would appear that in the first forty years of the twentieth

century, although the objective mechanisms were in place, medicine did not completely dominate birthing practices especially in the rural and remote areas. This was due primarily to the lack of medical practitioners to assist women in childbirth as well as the isolation of these settlements. Nevertheless women were continually socialized into accepting the physician as the only competent birth attendant.

An examination of the actual birthing practices suggests that the dominant birthing ideology was more intensely integrated into a society's birthing practices at the point of its origins, but was less influential in the more remote areas of the country. In the larger urban areas, where there existed universities with medical schools and an established profession of physicians with various medical specialties, the dominant ideology of birthing prevailed. Most women expected to be attended in childbirth by a physician and the nurse's role was to assist him during the delivery. The dominant ideology had become sufficiently integrated within society for it to have an effect upon the consciousness of most women.

However, as the dominant birthing ideology was directed outwards, away from the centre of its origins and towards the more rural areas, it lost some of its potential for influencing birthing activities. A belief in self-help and cooperation necessary for survival in the harshest of

circumstances was more powerful than that of the dominant ideology developed by the establishment. As a result, local physicians, nurses, and midwives often worked together in a congenial atmosphere providing women in childbirth with as adequate care as possible given the particular economic and social conditions. Nevertheless, over time and with an increase in the number of physicians, the dominant birthing ideology was able to take root and flourish within the rural areas.

Finally, farthest from the axis of its origins and in the remotest areas of this country, the dominant ideology had little effect. Physicians were (and still are) usually unwilling to work in such isolated conditions. Therefore trained nurses were not only allowed to practise (including midwifery) independently in these areas, but communities depended upon them to meet all their health care needs. Thus, nurses in their new found freedom not only provided exceptional health care to the people they served but developed an independence of character which was not easily tolerated by the medical profession. Once these nurses returned to the urban centres they were expected to revert to the submissive role as dictated by the dominant ideology. Nevertheless, it is still these remote frontier areas which provide nurses with the working conditions which allow them to develop their potential as independent health care workers.

By describing the birthing ideology as moving outward from the

center or axis of its origins to the remotest settlements of the country, it is possible to understand why birthing practices varied from region to region. This movement resulted in a dominant ideology having more or less of an effect upon the birthing practices of a given area, according to its particular location, social, and economic circumstances. However, after the 1940's it was only the most isolated areas which did not feel the effect of the newly developed system of maternity care, that of obstetrics.

The Integration of the Dominant Ideology into the Health Care System

A theme which has permeated much of this analysis is the relationship between the 'root ideology' which legitimates society, that of science and technology, and the development of an obstetrical system which is principally rooted in and legitimated by science. This model for maternity care arises out of a system of healing, allopathy, whose practitioners are of the upper and middle classes. As a result, there is a link between class interest and the development of obstetrics. Although it is the objective of this work to examine the origins of the ideology of maternity care and its determinate effects on class relations, it is hoped that such explanations are not understood as an instrumentalist argument whereby dominant ideology is reduced to a form of indoctrination generated within the dominant class. Dominant classes do tend to

'benefit' from the effects of dominant ideology, although not necessarily due to their own deliberate activity. Subordinate classes do tend to become politically quiescent, although the degree of incorporation is debatable. Nevertheless, it is necessary to avoid the oversimplified notion of 'one class doing something to another'. Therefore ideology should be understood as a set of practices or as real social relations. The effect of ideology is to be socially effective, although the ideological component is usually hidden from the actors.

Ideology plays a significant role at several levels within society. At the highest level there is the 'root ideology' upon which the state depends for legitimation and justification. According to Habermas the form of ideology required at this level is one which is similar to traditional societies in that it must provide a direct and over-arching system of values. Science and technology provides such a belief system for the legitimation of contemporary societies. It can be argued that at the turn of the century for the middle class and upper class, science was not only a method or discipline but a kind of "religion". In 1890, the social commentator Thaddeus Wakeman was asked what 'creed' best suited Americans. He replied:

The answer is, that which he knows to be true, - and that, in one word is *Science*. The majority of the American people are already *practically secularists* - people of this world Our people are

unconsciously welcoming the incoming sway of Science and Man; and this is proved by their absence from the Churches (Ehrenreich and English 1979: 71, original italics).

At a second level, ideology played a significant role in the legitimization of particular birthing practices. Obstetrics is a discipline within biomedicine, which is a system of healing predominantly rooted in science and based on anatomy, chemistry and molecular biology. With the development of obstetrics and over a period of about fifty years, three trends gained in momentum. The first saw the replacement of the female midwife by the male physician; the second, the transformation of birthing from a natural to a medical event; and the third, the transference of the birthing event from the home to the hospital. The significance of this third trend can be comprehended by examining the data published by Statistics Canada (1971-1977) on the percentage of births occurring in hospital and as outlined in Table 2. In 1926 only 17.8% of all births took place in hospital; P.E.I. had the lowest percentage with 2.7, B.C. the highest with 48.3. By 1942 (that is within 16 years) the percentage of hospital births in Canada was 53.7%. The major increase in hospital births took place in the first 20 years from 1926 to 1946. The increase in Canada was 49.8%. This was double the increase for the next 20 years (1946-1966 which is 21.6%). By 1966, 99.2% of all births in Canada occurred in hospital. It is difficult to understand why hospitalization for

Table 2 - Percentage of Births Occurring in Hospital, Canada and Provinces 1926, 1942, 1946, 1966, 1976 *

Year	Canada	P.E.I.	N.S.	N.B.	Qué.	Ont.	Man.	Sask.	Alta.	B.C.	Yukon	N.W.T.
1926	17.8	2.7	7.3	8.5	4.8	24.9	31.3	22.5	33.5	49.3	"	"
1942	53.7	36.9	57.2	34.9	22.1	72.7	77.4	69.3	70.9	89.2	"	"
1946	67.6	66.0	74.5	53.6	36.0	84.7	87.1	86.7	93.1	95.0	"	"
1966	99.2	99.8	99.6	98.8	98.8	99.7	98.9	99.3	99.0	99.2	93.2	77.6
1976	99.7	99.7	99.8	99.8	99.7	99.6	99.9	99.6	99.7	99.2	98.6	99.1

Statistics Canada (1971-77) *Births*. Vol. 1, 84-204.

* Percent of total live births

childbirth from the years of 1926 to 1946 was greater west of the Ontario-Quebec border. However, the Medical Care Act of 1966 is probably a major reason for the 99.2% figure by 1966⁴. Nevertheless, it can be concluded that the main push to transfer birthing from the home to the hospital occurred prior to 1940. Once a certain level of hospital birthing had been achieved, it was sufficient to let the system take its own course for the ultimate ends to be achieved. This resulted in 99% of all births occurring in hospital. Birthing had become a medical event requiring supervision by a predominantly male medical profession. The transformation process was complete.

At a third level is the ideology of the middle and upper classes which dominated the obstetrical system, and the effect it had upon the development of particular birthing practices. For Gramsci, there is no

such thing as an autonomous intellectual stratum. Physicians as members of an intellectual elite are attached to a social class and as such articulate the view of the social world appropriate to 'their' social class.

As far as the ruling class is concerned, it is an intellectual stratum that refines and presents its world-view and thus provides an important part of the apparatus whereby the ideological component of ruling-class hegemony is preserved and transmitted (Abercrombie et.al. 1980: 13-14).

Since birthing is an exclusively female event, it is the upper and middle class' view of women which is relevant to this discussion. As previously described, three general beliefs about women permeated the traditions of the upper class and tended to filter down to the emerging middle class. The first saw women as frail, dependent and in need of control by men. The second view perceived that women's primary function was to produce heirs and to enhance the husband's social and economic position. The third view required women to manage the welfare system, that is to do works of charity. It is these aspects of the articulated view of women which have become embedded in the practices and real social relations of our present day birthing system.

The first view, which requires women to acquiesce to subordination to men, is an integral part of modern obstetrics. Because of women's frailty, she is understood as requiring medication and anaesthetics for childbirth as by definition she is in a state of "pathology" or at least

imminent risk of it. As a result of being anaesthetized women are unable to feel the contractions of the uterus. Forceps become necessary to replace the muscle effort required for the birth of the infant. It is in this way that women are aptly described as being delivered by the physician, rather than as giving birth. Since women are deemed as dependent, they are upon entry into the hospital relieved of all decision making powers, and responsibility for their state is passed from them to the hospital personnel and physician in charge. A parturient woman becomes the passive patient who submits to the authority of the physician. The physician's maleness becomes a symbol of safety; the parturient woman's femaleness a condition in need of male medical control. Modern obstetrics has acquired a distorted orientation. It is male biased and pathological orientated. This is the first major effect of the dominant ideology upon the set of practices and real social relations involved in birthing.

The second effect was upon the nascent occupation of nursing. The view of women as enhancers of the social and economic position of men as well as workers for charity was subtly integrated into nursing. Symbolically, nurses were to the physicians what women were to their husbands. Since the inception of nursing, women were required to acquiesce to subordination by physicians. They were expected to obey

physicians and to be loyal beyond question. Isabel Hampton, in a speech at the World's Fair in 1893, characterized the nurse in a manner which was typical of the way nurses were viewed;

The hands of a nurse are the physician's hands lengthened out to minister the sick. Her watchful presence at the bedside is a trained vigilance supplementary and perfecting his watchful care; her knowledge of his patient's condition an essential element in the diagnosis of disease; her management of the patient, the practical side of medical science (cited in Stuart 1987: 146).

Since the ideology of the dominant classes projected the idea of women as appendages to their husbands, this same view was extended to include nurses in their relationship with physicians. Women, as nurses, assumed the same submissive, nurturing role which was occupied by Victorian wives.

Finally, it was the duty of women of the upper class to perform the important function of managing the private charitable and moral organizations. With the development of the capitalist class, the bourgeois woman and those of the upper class made greater demands for themselves by pushing for better education and greater equality of opportunity. Because of the dominant class attitudes, these women were channeled into occupations that dealt with women and children.

Eva Gamarnikow (1978:112) in her article "Sexual division of labour: the case of nursing" writes that it was the intent of the nursing

reformers to create jobs for women in health care, not to intervene in the hierarchical structure of the health care system. The struggle was to make nursing a paid job rather than a voluntary one. Although nurses were paid, their occupation retained the essential perception of women's role in society as managers of charity and moral organizations. Miss Nora Livingston, superintendent of nursing education at the Montreal General Hospital, in a letter of 1897 to Lady Aberdeen wrote about her concerns over the hiring of personnel for the V.O.N. She states;

It should not only be the *trained* applicant but the exceptional woman who should be chosen to serve in the highest of all service, that of God's poor. She must have breeding, tact, courage, self control ... (Gibbon 1947: 7 original italics).

This would indicate that nursing was perceived as being more of a vocation than a job and women who entered the field were fulfilling their moral as well as their charitable duties. The fact that in 1929 only eight percent of all Canadian public health nurses had ever married (Stuart 1987: 60), suggest that nursing carried with it the overtones of a vocation.

In her book *Taking The Veil*, M. Danylewycz (1987: 69-70) discusses the conditions surrounding women's work in Quebec during this period. Women were socialized into understanding their work experience in the context of the family. Through their experience they were taught

to think of themselves as:

an integral part of the family economy, the surrogate parent for the younger sibling, a vital yet individually dispensable machine operator, and a maiden in waiting expecting to contract a marriage and to set up an independent household the expansion of women's work and roles, combined with the dominant ideology that cast the "gentler sex" into the mould of mother and helpmate, thwarted women's attempts at self-improvement and tempered their expectations.

The result of the integration of this dominant class ideology into women's work was to create a socially effective practice whereby women were expected to give of themselves to their work in a manner which reflected the devotion of a mother or helpmate with little financial compensation.

The Social Conditions Relating to Midwifery 1900 to 1940

With the increased development of industrial capitalism in Canada, women became more directly integrated into the economy. Mass production required a large pool of labourers. As a result of this, women from the lower classes became a source of cheap industrial labour.

Women from the middle and upper classes were segregated into occupations which were considered as women's work, and women from all classes were paid lower wages than their male counterparts.

Gender attitudes which had gained greater acceptance during the latter half of the nineteenth century appeared to become more fully

integrated within society in general. Concern for women's physical and moral weakness influenced the position occupied by lower class women in industry. Similarly, it was deemed as necessary by society to segregate middle and upper class women into work relating to women and children. The internalization of the prevailing gender ideology is evident in the development of the occupation of nurse midwifery. These women acquiesced to subordination to physicians. Symbolically, they appear to have assumed the role of the Victorian wives; they assisted the physicians in their enhancement of their symbolic and economic capital; they worked for very low wages suggesting at least in part that nursing was an extension of women's function to do charity; and they accepted subordination with little protest. Childbirth mirrored the prevailing gender ideology. From 1900 to 1940 the pattern for contemporary maternity care was firmly established. Birthing, now understood as pathological or of having imminent risk, was under the direction of a physician, and took place in the hospital, a setting over which physicians had jurisdiction.

Not all women adhered to the beliefs surrounding their gender. Exceptions were those women of the suffragette movement who fought for and gained the right of women to vote (1918), and similarly, the acceptance of women as 'persons' (1929) under the British North America

Act. Nevertheless, once these two demands were achieved the movement lost strength until its revival in the 1960's. The gender attitude which gained in strength from 1850 to 1900 appeared to have become more firmly integrated within society and women's consciousness from 1900 to 1940.

Medicine continued to improve and develop during this period. As discussed in chapter one, the discovery of sulfa drugs and antibiotics led to a decrease in maternal mortality. "The impact of the major scientific discoveries of the golden era of medical research were being incorporated in practice, producing tangible results for the first time" (Torrance 1981: 17). The medical profession also made further achievements in its standardization of medical education. The Flexner report influenced the development of higher standards of education. It also reduced the number of students admitted to a program, the number of medical schools available to students, and increased the length of medical education. This had the effect of limiting medical education to mostly middle and upper class white males. The federal state intervened on behalf of the medical profession with the passing of the Canada Medical Act of 1902. Medical qualifications were standardized in Canada. The Medical Council of Canada was formed giving physicians one major body which could speak on behalf of all of them. "The hegemony of scientific medicine practised by

a closed, elite circle of men, was consolidated" (ibid 17).

As Gramsci has argued, the subordinate classes do not uniformly have a consciousness imposed upon them by the dominant class. Within the consciousness of women there remained (if only at the level of common sense) a perception of their own strength and independence. Women did not altogether forget the tales of their grandmothers, who played a central economic role in the development of this country, fought for the vote, and who had ten children without a physician ever entering the home. Despite the fact that women retained this consciousness, their incorporation into the prevailing 'root ideology' with its various manifestations tended to produce a moral and political passivity. The development of their consciousness to a state of self awareness and political activity was what women needed. With the resurgence of the women's movement in the 1960's this, in fact, has been occurring. As a result of this new development women began a new phase in childbirth, that of reclaiming the birthing experience.

Chapter 6

From A Dual To A Feminist Consciousness: 1940 To 1987

1940 to 1987 was a second period of major transition for women and midwives in Canadian society. More women than ever entered the labour force. This entry of women into the labour force did not translate into a higher economic status. Beginning in the 1960's women were assessing the dynamics of the social structure in which they found themselves. Their objective was to create a new self-understanding in order to change their social situation. They articulated their grievances and in the process sought to improve their social conditions. This period is marked by an all out effort by feminists to alter gender attitudes. Medicine itself had become technologically most advanced. Yet because of the overuse or misuse of technology, feminists believed that they had lost control over their bodies. As a result, health care became a women's issue. On the other hand, physicians, backed by their professional organization, sought to prevent any erosion of their power. For the first time, since the Ontario legislation of 1815 which exempted midwives in Ontario from licensing procedures, the state (Ontario) intervened on behalf of midwives by establishing a task force whose job it was to provide a plan for the implementation of midwifery in Ontario. Tensions and conflicts were prevalent in this period, as women and midwives

sought to reclaim birthing, and the medical profession attempted to retain all of its powers over maternity care.

A feminist Marxist analysis understands women's "victimization" as being identical to that of the generally exploited. According to Abercrombie et al. (1980: 14), Marx, Engels, and Gramsci argue that the working classes do not uniformly have a consciousness imposed upon them by the dominant class. They have a dual consciousness; one which is superficially explicit or verbal as it has been inherited from the past and uncritically absorbed; and a second which is implicit, and unites individuals to their fellow-workers "in the practical transformation of the real world" (ibid 15).

Since physicians are a part of the dominant class, it can be assumed that they are also members of the ruling intellectual force. As such they have been able to develop birthing practices which have monopolized the birthing event. Because women are identified as being exploited, it can be reasoned that those practices which have been promoted by the medical profession will have had prominence over those which have originated out of a women's culture.

It can also be argued, that although most women have submitted to the biomedical model of birthing under the supervision of a physician within the hospital setting, many have retained a belief in the

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naturalness of childbirth and the expertise of the female birth attendant. It took the reemergence of the women's movement in the 1960's to create an awareness of the basic distortion in orientation of modern birthing practices (i.e. the male gender bias). It was this along with increased technical interference which persuaded some women that the system must be reformed. By the 1970's, individual families were refusing to submit to the biomedical birthing system. Instead, they searched out and received help from midwives. Because of the demand for an alternative system of birthing, loosely-knit organizations of midwives were established in the various regions of Canada. By the 1980's the demand for midwives was sufficient for at least one provincial government, that of Ontario, to begin the process of recognizing midwives through the development of licensing procedures.

Between the 1940's and the 1980's nurse midwives continued to practise in areas where physicians were not available. Such activity was legitimated through the development of three university programs, one at the University of Alberta; a second at Dalhousie University; and a third at the Memorial University School of Nursing. As a result, there continued in Canada a two-tiered system of birthing attendants; one within the more populated areas which recognized only the medical profession; and a second, in the remote frontier regions such as the Yukon and the

Northwest Territories which recognized the university-trained nurse midwives as legitimate health care workers.

The Development of Nurse Midwives

In Alberta, Health care policy was clearly outlined. The Alberta Nursing Act of 1919 stipulated that public health nurses could in no way compete with physicians in those regions where there were sufficient numbers of medical practitioners. However, nurses could practise in the designated portions of the province where in the opinion of the Minister of Health, registered physicians were not available. With this policy, physicians were protected from entrance of any unwanted health care workers into what they considered as their domain, ensuring sufficient economic returns. In those areas where there were no hospitals or medical practitioners, provincial district nurses could assume responsibility for the public's health care needs. It was because of this policy that the University of Alberta, in 1943, administered the first course in advanced practical obstetrics for district nurses in Canada.

In September of 1943, four nurses, all with public health experience, were admitted into a three month program. The course provided instruction and clinical experience in antipartum, delivery, and postpartum care of pregnant women. The instructor was a former district nurse who held a certificate conferred by the Central Midwives Board for

Scotland. This first two months consisted of lectures from a professor of obstetrics and gynecology of the University of Alberta, manikin practice, and lectures on the care of the newborn and premature infants. The students also observed birthing in the two cooperating hospitals. The third month was spent in the field, where the students obtained practical experience. It appeared that the students did not receive enough cases to provide them with sufficient experience (Willis 1944; 250). With this limited education, the nurses returned to their stations in the remote parts of the province.

In 1961 the Central Midwives Board of England and Wales recognized the University's advanced practical obstetrics as the equivalent of a part of their midwifery program. Those nurses who satisfactorily completed the University of Alberta "Advanced Practical Obstetrics for District Nurses" possessed qualifications equivalent to the Board's first certificate. They, therefore, could be enrolled into the English program and after six months of further training, and the passing of the second examination be admitted as midwives (Madden 1962: 626). At this time, the University of Alberta offered the only program of its kind in Canada.

By the 1960's, the School of Nursing and the Medical School at Dalhousie University were discussing the problems of nurses who worked in the remote sparsely populated areas of the Canadian Northland. An

assessment of the services provided in the north indicated that a large number of nurses were either foreign born or foreign educated. This pattern had developed because it was desirable for the nurses to have had some formal preparation in midwifery and such training and education was difficult to obtain in North America. It was decided that a program should be developed which would prepare Canadian nurses for isolated regions in the Canadian north. Education would not only be in midwifery but also in those areas where the nurse was required to function beyond the scope of nursing elsewhere in Canada. From this idea, the "Outpost Nursing Program" at Dalhousie was born.

In September of 1967 the first class, eight students, all graduate nurses with at least one year of professional nursing experience, was admitted into a program which extended over two calendar years. Since public health nursing was an integral part of the program, graduates received a diploma in public health nursing as well as a diploma in outpost nursing. In the first year students remained in Halifax where they received clinical teaching in the areas of general medicine, surgery, pediatrics, and midwifery. Practical experience occurred within the three teaching hospitals in Halifax and under the supervision of the medical school personnel. Students were required to develop skills in the basic physical examination as well as in various specific procedures such

as the starting of intravenous infusions, suturing, and the opening of superficial abscesses. The second year consisted of internship under the direction of the University in selected hospitals and nursing stations. The students spent half the year exclusively within the area of midwifery at St. Anthony Hospital, St. Anthony, Newfoundland. The remainder of the year was devoted to further teaching and supervised experience in public health nursing, clinical medicine, surgery, and pediatrics.

Midwifery was emphasized. Every student was required to put in nine months of experience; three months in the first year and six months during the internship year. The students were also required to assist thirty to forty women in childbirth. They were given experience in postpartum care, management of the normal newborn and the premature infant, and the care of patients with abnormal courses. As well as obtaining extensive experience in antenatal clinics and family education, students made home visits to mothers and babies following discharge from hospital. The program was arranged in such a manner that it was the equivalent, not only in content but also in time, with the British pattern of midwifery. It was felt that the graduates could be expected to function at the same level of competence (May 1967: 35).

By 1981, Memorial University School of Nursing had become the third Canadian School of Nursing to offer a post graduate degree in

outpost nursing and nurse midwifery. It also was geared towards the nurse intending to work in the more isolated areas.

An analysis of the two articles by Willis (1944) and May (1967) suggests that most nurse midwives retained a dual consciousness as it related to birthing practices. Nurse midwives are subordinate to physicians. As a dominated group they have uncritically inherited and absorbed the dominant ideology i.e. that only physicians are capable and should assist women in childbirth. For example Willis (1944: 249) in discussing the university of Alberta program writes: "The object of this course definitely is *not* to establish a system of midwives in Alberta" (original italics). Similarly May (1967: 35) in reference to the outpost nursing program at Dalhousie University states: "It should be noted, also, that it is never intended for these students to use the specific skills developed within this program in other areas of Canada where such care is provided by resident doctors."

Nevertheless these nurse midwives also retained a consciousness which was at the level of common sense, incoherent, and yet unifying for its members. Common sense indicated that all women require assistance during childbirth. Since physicians were not willing or able to provide maternity care in the more remote isolated regions of the country, nurse midwives assumed this responsibility. Such a conscious perception of

their role was both incoherent and fragmented. If nurse midwives were educated and capable of assisting women in childbirth in isolated areas under particularly harsh conditions, they were certainly capable of such care in the more populated areas where greater resources were available. However, because nurse midwives were continually socialized into the view of the medical profession (that physicians must be in control of birthing practices) they failed to question the inconsistency of such a policy and as a result were able to function quite adequately with this dual consciousness. It was not until the 1970's that educators, such as Pat Hayes of the Alberta School of Nursing in Edmonton, pointed out the contradictory and fragmentary nature of such a health care policy.

In an article called "Midwives? In Canada? Lets hope so!" (1971) Hayes outlined the "hypocrisy" of our health care system. For example, we say we do not have midwives in Canada, because we have no midwifery schools. However, the government staffs northern outpost hospitals and many obstetrical units with midwives who have obtained their education in Great Britain, Australia, or New Zealand. We are not allowed to train midwives but if programs are established as practical obstetrics or outpost nursing, they become acceptable. According to health care policy, midwives are classified as "inferior beings" in the populated areas of the country. Nevertheless, they can be used as replacements for physicians in

regions considered as unsuitable for medical practitioners. Through such actions, we indicate that we believe that midwives are adequately qualified to give northern people, such as our native Canadians, services which for the rest of the population are performed by physicians. This suggests that midwives although lacking the necessary qualifications for other segments of the population are nevertheless qualified to serve natives .

In the United States nurse midwives practise in the large public hospitals or in the economically deprived rural regions. Few are employed in the power strongholds of the middle class. Similarly in Canada, skilled midwives are only used among the poorer groups that demand services which physicians are unable or unwilling to provide. "There are no monetary gains in serving the poor." (ibid 18). Hayes believes that now with medicare in Canada there are no large medically-indigent groups. Therefore there are few economic incentives to prepare midwives.

Hayes concludes her argument by stating that midwives must be universally accepted to practise in all areas of the country - rural and urban, suburb and inner city hospital, and community, as well as in the isolated regions. Midwives should be accepted not as poorly qualified substitutes for physicians but as highly qualified nurse practitioners. If Pat Hayes is representative of a new era of nurse midwives, it can be

concluded that the consciousness of these health care workers has evolved to the point where the dominant birthing ideology is far less acceptable.

What has caused this change in perception? It is my contention that the resurgence of the feminist movement in the 1960's has been a major factor, although not the only one, in the evolution of women's consciousness to a new state of self-awareness. This in turn has led women to demand more control over birthing practices and the reinstitutionalization of midwifery.

The Revival of the Women's Movement

The women's movement in Canada had its beginning in the suffrage movement, a group which is said to have been founded by the Toronto Women's Literary Club in 1876. A neutral name was deliberately chosen to avoid a public reaction. Seven years later the club was renamed the Women's Suffrage Association (Wilson 1982: 116). Key issues at the time were increased educational opportunities for women, property rights for married women, health and welfare reforms, and improved conditions of work for the increasing female industrial labour force.

In 1918, as part of a whole international political event, Canadian women were granted full federal franchise (ibid 117). Provincial voting rights were granted individually with the prairie women receiving the

provincial vote first in 1916, and women from Quebec last, in 1940. Once women had received the right to political participation the next step was to ensure women were "persons" under the law. Under the terms of the British North America Act and according to British Common Law "Women are persons in matters of pains and penalties but are not persons in matters of rights and privileges" (ibid 119). Although women could vote and run for public office, they could not become members of the senate as only "persons" could be appointed to the senate and women were not "persons". Five women from Alberta (Emily Murphy, Irene Parlby, Louise McKenny, Henrietta Edwards, and Nellie McClung) filed a petition to the Supreme Court of Canada in order to obtain a ruling. The Supreme Court upheld the original law. This was appealed and then reversed by the Privy Council in Britain. In October 1929, women finally achieved full citizenship and the first woman senator, Cairine Wilson, was appointed in 1931.

The organized women's movement lost momentum until the 1960's when the revival of feminism became wide spread. In Canada the movement was not a unified organization but was rather a myriad of concerned women in loosely organized groups, who sought to recast gender roles. The causes for this reemergence were complex. Increased industry had brought more women into the labour force. This in turn

created dramatic disparities in status. More married women with children were working and as a result experiencing pressures and frustrations.

Based upon the 1961 Census, Sylvia Ostry (1968) has explored the labour force behaviour of women in Canadian society. She found that the population of adult women who worked rose from a low of 14% in 1901 to almost 30% in 1961. In that same year, more than one-quarter of Canadian workers were female. This is in comparison to less than 15% in 1901. By far the greatest increase in the labour force was due to the women in the middle age group 35 to 44 and 45 to 54. The majority of this group, of course, were married. Just one-third of teen-age girls worked, but the proportion increased to one-half for young women aged 20 to 24. As women married and had children, a smaller proportion remained in the labour force.

At every age of the working cycle, labour force participation was much higher for urban than women living in rural areas. Farm women have usually worked on the farm but this was probably not taken into consideration. This was due to the fact that white collar, trade, and service jobs were concentrated in the urban centres.

Marriage reduced the desire of women to enter the labour market. In general, the participation rate of married women was below half that of

single women and at the child bearing and child rearing age, the gap was greater. The preference to stay home was bolstered by the social mores and in the case of small children, the views of eminent authorities in the field of child care (ibid 15). Participation in the work force was less for women with infants and pre-school toddlers, than for married women in general. In other words, whether a married women worked or not was influenced not only by the fact of children but also the ages of the children. The income of the husband had a direct bearing upon whether women worked or not. An analysis of the data indicates that the lower the husband's income, the higher the frequency of labour force membership of wives (ibid 25). These same women tended to return to their house keeping and children as soon as the husband's income made such a choice feasible. On the other hand, childless women may have been more influenced by consideration other than income in seeking jobs outside the home.

The better-educated married women were more likely to work outside the home. However when a husband's earning ability was very high, women were not as likely to work.

The 1961 Census data suggests that women who worked contributed substantially to the family's economic well being. Through her work, a woman was able to raise the family income on an average of 50% above

the husband's income.

Nevertheless despite the extent of female participation in the labour market and the range of jobs open to women, the average earnings of female workers were only slightly better than half those of men (ibid 39). Within the higher level occupational categories, disproportionately more women than men worked at the lower paid jobs, and job for job there were above average pay differentiation between the sexes.

In summary, this discussion of earning differences between men and women revealed that even after 'accounting for' differences in the work year, occupational deployment and 'quality' of labour between the sexes, there remained fairly sizeable pay gaps between the male and female workers in Canada (ibid 45).

Connelly (1977) has concluded that as the standard of living rose in Canada, married women whose husbands earned lower income, had to join the labour market in order to maintain their relative standard of living. In other words, these women do not work in order to close the gap between rich and poor families but to prevent the differences from increasing. Middle class women were less obliged to work and had more discretion about trade-offs between time and income. Marchak (1977: 7) believes that their unemployment rates are probably more cyclical.

Canadians were also influenced by the activities of American women. In 1966 Betty Friedan formed the National Organization of Women (NOW). The fact that Friedan was able to use extensive media contacts to

create an impression of the size and strength of the movement undoubtedly has had an effect upon Canadian women. According to Teather (1976: 315), the American movement acted as a catalyst rather than having a dominant or major influence upon feminism in Canada. The civil rights movement in the United States focused upon black rights and this was a major impetus to feminism there. In Canada, issues such as peace, international harmony, human rights, native rights, aspects of the ecology movement, and biculturalism were important in leading to a focus on women's rights.

What was occurring in Canada was a growing awareness of the contradictions of an affluent society, and the existence of inequalities. This in turn combined with the general radicalism of the 1960's. Out of this milieu, networks of communication began to grow. A first type of network originated within the traditional political and social organizations; a second out of a more loosely organized 'radical community'. Although the approaches differed, both networks were rooted in a perception of women's secondary status. Furthermore, the women involved in both movements were usually white, highly educated, and middle class. The obvious exception which comes to mind is Rosemary Brown who in 1975 ran for the leader of the New Democratic Party. They were able to provide the necessary organizational structure which in turn

had the capacity to unite the many disparate groups into a loosely organized social movement.

In her analysis of the women's movement in Canada, Lynne Teather (1976: 316) has labeled three separate branches of feminism which exists within the general movement. They are Women's Rights, Women's Liberation, and Feminism. As she indicates, these terms are only labels and like any labels, are difficult to apply in practice as there is overlapping of groups, individuals, and theories. Nevertheless, these three labels do correspond to categories as outlined by Jaggar and Struhl (1978: 70-74) in their work called *Feminist Frameworks*. Women's Rights can be equated with Jaggar and Struhl's Liberalism, Women's Liberation with Marxism and Feminism with Radical Feminism.

In liberal feminism the stress is always on the equality of opportunity. These feminists do not criticize as such social inequalities in wealth, position, and power.

What they do criticize is their distribution on the grounds of some inherited and not obviously relevant characteristic such as family, race, or sex. Liberals believe that each individual should be able to rise in society as far as her or his talents permit, unhindered by restraints of law or custom. The proper reward for the exercise of an individual's talent should be determined by the demand for such talents in a market economy (ibid 70).

According to liberalism, the roots of women's oppression lie in a lack of equal civil rights and educational opportunities. Therefore

women's oppression can be tackled directly through an attack on sexist discrimination. Once this discrimination is eliminated women will be liberated.

Liberal feminism, or in Teather's term Women's Rights, originated in Canada within the traditional political and social organization which were earlier represented by the suffragists i.e. business and professional bodies, service, and church organizations. Women in this group are frequently middle-class, married women of middle-age or over.

In 1966, Laura Sabia, then president of the Canadian Federation of University Women, invited forty national women's groups to discuss the possibility of setting up a government commission to study the situation of women in Canada. This resulted in the Committee for Equality of Women. A brief was prepared and an appointment arranged with Prime Minister Lester Pearson. He failed to meet the delegation but instead sent Judy La Marsh and Lucien Cardin, Minister of Justice. This was taken as a personal affront by the women and so the confrontation began. Because of their protest, a Royal Commission on the Status of Women was appointed with Anne Francis as head. This proved to be an amazing catalyst and focal point for women. In 1970 the report was tabled in the House of Commons and in 1973 one of the recommendations was accepted. This resulted in the establishment of the Federal Advisory Council on the

status of Women. Since then it has been concerned with such things as equal pay, child-care services, birth control and abortion, family property law, rape and wife abuse, and women and politics.

Other organizations which could be listed as Women's Rights groups are the National Council of Women (founded in 1893 by Lady Aberdeen), the Canadian Federation of University Women, YWCA, and the National Council of Jewish Women of Canada. These groups approach the problems of women in a variety of ways. For example, the National Council of Women is interested in women's rights which are based on traditional values i.e. her role in the family or as a special moral force. Nevertheless the council does support the more radical issue such as the removal of abortion from the criminal code. Other organizations are more adamant in promoting women's equal status. Some women within the YWCA and the Canadian Federation of University Women are engaged in issues such as legal inequities and employment discrimination. Although differences in viewpoint tend to be blurred when it comes to practice, groups that fall within liberal feminism do basically work from within the existing social structure. As a result they often show the ambiguities of such a position (Teather 1976: 316-321).

All the presumptions of Liberalism are challenged by Marxists.

For the Marxist, what persons are like-their motivations, interests,

and abilities, and even their needs—is very largely a function of the form of society in which they live and of their place in that society. Yet, insofar as human beings create forms of social organization, persons are not seen as totally passive beings at the mercy of their environment; rather, as they create their society, they are the ultimate and active creators of their own nature (Jaggar and Struhl 1978: 71).

Marxists reject the liberals belief that it is possible to have a genuine equality of opportunity for the development of human potential as long as individuals live within a class society. In such a society many produce the wealth, but the wealth remains within the hands of a few. All aspects of life, including the conditions under which people work, the education they receive, and even their personal relations, are determined by the profit motive.

Marxist theory locates women's oppression within a particular system of social organization. As previously indicated the traditional Marxist understands women's oppression as being rooted in the introduction of private property. Ownership of the means of production is controlled by relatively few persons and those are overwhelmingly male. This in turn leads to the institutionalization of a class system. Imperialism and contemporary corporate capitalism are but the latest phase of this development.

According to Marxism the key to understanding social change is to recognize the irreconcilable conflict between economic classes. Gender

oppression is a secondary phenomenon, a symptom of a more fundamental type of oppression. Therefore prejudice against women will disappear only after a social revolution in which the means of production are once more the property of society as a whole.

Marxist feminists evolved from the student activism of the 1960's. Members of this group were in general young, middle-class, and a part of the campus politics of the New Left. Theories of change were arrived at through an analysis of basic oppression in society, particularly as it related to blacks, students, and the working class. Women viewed themselves as a similar powerless group.

Over the next few years there developed a difference in analysis within Marxist Feminism. One view saw the women's plight as a part of the greater struggle for a socialist solution; the other viewed women's oppression as a struggle in its own right. The first group accepted the traditional Marxist approach which presented capitalism and the resulting subordination of women as the historical result of the first division of labour. The second "assigned the cause of women's oppression to a male-dominated society in which sex role stereotypes relegate more than one-half of the population to a lesser status" (Teather 1976: 322).

Initially this philosophical difference was not divisive. It was only when women as members of the New Left organizations were denied credibility

because they were women that these feminists left in a rage to form liberation groups.

In Toronto, a number of women organized the first "Women's Liberation" group in Canada. In a paper presented to the Student Union for Peace Action (SUPA) membership conference, they outlined their objections to being cast in the traditional female roles i.e. as typists, fund raisers, community organizers etc. Their reaction had evolved out of a basic theoretical point. It was their contention that men in the organization did not understand their movement or the concept of liberation. As a result the women had decided to form their own group. They then applied their energies to the causes they deemed as important, day care, working women, marital breakup, education, birth control information, abortion, and oppression against women.

In the period between 1968 and 1972 the movement moved from the major cities to places such as Regina, Saskatoon, Winnipeg, Hamilton, Kingston, and Halifax. In 1969 a conference was held in Sudbury as well as in Vancouver. The abortion Caravan in 1970 travelled through the country providing a forum for women. In Ottawa, members chained themselves to the seats in the House of Commons to protest the abortion issue.

Marxist feminists tended to work in collective, non-structured,

associations. This resulted in groups which formed and disbanded on an ad hoc basis. Many were proud of this lack of organization, but non-structure resulted in a tendency towards fragmentation. There were also disagreements on philosophy such as should they be organized as women or involve themselves in the wider political format. Division occurred and some centres went so far as to disallowing women who were members of what was regarded as male-dominated left organizations from sitting on the management boards. Other women saw the learning of political and organizational techniques as necessary for their own development. Out of this milieu, there grew two distinct orientations. Women who wished to be more politically active, joined the radical leftist groups; other women, while working from Marxist concepts, remained independent from leftist organizations. Based upon their earlier experiences within the movement, they sought to develop their own theories and praxis.

The seventies saw the emergence of a new awareness among working-women across Canada. For the first time in its history, the labour movement focused upon women's issues. Grace Hartman and others on the status of women in the Canadian Union of Public Employees (CUPE) formulated new policies with regard to working women. There was a commitment to working class women and class analysis. Between 1966

and 1974, women within the movement passed through the initial organization into various fields of interest as the movement itself evolved into new phases.

The third framework is Radical Feminism. "What distinguishes radical feminism from all other feminist theories is its insistence that the oppression of women is fundamental" (Jaggar and Struhl 1978: 71). This form of feminism is the least developed and systematic of the theories and can be interpreted in several different ways. According to Jaggar and Struhl (1978), it may mean:

1. That women were, historically, the first oppressed group
2. That women's oppression is the most widespread, existing in virtually every known society
3. That women's oppression is the deepest in that it is the hardest to eradicate and cannot be removed by other social changes such as the abolition of class society
4. That women's oppression causes the most suffering to its victims, qualitatively as well as quantitatively, although this suffering may often go unrecognized because of the sexist prejudices of both the oppressors and the victims
5. That women's oppression ... provides a conceptual model for understanding all other forms of oppression (ibid 74-75).

Feminists who belong to this particular branch of the movement understand that women can only analyze their personal oppression as women and not as part of another group or class. According to Jaggar and

Struhl (1978) there is no systematic body of feminist theory, and yet often their theory is to be found most clearly in practice, for example in women's places, resources centres, and action groups.

One of the founders of the Radical Feminist movement in Canada is Bonnie Kreps. In June of 1968 she presented a brief to the Royal Commission in which she clearly outlined the need to eradicate the sexual division on which our society is based. In March of 1969, a group of women separated from the Women's Liberation Movement to form the New Feminists. The objective of this organization was to awaken the consciousness of women as to the nature and extent of their oppression. They wished to eliminate gender roles through fundamental changes in society. Like other feminists, they were concerned with abortion, birth control, access to education for women, and equal job opportunities. They also added to this list the socialization and the family in relation to gender roles.

In 1973 the New Feminists disbanded. Nevertheless many of these women remained involved in writing, teaching, and women's groups. The reason for disbanding may have been simply that the members had moved on to another stage in their development. The problem may have been more fundamental. Teather (1976) believes that although the Radical Feminists had been able to identify and articulate women's problems, a

necessary first step, they lacked the analysis and strategy to support their vision. By 1976, there were no specifically titled "Feminist" groups although radical feminist theory formed the basis for many women's centres as well as for individual women.

It is important to note, that although labels are used to facilitate identification of the various facets of the women's movement, such clear distinctions do not usually exist. There is often a blurring and merging of groups, individuals, and theories. Since its reemergence, the movement has diversified as women passed through stages of discovery, to consciousness-raising, to organization, and then reorganization. This has resulted in a number of disparate groups within the country, something Teather (1976: 333) refers to as the feminist mosaic. Nevertheless, the major impact of the women's movement is clear. Prior to the 1960's women's incorporation into the dominant ideology had resulted in moral and political passivity. With the reemergence of the organized feminist movement, women developed their consciousness to a new state of self-awareness. This in turn led to political activity.

Midwifery in Canada: 1970 to 1987

Within the present medical setting, male dominance and professional dominance have tended to reinforce each other. There is a belief among feminists that current medical knowledge and practices

have had the indirect result of alienating women from their bodies. Our present system of birthing is but one obvious example of this alienation. The physician's control of the "delivery" and the use of complex technology to monitor the birthing process contribute to the making of women into passive objects of their labour. The wide spread use of Cesarean section and drugs also further removes women from conscious and full participation in the birthing process.

One of the major effects of conscious raising among women has been the development of an understanding of this passivity. This in turn has resulted in a demand by women for control of the major decisions effecting their health. " 'Control' in the sense is the power to decide and is a radical demand, to be clearly differentiated from the victim-blaming that professionals call 'taking responsibility for one's health' " (Fee 1983: 8). This demand for control of ones' body, particularly as it relates to the birthing process, has united two very different groups of women; traditional women who revel in their reproductive capacity; and radical feminists who are engaged in freeing women from the shackles of childbirth. The fact that individuals from such opposing groups have formed an alliance in an effort to legitimate midwifery within the Canadian health care system is an indication of the intensity of their convictions.

For some women, every birth is holy. Ina May Gaskin (1978: 11) in her book *Spiritual Midwifery* explains that:

The knowledge that each and every childbirth is a spiritual experience has been forgotten by too many people in the world today, especially in countries with high levels of technology. This book is revolutionary because it is our basic belief that the sacrament of birth belongs to the people and that it should not be usurped by a profit-orientated hospital system.

The role of the birth attendant, then, is to assist the mother as well as the other members of the family in the full participation of this spiritual event.

In the personal preference of her book *Midwifery is catching* (1985) Eleanor Barrington outlines her beliefs about and experience with childbirth. She understands birthing as a mostly safe, but always sacred event, one which must be understood as a natural challenge, rather than an ordeal to be avoided. Her own conviction about birthing was arrived at after observing several birthing events both in home and hospital. The birth which appeared to have had a lasting effect upon her was that of the first childbirth she observed, a home birth attended by a midwife. She describes it as follows:

Here mother Christine had laboured only five hours for this first child. A study in concentration, she channeled her energy with deep sighs down through her overbloomed belly, smoothing through the pain of each contraction.

Iselina's birth was not an event too holy for humour, nor too magical to admit the midwife's medical precautions. But its essence was

reverence. Reverence for both mother and child. They governed the progress of the birthing. They experienced its completion in uninterrupted bonding (ibid 7).

As a result of her many observations and with the support of her doctor and midwives, Barrington along with her husband made the personal choice of a home birth with alternate hospital arrangements. Her labour was long, twenty-four hours, and painful. She felt that had she been in hospital she would have succumbed to pain-killing drugs. Perhaps her non-interventionist doctor would have felt pressure to do something. In spite of her conviction about natural childbirth, she may have even joined the Cesarean section statistics.

The midwives, Theo and Mary, did not find her progress abnormal. Instead, they responded to each need, assisting in every possible way. Eventually her son Liam was born. Barrington writes:

The immediate pay-off for my hard labour was Liam's vibrant good health. He was born breathing, pink to the toes, alert. He wasn't drugged and he was met by tender hands. My son didn't bother to cry, preferring to suck instead His birth brought me a personal windfall as well. I discovered my own powers of concentration, healing, and meditation. I might never have otherwise put myself to a test that has won me great confidence. Now I understand why women are so strong. A standard medical birth would probably have denied me that knowledge (ibid 10).

Barrington's description of her birthing event is an example which represents the views of a particular segment of the female population. They understand childbirth as an opportunity for human fulfillment. This

is in stark contrast to radical feminist writers such as Shulameth Firestone (1971) who trace women's oppression to their child-bearing function.

Firestone believes that because women must bear children they are dependent upon men for physical survival. This has ultimately lead to women's oppression. If women's subordination is grounded in biology, it is nevertheless biology changed by technology which will bring about their liberation. Firestone implies that such a liberation requires a biological revolution, one which permits the extrauterine reproduction of children. This in turn will eliminate the physical dependence of women on men. Although these two views on women's capacity to reproduce are at opposite ends of the spectrum, there is a single conviction which permeates both perceptions. It is the right of women to control their own bodies. It is this conviction which has united the factions into a feminist alliance for the promotion of midwifery.

The midwifery movement has evolved out of the mutual interests of midwives, feminists, and mothers. Some women have chosen the occupation of midwife because it offered them an avenue for feminist action. Often, they have belonged to politically-motivated women's self-help health groups. Others are women who have practiced midwifery for years and have become feminists because of the experiences they have

encountered in their work. They question the male authorities which have challenged both the validity and legality of their occupation. They feel vulnerable to the legal harassment from medical institutions. Midwives also react against a birthing system which appears to be routinely managed for the convenience of the physicians. It is their belief, that such a maternity system poses health risks for both mother and child.

A third group, parturient women, are also interested in the midwifery movement. Many of these women are developing feminist perspectives. Holly Nimmons of the Midwifery Task Force of Ontario describes their views:

'It is a powerful experience as a woman to be supported by other women in such a dramatic event as giving birth. It is even more impressive to realize the vast difference in care between a female midwife and a male doctor. Seeing their needs better served, midwives' clients learn to look more to other women for support' (Barrington 1985: 151).

Thus midwives, feminists, and mothers formed an alliance with the objective of heightening awareness of the midwifery issue within mainstream Canadian politics.

However, there were divisive issues. Midwives with particular religious views could not accept the anti-abortion stance which many feminists embraced. Nevertheless, by the 1980's, the more moderate midwives were ready to join with feminists under a 'Pro choice - Pro

Baby' banner. This relationship was formalized in 1984. At that time, the National Action Committee on the Status of Women declared their intention to lobby for legalized midwifery. Gradually the concept of choice was defined. It could mean; (a) a choice of whether or not to conceive i.e. birth control; (b) a choice of whether or not to carry a pregnancy i.e. abortion; and (c) choices in childbirth i.e. midwifery or the medical model. Midwifery became integral to the women's movement, and feminism lent to the midwifery movement the political savvy and a complex organizational structure which had the capacity to unite the group into an organized movement (ibid 153).

Eleanor Barrington (1985) provides the most detailed account of the reemergence of midwifery in the 1970's and 1980's. Her description suggests that midwifery, within a period of fifteen years, evolved from an occupation of isolated, independent individuals to a highly sophisticated movement. Originally women began practicing midwifery in response to consumer's demand. From the West to the East coast, midwives, either alone or in partnership with a physician, assisted in home births. The demand for this type of maternity care led to the formation of provincial midwifery organizations. In response to this challenge, medical authorities created regulations which were intended to curtail midwifery activity. Legal proceedings were also instigated.

This in turn provoked the development of more sophisticated midwifery organizations. Further legal proceedings, in Ontario, eventually led to a coroner's jury recommending that midwifery be legalized under the Ontario Health Discipline Act. Within a period of fifteen years midwives in Ontario saw the possibility of their legitimation within the health care system.

In 1971, with federal government funding, the Vancouver Free Childbirth Education Centre was opened with the objective of providing free prenatal education to transient youth. It was operated by twelve persons including Cheryl Anderson, who two years later travelled to Santa Cruz California where she studied midwifery. She later studied medicine. The following year she returned to Vancouver, and opened the Vancouver Birth Centre. Women interested in home births came to the centre. Eventually Anderson along with one other midwife attended women at home. They practised alone or with help of the physicians, assisting about ten women per month.

Women interested in midwifery apprenticed at the centre. They studied prenatal care and education, daycare, and post partum counselling, and assisted at ten births a number which was later raised to fifty births. Statistics from the centre indicate that in one year the many midwives attended eighty-six home and hospital births. There was

one infant death, a tiny twin boy born in hospital. Centres were opened on Vancouver Island and in the Kootenay District around Nelson B.C. One study showed that in the Kootenay's, eight percent of the birthing population consisted of home births attended by midwives (Barrington 1985: 35).

In Nova Scotia, in 1973, there was one midwife attending births along with a physician who performed home births . By 1975 there were midwives quietly practising in Prince Edward Island, Quebec, Ontario, and Saskatchewan. In Toronto, physicians such as Dr. John McCoulagh handled the rapidly increasing demand for home births. Not until 1978 did the Toronto midwife movement begin to take form. Ontario women seeking a midwifery education traveled to the Daniel's Maternity Center in El Paso, Texas. Others chose to develop their skills by working with physicians who practised home births. Initially, they held only prenatal clinics. However, when in 1983 the College of Physicians and Surgeons pressured the physicians to discontinue home births, the lay midwives attended births without the assistance of physicians. In the face of this new responsibility, they worked in pairs.

In Edmonton, in 1978, Dr. Benjamin Toane initiated home births. Because of the program of Advanced Obstetrical Nursing at the University of Alberta, nurse midwives were more commonly accepted by the public.

In Manitoba and Quebec, the demand for midwives was on the increase. Although the practicing midwives were few in number, an estimated 200 active midwives in Canada in 1985 (Fredericks 1985: 64b), they made a powerful impact upon the system of maternity care. Parents, civil libertarians, and consumers questioned the present childbirth system. Midwives began to organize, and the medical establishment responded by threatening the withdrawal of medical services from those women who insisted on home births with midwives.

The first organization in the midwifery movement developed in British Columbia. In 1976 the Campaign Association for the Legalization of Midwifery (CALM) was initiated as a subcommittee of the Maternal Health Society. The group gained little attention until 1981 when it sponsored a conference in Vancouver called "Midwifery is a Labour of Love". Out of this conference was born the Interdisciplinary Midwifery Task Force (MTF) of British Columbia and the Midwives Association of B.C. The objective of MTF was midwifery legislation for the province.

In 1981, midwives in Ontario formed the Association of Ontario Midwives. Following the B.C. example, they scheduled a conference for the same year. Subsequent conferences were held in British Columbia, Ontario, and other provinces. In order to gain respectability, well known international figures, such as Professor G.J. Kloosterman of Holland, were

brought in for the occasions. In 1984 the Ontario Nurse-Midwives and the Association of Ontario Midwives officially merged to form the Ontario Association of Midwives. Since this was an occupational association, consumers and other health professionals formed another organization, the Midwifery Task Force⁵. Its purpose was to serve as a support group for midwives through the raising of funds and the lobbying for official recognition of midwifery.

According to Habermas, social institutions are legitimated through a three pronged process; (1) a steadily increase in the level of material wealth; (2) the development of bureaucracies with the ability to exercise political decision making; and 3) recognition by institutions such as parliamentary democracy. In 1977, no matter what their training, some midwives for their own self protection charged \$50-75 for counselling and nothing for assistance at childbirth (Alldritt and Webb 1971: 53). In British Columbia, by 1985, midwives were charging \$500 to 750 for a assisting at births (Fredericks 1985; 64b). This increase in economic capital suggests a greater acceptance of midwifery, particularly within British Columbia. However, this is the midwives' only achievement in their struggle for legitimation. Although they have developed provincial organizations which are able to lobby on behalf of their members, midwives do not yet have the right to develop professional organizations

with the power to make political decisions. Even though *The Report Of The Task Force On The Implementation Of Midwifery In Ontario 1987* was submitted to the government in October of that year, midwifery has not yet gained recognition by a parliamentary democracy. This would indicate that midwives have much left to achieve.

Nevertheless, the medical profession perceived these developments as a threat to their hegemony and the prevailing, dominant birthing ideology; birthing as a medical event, in the hospital under the supervision of a physician. In order to maintain jurisdiction over what they consider as their domain, physicians, through their provincial Colleges of Physicians and Surgeons, applied coercive pressure and punitive measures against those parties involved in the midwifery movement; physicians, parents, and midwives.

A successful midwifery practice requires good professional relationships. Midwives need medical consultations, particularly in emergencies and doctor back-ups for hospital transfers. Pressure was placed upon physicians to stop providing prenatal or backup care to mothers planning home births with midwives. It was assumed by the medical profession that if all medical services were withdrawn the parturient woman would soon come to her senses and accept the prevailing birthing ideology.

In Toronto in 1983, the College of Physicians and Surgeons of Ontario indicated through veiled threats that local physicians must stop assisting women in home births. Two British Columbian physicians, who regularly attended women in their homes, lost their privileges at St. Paul's Hospital, their preferred maternity centre. The charges against the physicians were unrelated to home births (as they as yet are medically accepted) but the timing was such that it appeared more than a coincidence (Barrington 1985). The Alberta College of Physicians and Surgeons in 1981 banned physician attendance at home births, a ruling specifically aimed at Dr. Benjamin Toane who regularly assisted women in home births. In general, such measures had the desired effect. Because some physicians feared punitive measures from their medical organizations, they ceased cooperating with midwives and assisting at home births.

The second measure employed by the medical establishment was to punish those parents they considered as behaving in a deviant manner, by withdrawing medical services. When the Kootenay Parent's group in British Columbia challenged the British Columbia College on its policy of withdrawing prenatal care from mothers planning home births, the Deputy Registrar of the College replied "An individual or family has no 'right' to the provision of any kind of medical service from a licensed medical

doctor, if that doctor is of the opinion that the requested service is not in the best interest of the patient or offspring' " (Barrington 1985: 148).

Thus, publicly paid physicians were free to deny care to home birth parents. In a similar manner, the registrar of Alberta's College, Dr. Roy Le Riche was quoted in Calgary Magazine, as stating " 'We don't care if mothers have their babies in manure piles at home, as long as they don't involve the medical profession.' " (ibid 145). It appears that some members of the medical profession are so determined to control birthing in Canada that they are willing to risk the health and welfare of those women who refuse to comply with the prevailing power and relationships. The third constraint upon the further development of midwifery in Canada is the possibility of legal proceedings. Midwives operate in a constant fear of being charged for either negligence causing harm or death or practising medicine without a license. It should be noted that in the past charges against midwives and the investigation which have lead to an inquest were instigated by reports from medical professionals not parents (ibid 138). This is in contrast to civil medical practice suits which occur when parents bring a case against their physician.

There are various interpretations of the legality of midwifery in each province but in general it is accepted that the practice of midwifery by anyone except the physician is not legally sanctioned. The one

exception is Newfoundland where the law states that only those licensed by a Midwifery Board can use the title of midwife and charge fees for assisting women in childbirth. Problems in interpretation of the legality of midwifery appear to arise from a failure to define what is meant by obstetrics and midwifery. For example L.S. Dranoff (1986: 186) a lawyer writes: "In New Brunswick Nova Scotia, Prince Edward Island, Ontario, the Northwest Territories, and the Yukon, the laws make no reference to midwives but clearly state that only licensed doctors may practise obstetrics". In contemporary society these two terms (midwifery and obstetrics) may mean something quite different. In the 19th century when the legal documents with regard to the licensing of physicians were written the terms were interchangeable. This may account for the confusion. Nevertheless as Pannell (1977: 74) has pointed out: "The law is fuzzy, but provincial physicians' groups unanimously declare nurse midwifery illegal- and its rarity is assured, anyway, by not being covered under the various provincial health-care insurance schemes".

Criminal negligence charges have been brought against a few midwives in the past nine years although no midwife or parent in Canada has been imprisoned in connection with a home birth (Barrington 1984 139). In British Columbia Margaret Marsh was fined a token of ten dollars in the death of a home born infant. However, Marsh was not a midwife but

a former physician who was suspended from the British Columbia medical registry in 1971 (Alldritt and Webb 1979: 54). In the same province, two midwives, Sullivan and Lemay, were charged with criminal negligence in the May 8, 1985 death of a baby boy. At the inquest and under the questioning of the defense lawyer, a physician agreed that the death of the infant by asphyxiation is the most common cause of death in newborns. The reason for it is often impossible to pinpoint. It was suggested that a licensed physician would not have faced criminal charges in a similar death. The father of the infant was also not sure that the midwives should have been charged. He stated " 'I can't turn around just because we had a disaster and pin it on someone' " (Deaton 1986: 37).

It is the case of baby, Daniel McLaughlin-Harris, who died in Toronto Hospital for Sick Children in October of 1984 which has had the greatest impact on the midwifery movement in Ontario. This inquest was not the first in the province, but the focus of the inquiry on the role of midwives in the health care system made it unique. The jury, following the testimony of thirty-nine witnesses in a period lasting three weeks recommended that midwifery be legalized in the province of Ontario. It suggested a profession of midwifery which would operate as a legal entity within the health care system⁶.

Midwifery moved one step closer to legalization in January 1986 when the Minister of Health, Murray Elston, announced the appointment of a special task force to make recommendations with regard to educational standards for midwives and the regulation of practice. In October of 1987 *The Report Of The Task Force On The Implementation Of Midwifery In Ontario 1987* was presented to the government. This, along with the Health Professions Legislative Review which heard submissions on behalf of midwives are the major events leading to the announcement that midwifery would be established as a self regulating occupation. Midwives now await further action on the implementation of this report.

Because midwifery was slower to develop in Quebec than other provinces, it is surprising that the government of Quebec was the first to take an active interest in institutionalizing midwifery. In 1981 officials participated in a conference, *Accoucher ou Se Fair Accoucher* (To Deliver or To Be Delivered). A government report on the potential for midwifery services was to be presented to the Minister of Education and published in 1983, and Naissance-Renaissance, the organization supporting midwifery received funding for film projects, staff, and a magazine. Unfortunately the report was never released. It is not known whether it was intervention from the medical lobby or lack of interest on the part of the consumer organizations which caused the government to change its mind.

Nevertheless, by 1984 the demand for services exceeded the supply of midwives.

Although it is the development of the midwifery movement which has focused attention upon the problems associated with the prevailing dominant birthing ideology, the people of the North, the Inuit, share many of the same concerns. Lesley Paulette recently completed a study on maternal and infant health and family-centered maternity care for the Native Women's Association. After interviewing fourteen or fifteen elders and young people in various northern communities (i.e. Fort Franklin and Fort Rae) and after reading the available literature and research, Paulette concluded that the experience of giving birth has shifted from the family and is no longer a 'shared experience'. Women, who once turned to their husbands, the elders in the community, or other family members for support, advice, and assistance before, during, and after giving birth, have replaced this family and community network with the hospital, physicians, and nurses. Because of their dependency upon the health care system, women are taken outside the community, where they give birth alone. This in turn is an added factor in the growth of a generation gap. Young women no longer make use of traditional resources. Paulette has recommended to the Native Women's Association that a way be found to reintegrate traditional knowledge about birth and maternal

health. " 'The traditional knowledge needs to be documented' Paulette says" (Casimirri 1987). Inuit women such as Martha Angugatig Ungalaag and Ruth Tuluiialik have also recognized the need. They have vividly described birthing practices among Inuit⁷.

It is clear that the present system of maternity care does not meet the needs of many women. Such women will not accept pregnancy and childbirth as a medical problem. They perceive it as a natural healthy aspect of human life. They will no longer allow for the alienation from their bodies that professional control entails, and they demand control of major decisions affecting all aspects of their health, including the birth of their children. Within the past twenty years the consciousness of women has evolved from a dual to a feminist one. As a result of this self-awareness, women have begun a new phase in Canadian maternity care, that of reclaiming the birthing experience.

The Social Conditions Relating to Midwifery 1940-1987

This period is marked by the entrance of many women into the labour force. The 1961 census indicates that one quarter of all workers were women and 30% of all adult women workers (Ostry 1968). The census also shows that many of these female workers joined the labour force because of their husbands' lower incomes. Their primary motive for working was to maintain their relative standard of living. However, the

average earnings for women was only slightly better than half for those of men (ibid 39). Thus, women who worked became painfully aware of the disparities, pressures, and frustrations encountered by women in a predominantly male labour market.

Out of this growing awareness of the contradictions of an affluent society and the existent inequality, and in a milieu of a more general radicalism of the 1960's feminism reemerged in Canada. The conscious raising activities which were an outgrowth of this revival brought feminists to a new self-understanding of the illusions perpetuated for the purpose of sustaining a particular form of living. As a part of the new conception of themselves and their situation, these same women began to articulate a growing awareness of their lack of control over their bodies and health care needs. The formation of a women's health care movement was a natural expression of their concerns and "pro choice" became a central theme. The term *choice* became associated with three major health care issues; birth control; abortion; and natural childbirth. Once feminists had outlined the dynamics of the social situation in which they found themselves, they set out to alter their social conditions. Through education of Canadian society, they sought to change gender attitudes.

The increased use of technology within medicine transformed childbirth into a medical technological event. The overuse and/or misuse

of instruments, medication, and procedures such as foetal heart monitoring, and elective inductions had the effect of frightening some women. As a result, they rejected this model of birthing and looked to alternative maternity care. In response to this demand, midwives, either working alone or in cooperation with physicians, assisted women in natural home births. Nationwide between 1975 and 1980, 8000 births occurred in the home (Deaton 1986: 37)⁸.

Physicians were not prepared to relinquish to the emerging occupation of midwifery any of their control over birthing. In the early 1980's backed by their powerful provincial medical organizations they responded with veiled threats against those who participated in home births. Medical practitioners were threatened with punitive measures unless they ceased cooperating with midwives and assisting women in home births; parents, with the withdrawal of medical services; and midwives with legal proceedings. In the few instances where a newborn infant death did occur midwives were charged and taken to court. It was out of such an incident that a provincial government for the first time in over one hundred years intervened on behalf of midwifery. The Ontario government appointed a task force which was to provide a plan for the implementation of midwifery in Ontario.

Although the revival of midwifery can be attributed to the social

conditions of this period; the growing awareness of the disparity in the economic status of women; the reemergence of feminism; the rejection by some women of the medical technological approach to childbirth; and the intervention by the state on behalf of midwifery, there is also a new element which has been added. I refer to the emergent institutionalization of midwifery. Unlike their counterparts from the previous century, contemporary midwives when harassed and threatened by the medical profession, refused to abandon their occupation. No longer are they isolated by cultural, economic, geographical, and language barriers. Although like their ancestors modern midwives function within the ideology of self help, they nevertheless have developed an allegiance to a model of midwifery which openly opposes the prevailing medical one. More importantly, organizations have successfully united midwives. They do not have the power to make regulations for their members nor have they been legitimated by the state. However, their political alliance with the women's movement, has provided midwives with the "Know-how" and the complex organizational structure which unites them into an effective political lobby.

In his discussion of the critical model, Fay (1975: 107) writes that progress within society occurs not simply when the conditions of people's lives are altered but:

when their understanding of themselves is changed in specific ways as well. All of this means that the policy expert must try to persuade those in whose name he [she] is acting to adopt a new picture of themselves, to interpret their experiences differently.

Through the past twenty years women and midwives have sought and have achieved to a certain extent a new understanding of themselves. In 1986 the Minister of Health for Ontario appointed a number of policy experts to research and to make recommendations with regard to the qualifications and regulation of midwives. In the fall of 1987, the appointed task force submitted *The Report Of The Task Force On The Implementation Of Midwifery In Ontario 1987* to the Ontario government. It is essential to examine this document in order to understand if the report takes into account the demands of women and midwives. Did the task force interpret the demands of the midwives in a manner which coincides with the new picture midwives have of themselves? Or did they, in fact, outline a policy which will perpetuate the status quo?

Chapter 7

The 1987 Task Force Report On Midwifery For The Province Of Ontario

Involved in the critical approach is the goal of assisting the actors to understand what they want and need, in order that they may define themselves more coherently. Once the defining has occurred, the policies initiated should reflect the new picture actors have of themselves. In the fall of 1987, the task force submitted its report for establishing midwifery in Ontario. In this chapter, I will examine this document in order to establish whether it reflects the new interpretation midwives have of themselves. To do this, I will give an abbreviated version of the task force's recommendations and then follow with an analysis of the report.

On January 23, 1986 the Ontario Minister of Health, Murray Elston, announced that the government intended 'to establish midwifery as a recognized part of the Ontario health care system' (*Report Of The Task Force ... 1987: 11*). Midwifery would become a regulated health profession. In order to provide a plan for the implementation of midwifery in Ontario, a task force was appointed whose job it was to decide

how midwifery should be practised in Ontario;

how midwives should be educated;

requirements for entry to practice, scope and standards of practice, and governance of the profession;

whether midwives should operate as independent practitioners or as part of an organized service;

the setting in which midwives should provide their services; and

optimal relationships between midwives and physicians (ibid 11).

Mary Eberts, a lawyer, was appointed as chairperson. She was to be assisted by three others; Alan M Schwartz, a lawyer; Dr Rachel Edney, a family practitioner; and Dr Karyn Kaufman, an associate professor at McMaster University School of Nursing. The purpose of the task force was to decide the scope and the framework of practice, the qualifications, regulations, means of integration, and the ultimate requirements for midwives in Ontario. All of this was necessary before midwives could be licensed within the province.

The regulation of licensing of medical personnel within society ostensibly is to provide quality health care and protection for the citizens. It is understood as a means of promoting orthodox practitioners, and prohibiting unorthodox practices. Its positive functions are described by De Vries (1985: 4) as follows:

- 1) it prevents the delay of effective treatment;
- 2) it protects a gullible public from fraud;
- 3) it standardizes treatment according to objective criteria; and

4) it avoids undue economic cost to the patient and society.

In general, the informed public would concur with the desirability of these objectives, and accept that to a certain extent such goals have been achieved. Nevertheless, a further analysis of the policy of licensing suggests a negative consequence, that of the creation of a professional monopoly.

Social scientists such as Freidson (1970) have noted that licensing laws (i.e. those given to the medical profession), while attempting to guarantee quality and the protection of the public, also give the profession a restrictive monopoly over practice. Laws which were originally passed to prevent the use of a title by the unlicensed have evolved in a monopolistic direction whereby it has become a criminal offense for the unlicensed to perform any act which is specifically reserved for the licensed professional. According to De Vries (1985) licensing laws do not exist only for the protection of the public but also for the protection of the profession.

In terms of the immediate situation in Ontario, the task force first must secure quality health care for its citizens. Nevertheless, there is another major concern it must address. Since the medical profession has already created a restrictive monopoly over birthing practices, it must also ensure that a profession of midwives who are experts in the care of

normal pregnancy and delivery gain control of those practices which fall under their jurisdiction.

The Task Force Report

In order to produce a thorough report, the task force gathered information about how midwifery is practised both inside and outside of Canada. They consulted extensively with organizations representing physicians, nurses, hospitals, health science educators, and midwives. Public hearings were held in Toronto, Ottawa, Hamilton, Windsor, Kingston, London, Thunder Bay, Dryden, and Sudbury. More than five hundred women's groups, consumer organizations, and individuals submitted reports. The task force commissioned two surveys; one focusing on nurses, and a second on midwives currently practising outside the official health care system. They also assembled an extensive collection of literature on midwifery. Members of the task force visited midwifery schools, practices, and regulatory bodies in Denmark, The Netherlands, England, Scotland, Wales, and United States. Based upon the information collected through this extensive research, the task force, with the assistance of their staff, produced the report, which they submitted to the Minister of Health, Murray Elston, and the Minister of Colleges and Universities, Greg Sorbara, in the fall of 1987.

The report is lengthy - 426 pages. Therefore only a brief summary

is possible. Nevertheless, it is the purpose of this analysis to outline the major recommendations according to the titles of the significant chapters.

The Midwife's Scope Of Practice

The task force chose to define the midwife's scope of practice according to the definition adopted by the International Confederation of Midwives in 1972 and the International Federation of Gynaecologists and Obstetricians in 1973. It is the one now used by the World Health Organization. It reads as follows:

A midwife is a person who, having been regularly admitted to a midwifery education program, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery; sphere of practice; 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 measures in the absence of medical help. She has an important task in health counselling and education, not only for the patients but also within the family and community. The work should involve antenatal education and the preparation for parenthood, and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service (*Report Of The Task Force*, 1987: 85).

Midwives, who will be acknowledged as specialists in 'normal'

reproductive care, will have as their primary client group, women with healthy, low risk pregnancies for whom are predicted labour and childbirth without complications. Women with risks will come under the appropriate care of physicians. The following are the basic elements of the midwife's activities:

- 1) carrying out examinations necessary to establish and monitor normal pregnancies;
- 2) advising on and securing the examinations necessary for the earliest possible diagnosis of pregnancies at risk;
- 3) providing education and preparation for childbirth, including advice on exercise and nutrition;
- 4) caring for and assisting the mother during labour and monitoring the condition of the foetus by the appropriate clinical and technical means;
- 5) conducting spontaneous vaginal deliveries;
- 6) recognising the warning signs of abnormality in the mother or infant that necessitate referral to a physician;
- 7) taking necessary emergency measures in the absence of a physician;
- 8) examining and caring for the newborn infant;
- 9) caring for the mother in the postpartum period and advising her on infant care and family planning (ibid 86).

According to the *Health Disciplines Act*, medical acts may not be performed by non-physicians. In order that practices, such as those related to obstetrics, can be performed by health care personnel other

than physicians, they must be delegated by the medical professional institutions. For example, The College of Physicians and Surgeons of Ontario (CPSO) may create regulations 'authorizing persons other than members to perform specified acts in the practice of medicine under the supervision or direction of a member' (ibid 86). It is the recommendation of the task force, that medical acts relating to the care of women with low-risk pregnancies be delegated to midwives. Fearful of the midwives entanglement with technology, the task force also recommends that the governing body for midwifery be vigilant to ensure that midwives do not become involved with technology at the expense of clinical skills.

The midwife must also direct her client to visit a physician. The recommended standard of practice is a minimum of two mandatory visits, one as early as possible, the second at the 32 or 34 weeks. There could be a third optional visit during the pregnancy but additional medical visits are discouraged. It is up to the governing body for midwives, the College of Physicians and Surgeons of Ontario, and the Society of Obstetricians and Gynaecologists of Canada to work out the criteria for consultations with and referrals to physicians.

The Framework of Practice

This chapter of the report outlines where midwives should work, the midwife's employment status, method of payment, with whom she works,

and liability insurance. The ideal midwifery practice should provide continuity of care. Midwives must work with their client through every stage of the reproductive cycle. This would include pregnancy care, labour, childbirth care, and postpartum care, as well as counselling, education, and emotional support.

A midwife, while focusing upon low risk pregnancies and normal childbirth, should have access to both institutional and community settings, although she will consult and make referrals to physicians particularly as it relates to the ordering of medications, tests, and procedures. The care she provides must be cost-effective, continuously evaluated for its effectiveness, and responsive to consumers needs and preferences. To ensure that this will occur, a midwife will engage in continuing education and peer review.

The task force recommends several practice models within which a midwife may be employed. The first is hospital employment. The midwife who is employed by the hospital to provide care to clients or patients of the hospital, could report through the director of midwifery services to the chief executive officer of the hospital or an executive vice-president for administrative purposes, and to the head of the department of obstetrics and gynaecology. A problem of this practice model is the probable lack of continuity of care and limited scope of

practice.

Other areas in which midwives could work are in birthing centres, community health centres, for boards of health, in private practice, and in cooperation with physicians. The prime requisite for all of these practice models is that the midwife provides safe and effective care. To ensure that this will occur, the task force recommends that no midwife be employed in a practice, service, agency, or health facility except those approved by the Ministry of Health. Such approval would make certain that:

each new practice will serve the needs of an identifiable clientele; that midwives will have adequate links with physicians, hospitals, and possibly other community agencies; that the practice will offer continuity of care throughout the reproductive cycle; and that the practice will monitor and evaluate its effectiveness (ibid 97).

At the present time, the *Public Hospitals Act* allows for the appointment of physicians to the medical staffs of hospitals. However, there are no provisions for appointing midwives to hospital staffs and this therefore would prevent midwives from being granted hospital privileges. To overcome this problem, the task force recommends that the *Public Hospital Act* and regulations be amended to empower hospitals to appoint midwives to their staff. Because the procedures currently established for appointing physicians may not be suitable, it will be necessary to establish other structures and procedures for

appointing midwives to the staffs of hospitals.

The funding of midwives is an other major issue. The task force believes that midwifery care should be equally accessible to all women, not only to a minority who can afford to pay for the services themselves. Therefore, they recommend that midwives be prohibited from seeking or obtaining payment for their services directly or indirectly from clients. The fact that midwifery will be fully integrated into the health care system suggests that midwifery services should be paid for by the province. The task force considered the fee-for-service option. However they rejected it as they felt it was an inappropriate way of remunerating midwives. Payment on the basis of fee-for-service requires not only the necessity of preparing a fee schedule, but that a midwife be paid for each service rendered. This itemization of every unit of service is fundamentally inconsistent with the holistic philosophy of midwifery care. It also encourages the care giver to increase the volume by working faster and spending less time with each client. The result could be an increased cost to the system.

Instead, the task force recommends that the Ministry of Health provide funding to midwives working in all the models of practice on the basis of global, program-based budgets. Within Ontario, there is a small group of physicians who work within Health Service Organizations (HSOs).

They do not bill OHIP on a fee-for-service basis but receive global payments based on 'capitation'. According to a patient's age and sex, and the value of OHIP services consumed by an average person of the same age and sex, the Ministry pays the HSO an amount for each patient enrolled on the roster. This amount is increased if the HSO provides special services. Out of this funding, the HSO pays its operating expenses and salaries. As a consequence of this type of payment, there is an incentive to employ non-physician care givers when it is efficient to do so. In the case of HSO's it may be attractive to employ midwives.

At the present time, midwives who practise in Ontario carry no liability insurance coverage. Insurance companies will not provide them with insurance as they regard midwifery as a non legal act. Interestingly enough, the present malpractice insurance crisis is largely restricted to North America. The task force on its visits to Denmark, the Netherlands and the U.K. found that it posed no problem for midwives from these countries and that few carried insurance. Nevertheless, the task force recommends that liability insurance be mandatory for practising midwives. It is suggested that the midwife's professional association develop a self-financial program, similar to that which has been developed for nurses through the Registered Nurses Association of Ontario (RNAO) and the Ontario Nurses Association (ONA).

The whole area of home births has been dealt with by the task force. Since I wish to discuss this in more detail in the next chapter, I will list only their recommendations. The task force recommends that the governing body for midwifery in cooperation with appropriate professional organizations and authorities compile a home birth protocol which would cover the assessment of risk and contraindications of home births. It is also necessary to establish a standard of practice, and a practice advisory service which would guide midwives with regard to the care of women who choose to give birth at home despite contraindications. In cases of emergency there should be available a "flying squad network" which would take responsibility for providing transportation during labour if needed. The Ministry of Health should establish a home birth registry for the reporting of the mortality out-comes of all home births within the province.

Qualifications for Practice

The discussion in this chapter of the report includes consideration both of qualifications for entry to midwifery education programs and of the nature and content of these programs. The arguments presented to the task force evolved around two points; whether nursing should have a monopoly over midwifery; or whether midwifery is an occupation in its own right separate from nursing. Having considered the various

arguments the task force decided to recommend multiple routes of entry to midwifery education in Ontario. Therefore midwifery education would consist of two integrated streams; the first, a four year stream, would lead to a baccalaureate degree in midwifery; the second, a twelve to eighteen month stream, to a diploma in midwifery for those who have already achieved a university-level preparation in nursing.

For those applicants with no university level education in nursing, the baccalaureate program will be the core program for midwifery education overall. It will provide the necessary knowledge and clinical skills, and the distinctive ethos and ideology of midwifery. Nurses who have completed their university education will obtain the additional academic and clinical education through the diploma stream. The task force recommends that both streams be offered at the same educational institution. This would allow for the sharing and intermingling of courses, teaching, and clinical experience. Such a program would be located at one of Ontario's health science centres and attached to a university.

Because of the special problems in Northern Ontario the task force felt it necessary that parts of the midwifery education program occur in Northern Ontario communities. Nevertheless, it will be necessary for midwifery students to attend university in the major centres where the

health science centres are located. Therefore, it is proposed that the university does not restrict admission or give preferential treatment to applicants who reside in the area. Applicants should be admitted from every part of Ontario. The clinical components of the program should be arranged in community hospitals and suitable primary health care settings in various locations in Ontario. French, where possible and according to the need, as well as English should be used as a language of instruction.

According to the task force report, the selection of students should be based on personal suitability for midwifery, maturity, motivation, resourcefulness, service orientation, and ability to relate to others, as well as academic achievement. They felt that life experiences such as home making, child rearing, and volunteer activities were important considerations in accepting students into the baccalaureate program.

The program should be structured as "two plus two". In the first two years, the students would concentrate on academic subjects such as those in the humanities, social sciences, basic sciences, and health sciences. Wherever possible, the courses should be shared with students in other health disciplines. The midwifery practice subjects would be concentrated in the second two years. These second two years would be shared with the diploma students. Clinical placements for both streams

would be shared.

At the present time there is difficulty in arranging clinical placement sites for nursing students, medical students, and interns in education institutions. This is partly due to the declining birth rate, and the fact that the rationalization of obstetrical services has concentrated obstetrical beds in fewer hospitals. Because of this, the task force recommends that community hospitals with Level 1 and Level 2 obstetrical centres, community health centres, and physicians' offices in various parts of the province, be used to provide clinical placement sites.

For students in both the diploma and baccalaureate streams, the following is an example of the possible requirements of a midwifery education program.

1. Advising of pregnant women, involving at least 100 prenatal examinations
2. Supervision and care of at least 40 pregnant women
3. Conduct by the student of at least 40 deliveries; where this number cannot be reached owing to the lack of available women in labour, it may be reduced to a minimum of 30, provided that the student assists with 20 further deliveries
4. Assistance with one or two breech deliveries
5. Experience of episiotomy and initiation into suturing
6. Supervision and care of 40 pregnant women at risk
7. At least 100 post natal examinations and examinations of normal

newborn infants

8. Supervision and care of mothers and newborn infants, including pre-term, post-term, underweight and ill newborn infants

9. Care of pathological cases in the fields of gynaecology and obstetrics, and disease of newborn and young babies

10. Initiation into the care of general pathological cases in medicine and surgery (ibid 129-130).

The establishment of the midwifery education programs as well as the salaries for clinical instructors and supervisors of student midwives would require special funds from the Ministry of Colleges and Universities or the Ministry of Health. It is the recommendation of the task force that adequate grants be made available.

Regulation of the Midwifery Profession

Since midwifery is to be given legal recognition it is necessary to establish a regulatory structure for the profession. It is the recommendation of the task force that midwives who are regulated through a system of licensure be given the titles "midwife" or "licensed midwife" and that such titles be protected. This would be done by a College of Midwives which will be established to regulate midwifery. The council of the College will be composed of thirteen members; one obstetrician; one general practitioner whose practice includes obstetrics, one neonatologist, one nurse with maternal/newborn nursing experience, one hospital administrator, one childbirth educator, five consumers,

representatives of women's health organizations, minority groups etc, and two lawyers who practise in the fields of administrative and corporate law. It is the hope of the task force, that the College of Midwives will eventually be composed of nine to fifteen members who have been elected by midwives; three to five public members appointed by the Lieutenant Governor in Council; and one person appointed by the university which administers the midwifery program. In the meantime students in the midwifery integration program and foreign-trained midwives waiting to present their credentials will provide liaison and advice to the interim council. As soon as midwives become licensed, after successfully completing the program, they should be appointed to the council.

The council will be required to form an executive committee as well as a second committee which will be responsible for registration, fitness to practice, continuing competence assurance, complaints, and discipline. The College of Midwives, itself, would share administrative services, offices faculties, and staff with one or more of the governing bodies of other unrelated health professions.

As well as processing applications for licenses from Ontario and out of province graduates, the college will have to establish criteria for recognizing the qualifications of foreign-educated midwives. Such criteria should be related to the equivalence of educational preparation,

the recency, and relevance of practical experience. It will be necessary for the college to set and administer an examination for all midwives who wish to be licensed in the province of Ontario and systems must be established to assure continuing competence. The college will have the power to prosecute people who contravene the midwifery legislation. The College of Midwives will have to be subsidized by the Ministry of Health until the profession has sufficient members to bear the costs of its operations.

Integration of Current Practitioners

At the present time, within Ontario, there are approximately fifty-midwives currently practising outside the official health care system and about nine hundred nurses. The task force recognizes that their midwifery skills and experience should not be wasted. Therefore it recommended that a midwifery integration program be established. This program would be offered for a limited time only.

Individuals who apply to this program must obtain satisfactory scores in written and clinical examinations. They also will be placed in hospitals where their competence will be assessed. They will then be given an opportunity to write the provincial midwifery licensing examination. The integration program will be administered by the same institution that provides the basic midwifery education program.

It is the belief of the task force that within the first two years of the implementation of the program there will be a pool of fifty midwives. At the end of five years there will be one hundred and twenty midwives and by the year 2000, the education program would graduate a further one hundred and fifty midwives. This number depends in part on how many foreign-trained midwives are brought into the Ontario system.

A Critique of the Report of the Task Force

On the surface, the report of the task force appears as a comprehensive document whose recommendations if accepted would lead to the establishment of a "profession" of midwives. Such a conclusion is misleading. In reality, the task force has provided the basis for another health care occupation, one which can be distinguished from an established profession by its lack of autonomy, responsibility, authority, and prestige.

The sociologist Eliot Freidson (1970) has defined a profession (with particular reference to medicine) as an occupation which is distinct from other occupations in that it has been given the right to control its own work. It has received legitimate organized autonomy.

A profession attains and maintains its position by virtue of the protection and patronage of some elite segment of society which has been persuaded that there is some special value in its work. Its position is thus secured by the political and economic influence of the elite which sponsors it—an influence that drives competing

occupations out of the same area of work, that discourages others by virtue of the competitive advantage conferred on the chosen occupation, and that requires still others to be subordinated to the profession (ibid 72).

Autonomy is the test of professional status, and self-regulation the test of professional autonomy.

Within the health care system there are several occupations which provide services related to healing. If these occupations remained unregulated, they could not only become fraudulent practices but, in fact, could also become healing consultantships, competitive with physician's practices. However, the services offered by these occupations are useful to physicians and necessary to their practices although threatening to their monopoly. The solution to the physicians' problem was not to be found by driving such occupations out of practice but rather by gaining control over their activities from the state. The medical profession was then able to limit what they could do, and supervise or direct their activities. Through the state, physicians have made it not only illegal for other workers to compete against them, but also have obtained the right to direct activities of related occupations. I refer to health care workers such as medical social workers, clinical psychologists, occupational therapists, and nurses. For example, nurses have their own university programs, and control licensing boards. In general nursing gives the appearance of being autonomous. Nevertheless, the work its members

perform remains at least partially subject to another occupation, that of medicine. Midwifery, if established on the basis of the report of the task force will suffer the same fate. Its autonomy is only partial, being second-hand and limited by the dominant profession of medicine.

In chapter four, "The Midwife's Scope of Practice", the report outlines how the medical profession will limit as well as supervise or direct the activities of the midwife.

The College of Physicians and Surgeons of Ontario (CPSO) may make regulations 'authorizing persons other than members to perform specified acts in the practice of medicine under the supervision or direction of a member' (*Report Of The Task Force ... 1987: 86*).

The following statement reinforces the medical profession's authority.

Whenever a medical act is delegated, a physician remains responsible for supervising or directing the performance of that act by the delegate (*ibid 87*).

It is the physician who will determine how a woman will give birth, not the parturient woman or midwife.

The purpose of the first visit is for the physician to conduct a physical examination and take a complete history in order to diagnose any medical problems and to assess whether the woman may appropriately be cared for by a midwife the midwife must direct the woman to visit a physician.

Therefore, although the report gives the appearance of establishing midwifery as a state-supported autonomous profession, because of its recommended university program and College of Midwives with licensing

responsibility, in reality, it is establishing an occupation whose activities will be delegated and supervised by the medical profession.

The report discusses the difference between nursing and midwifery. The underlying assumption is that nursing is an occupation controlled and direct by medicine; "midwifery is a profession" (ibid 121). It is ironic, that if midwifery is established according to the recommendations of the task force, the work its members perform will be subject to the medical profession. The failure of the task force to draw explicit attention to this problem is a major flaw of the report.

There is a second flaw. It is the inability of the task force to delineate the epistemological problems of the present obstetrical system which is rooted in science, or to indicate the need for an alternative conceptual framework (or frameworks) within which midwives will function. The report suggests an awareness of a problem. Yet it does not outline the basis of the problem or offer a solution. For example, the report states:

... we are concerned that excessive delegation of medical acts could lead toward midwives having more competence with technology at the expense of clinical skills involving direct patient care (ibid 87).

Therefore the task force recommends that:

the governing body for midwifery be vigilant to ensure that delegation of medical acts is used sparingly so that it does not produce more competence with technology at the expense of clinical

skills (ibid 87).

The report continues by quoting from a World Health Organization article which indicates that European midwives are spending too much time at the desk using electric foetal monitors, rather than sitting with women in labour.

The underlying assumption (aside from the protection of medical dominance) is that mastery of technology is at the expense of "clinical skills". In fact, there is no evidence to support the assumption that learning is intransitive.

The over-use of technology is the manifestation of a broader problem, that of a system of maternity care which is rooted in science. As Fay (1975: 44) has stated; "science is linked to the promise of possible technical control". Although science gained prominence through the development of industrialization and its use in the rational management of the labour force, it has become an integral part of almost every aspect of life. Biomedicine is legitimated because it is based on science. Wherever science is employed, and that includes its use in medicine, it exhibits its major characteristic, that of technical manipulation and control. Implicit within science is the use of technology. However if the policy makers wish to ensure that technology in midwifery is not over used at the expense of clinical skills, they must

be receptive to alternative theories or concepts, ones which are not rooted in science.

A theory is an entity at the conceptual level. It is a device once verbalized and hence communicated which proposes to guide, control and shape reality, although it is not in itself reality. It is a conceptual system invented for some purpose and if it is a true or valid theory, it fulfills the purpose for which it was proposed. Within disciplines, such as those related to health care, there are situation-producing theories in that they are constructed to guide action to the production of reality (Dickoff and James 1986: 103). These theories are built for a purpose and the purpose is practice.

The concepts or theories which guide practices in contemporary maternity care are rooted in science. They therefore bring to the maternity system that characteristic which is integral to science; technological control. Therefore if midwives sincerely desire to limit the use of technology, they must first construct the necessary theories or concepts which will guide, control, and shape their clinical skills into the desired reality.

The report contains a misconception which should be corrected. In the chapter on the qualifications for practice, the following statement is made:

Many of those who support multiple routes of entry disagree with statement that the philosophy of modern nursing fits with the philosophy of midwifery care. They say that nursing's philosophical approach to childbirth is essentially the same as the medical perspective, in which pregnancy and childbirth are viewed as diseases or abnormal conditions, requiring active management by medical experts using a panoply of technological devices (ibid 121).

Although the report continues to outline the critics of nursing argument, there is no attempt to assess whether the statement is valid or invalid. It is accepted as such.

The critics of nursing contend that nurses function within a theoretical framework which is based on the medical model and therefore rooted in science. They understand that this model is in conflict with their perception of a midwifery model. The fact that the task force accepted such a statement without offering any further explanation indicates on their part either a bias, or an abysmal lack of information on the state of contemporary nursing practice.

Beginning with a conference in the mid 1960's at Case Western University, nurses have accepted the need for developing their own nursing theory. In rejecting the current medical model, they confirmed "that theories are significant for the practice of nursing, that the practice of nursing is amenable to theoretical development, and that nurses are capable of developing theories" (Meleis 1985: 18). The next step focused on theory development, its components, and the process of

theory analysis and critique. In 1970, Martha Rogers, in her book *Theoretical Basis of Nursing*, outlined a conceptual model for nursing practice, *unitary man* (later renamed *unitary human being*). Since then there have been a number of theories published by authors such as Sister Callista Roy, Imogene King, Dorothea Orem, and Ida Orlando, to mention only a few.

Although these theories tend to be considered in terms of their contrasting and competitive view, areas of agreement can be identified. First, there is a holistic approach. Nursing theorists reject conceptual approaches which view nursing care only through a biological or psychological perspective. "Nursing clients are more than the sum total of psychological, sociological, cultural, or biological beings" (ibid 182). Recipients of care are understood as responding to events in a holistic way, and any form of assistance is only meaningful if the whole unit is considered. It is the role of the nurse to help their clients meet all their needs. Contemporary nursing theory has searched out its philosophical underpinnings. In so doing, it has referred to interaction theory, phenomenology, and existentialism. Not only has nursing rejected a philosophical approach which is based on the medical perspective, it has developed the attitudes or approaches advocated by these same critics of nursing

Omitted from the task force report is any mention of the multicultural nature of Ontario society. If midwifery is established as outlined by this report, it will reflect the culture of the dominant majority who will understand the culture of the midwifery system and will feel comfortable about using it. It will mean that as clients, their access to the facilities will be relatively unimpaired at both the service and the structural level. However members of minority ethnic groups may find that cultural barriers impede their access to the resources.

On June 24th 1987, the Honourable Lily Munro announced a new multicultural strategy for Ontario. All government agencies, ministries, boards, and commissions are required to deliver culturally sensitive and responsive programs and services. In official correspondence of February 29th, 1988 to Ontario health institutions, the Honourable Elinor Caplan, Minister of Health stated: "As Minister of Health, I strongly support this initiative and I am committed to seeing that the Ministry does its share to ensure that the multicultural strategy is a success" (Caplan 1987 1)

Therefore it is imperative that a strategy based on a multicultural approach to midwifery is implemented from its onset. Courses and field experience which reflect the multicultural dimensions of Ontario should be a prerequisite to any degree in midwifery. Midwives, who represent Canadians of various ethnic origins, i.e. Native Canadians and Canadians of

Jamaican, Latin American, Indian etc. origins, should not only be an integral part of any midwifery services to these groups, but should be actively involved in the establishment of such programs.

In an analysis of the effect of licensing on midwives in Arizona, Texas, and California, sociologist R.G. DeVries (1985) drew three conclusions. First, he found that state sanction to practice does not bring autonomy to midwives, but instead formalizes the dominance of physicians over them. In those areas where midwives had been licensed, they have suffered an increase in surveillance and control by physicians. Medical practitioners are able to deflect any challenge to their authority because of their cultural prestige, and their formidable political power which their medical professional organizations effect when any of their interests are threatened. The cultural power of physicians is continually reinforced through the electronic and printed media which carry stories on the advances of scientific medicine in the "war" against disease and illness. Because of this cultural authority, the testimony given by physicians before legislative bodies carries with it the status of "expert advice", thereby enhancing their influence over legislation.

Second, physicians assert and maintain their jurisdiction over related health care occupations through their exclusive authority to diagnose patients. Midwifery licensing laws stipulate that midwives can

attend only women who are expected to have "normal" or trouble-free pregnancy and delivery. However "normal" is not usually defined, and therefore the decision is left to physicians who have the power to restrict it to a highly select group of women. In fact, according to DeVries, it is in the interest of the physician to classify all pregnancies as "abnormal". Because the power to diagnose is given exclusively to medical practitioners, they are granted wide control over potential competitors.

Third, DeVries found that licensing bills introduced in California and Texas legislatures and restrictive revisions in the Arizona law, as well as current attitudes toward home birthing by medical professionals, indicate that licensure pushes the lay midwife towards more medical training and direct medical supervision.

These changes will bring individuals with a different set of motivations into lay midwifery, alter client-practitioner relationships, and significantly influence the nature of midwife-attended birth. These facts and the examples of past midwife licensure indicates that the law will continue to change the nature of this occupation (ibid 146).

The findings of DeVries study outlines the results of a system of licensure which fails to, (1) remove midwifery from under the authority of the medical profession and grant autonomy and control of midwifery to midwives; (2) define pregnancy as natural, define what is meant by

"normal" pregnancy and delivery, and grant a profession of midwives a monopoly over the care of "normal" pregnancy and delivery; and (3) indicate the need for, or offer alternative theoretical frameworks within which midwives will function. Since these are the same needs which the task force failed to confront, it is not difficult to conclude that if the recommendations of the task force are put into effect, midwifery in Ontario will suffer the same fate.

Within the appendices of the task force report is a short history of midwifery in Canada. There are two problems with this history: the first is a misuse of the term "culture"; the second is the failure of the author to place the midwifery practices described within their cultural context.

The author of the history has hypothesized that there existed within Canada a "native birth culture" and "a popular birth culture". According to the examples used to illustrate this assertion such birth cultures are not limited by time (history), economic, social, or cultural conditions.

The anthropologist E.B.Tylor defines culture as:

that complex whole which includes knowledge, belief, arts, morals, law, custom, and any other capabilities and habits acquired by man as a member of society (Kottak 1978: 20).

A shorter definition is that offered by *The Random House College*

Dictionary 1984; "the sum total of ways of living built up by a group of human beings and transmitted from one generation to another". A "birth

culture" would be defined as the knowledge, beliefs, morals, law, custom, habits, and practices which are central to birthing within a given culture, and which are transmitted from one generation to the next.

Through the use of the term "culture" the author implies that there existed among the various indigenous peoples in Canada as well as among pioneer women in Canada shared knowledge, beliefs, morals, laws, habits, and practices "with some variation" as they relate to birthing. However, the case studies presented in no way validate this assumption. In reality the writer has described the birthing practices i.e. the habitual or customary way of assisting women in childbirth. These practices are rooted more in socio-economic conditions than in any beliefs about birthing. There was also a greater variation in birthing practices than described. For example, a major segment of society, those women who preferred physicians, has not been taken into account.

A major problem with this history is the fact that the author failed to place the empirical evidence for her hypothesis within the cultural context. Midwifery practices are adaptive. They evolve and change in accordance with a particular configuration of cultural, social, and economic circumstances. They cannot be accurately understood apart from the total context. Once decontextualized, they become fixed, lacking development and vitality. In the end such decontextualization leads to

distortion. In this history, the distortion is evident in the writer's description of the relationship of midwifery to nursing. Chapter titles, such as "The Nurse as Propagandist" and "Public Health Nurses ... Obstetrical Schizophrenia" create a negative impression of nurses. The first title suggest that nurses methodically spread information or ideas to promote obstetrics in order to injure "the popular birth culture". In other words, nurses purposefully acted as the lackeys for the medical profession. The second title conveys the impression that the public health nurses were not mentally healthy. These two titles suggest systematic distortion. If the author had chosen to develop her ideas by relating the development of nursing and the disappearance of midwifery to the institutions and relationships of power, she may have presented a more accurate picture of the problems encountered by both these female occupations.

A Summary of the Report of the Task Force

In the fall of 1987, the task force presented its report to The Minister of Health and The Minister of Colleges and Universities. It recommended that midwives in Ontario be acknowledged as specialists in "normal" reproductive care. Nevertheless, the medical acts related to the care of low risk pregnancies must be delegated and supervised by physicians. The midwife must first direct her client to visit a physician.

The task force recommended several practice models; hospitals; birthing centres; community health centres; boards of health; private practices; and in cooperation with physicians. All practices will require the approval of the Minister of Health. Funding for midwives will be on the basis of global program-based budgets. It was felt that this form of payment was fundamentally consistent with the holistic philosophy of midwifery care. Liability insurance will be mandatory for practising midwives.

Having considered the various options, the task force decided to recommend a multiple routes of entry education. There will be two integrated streams; the first, a four year stream from which a midwife will receive a baccalaureate degree; the second, a twelve to eighteen month stream from which a university graduate nurse will receive a diploma in midwifery. Both streams will be offered at the same educational institution. Selection of students for the program will be based upon personal suitability, as well as academic achievement.

A College of Midwives will be established to regulate midwifery. Its function will be to process applications for licenses, and to dispense the title of "midwife" or licensed midwife" to all those who meet the requirements. It also will have the power to prosecute people who contravene the midwifery legislation. Midwives presently practising in

Ontario, outside the official system, will be brought into the system through an integration program. These midwives will be required to obtain satisfactory scores in both written and clinical examinations.

This is a summary of the task force report. The question of whether the document reflects the new interpretation midwives have of themselves may now be answered. Although the report offers sound recommendations for the structure of a midwifery occupation, it fails to address the fundamental question related to the development of a profession i.e. autonomous control over one's work. Midwives remain under the jurisdiction of physicians. The work that midwives do will be delegated and supervised by medical practitioners. Therefore midwives will not become specialists in normal reproductive care.

Related to the development of midwives as specialists in normal pregnancy and childbirth, is the problem of the required length of education. To hold a position of prestige and authority within the occupational hierarchy, midwives must become involved in the production and dissemination of knowledge. Professions have a mandate to produce and generate certain kinds of knowledge for society as a whole. The power and influence over normal birthing that the midwives seek, clearly lies in the degree of control of knowledge which they are able to assume, and the management and exercise of this knowledge. A significant

feature of professional activity is that it is often based on specialized knowledge and technology. In order to substantiate any occupational claim to a privileged status, midwives by necessity will have to demonstrate an intellectual seriousness. This in turn requires a long period of education. Therefore the length of education as outlined by the task force report is minimal. In reality, if midwives are to become experts in normal reproductive care a longer education period may be required.

There is a second aspect to this problem, and it is related to the type of maternity care that midwives wish to offer parturient women. This care is based on a perception of childbirth as a natural rather than as a medical, technological event. The report, although recognizing the problem of technology, failed to come to terms with the issue. As long as midwifery remains under the supervision of the medical profession and medicine bases its legitimation on science and thus technology, midwifery will have a difficult time redefining birthing as a natural rather than a medical event.

From the analysis of the task force report, I have concluded that the recommendations do not lead to the establishment of midwifery as an autonomous profession. Therefore, the next logical question is to ask "what must be done to achieve this goal". I would suggest that there are

two requisites which must be fulfilled before this can be accomplished.

The first is the labelling of parturition as natural, the defining of the term *normal pregnancy*, and the granting of midwives a monopoly over the care of "normal" pregnancy and delivery. The accomplishment of this goal will lead to the removal of "normal" pregnancy and delivery from under the authority and supervision of physicians. The second is the recognition of the need for, and development of alternative theories for midwifery.

These issues are the key to the successful development of a profession of midwives and will be discussed at length in the following chapter.

Chapter 8

Reclaiming The Birthing Experience

According to the critical model of social science, a social theory does not simply offer a picture of the way that a social order works, instead, a social theory is itself a catalytic agent of change within the complex of social life which it analyses (Fay 1975: 110).

The practical intent of critical theory is accomplished through a number of ways. One is through the articulation of the felt grievances of the specified group of actors. This I have done, through an analysis of midwifery in Canada from 1788 to 1987. Another step is to provide a vocabulary which expresses the conceptualization of the actors' situation and which will yield explanations of their frustrations. The expressions which best articulate the midwives' situation and helps to explain their frustration include the following; lack of autonomy; delegation of acts and supervision by physicians; parturition as a pathological rather than a natural event; and the use of science, with its implicit technical control, as the epistemological basis for maternity care. According to Fay, the conceptualisation of the actors' situation is followed with the offering of a program of action which is intended to help the actors achieve their desired ends. This then is the purpose of this chapter; to offer midwives a program which may help them accomplish their goals.

I would point out that the reclaiming of the birthing experience

involves two major groups of players; women in general and midwives. First, there is a reclamation by women of their bodies, particularly as it relates to birthing. As indicated in chapter 6, women are seeking to regain the power to make decisions on the type of birthing environment they may experience in the cases of normal childbirth. Second, there is a reclamation by midwives of their role as principal birth attendants in the cases of normal pregnancy and childbirth. The midwives' goals, as outlined in this study, coincide with those of the women who seek to reclaim the birthing experience. Midwives understand women as competent persons who are able to manage the natural process of birthing. Therefore, although in this chapter I refer to the reclaiming of the birthing experience by midwives, it is to be assumed that the end results of such a process is the regaining of control over birthing by women in general.

In assessing medicine's appropriation of midwifery, it can be concluded that physicians received official control over their work, and authority to supervise related health care occupations through the support of the state. Therefore, the foundation of medicine's hegemony is clearly political in character. The state aided in establishing and maintaining the profession's preeminence. The medical bureaucracy has formal representatives, whether they are organizations or individuals,

who directly attempt to ensure that the state puts into effect policies desired by this occupational group.

The most strategic and treasured characteristic of the profession—its autonomy—is therefore owed to its relationship to the sovereign state from which it is not ultimately autonomous. And the autonomy of the individual practitioner exists within social and political space cleared and maintained for his benefit by political and formal occupational mechanisms (Freidson 1970: 23–24).

It is evident that the professional autonomy is not absolute as the state ultimately has sovereignty over all and grants the profession its autonomy. Nevertheless, as long as medicine is free of external evaluation and management by other occupations in the division of labour

its lack of ultimate freedom from the state, and even its lack of control over the socio-economic terms of work do not significantly change its essential character as a profession. A profession need not be entrepreneur in a free market to be free (ibid 25).

It is clear from Freidson's analysis of medicine, that if midwifery is to establish itself as a profession in the true sense of the term it must achieve two goals: (1) state recognition as the preeminent authority of normal parturition; and (2) freedom from technical evaluation and domination from external organizations i.e. medicine. Involved in the achievement of these goals is the redefining of parturition as a natural event, the defining of a normal pregnancy and the development of alternative theoretical or conceptual frameworks which will guide, and

shape the clinical skills of the midwives into the desired reality. Basic to the accomplishment of this task is a radical change in consciousness.

Women in general, and midwives specifically, must come to the realization that if women are to truly reclaim their birthing experience they must attack the political issues which are crucial to women's control over birthing.

From a Pathological to a Natural Event: Redefining Birthing

Prior to the latter half of the nineteenth century birthing was regarded as a fundamentally natural process which in general did not require any artful assistance. Teachers of midwifery taught the conservative tradition which stressed the adequacy of nature and the dangers of instruments. For example, in 1807 Samuel Bard, Dean of King's College Medical School, wrote a text on midwifery in which he refused to discuss forceps because he believed that intervention by unskilled physicians, often inspired by Smellie's writings, were more dangerous than the worst cases left to nature (Wertz and Wertz 1981: 176). However, despite the theory of the naturalness of birth and the dangers of intervention, obstetrical practices moved in the opposite direction to less reliance on nature and more intervention.

Beliefs about birthing are linked to the type of intervention or lack of intervention provided to parturient women. For example, beliefs about

the naturalness of childbirth results in a non-interventionist approach. Therefore as the approach evolved from a non-interventionist to an interventionist one, so did the ideology surrounding birthing. This has resulted in a system of maternity care which portrays birthing as a pathological event requiring intervention on the part of the physician. To understand how this transition may have occurred it is necessary to examine the development of the lying-in hospitals.

The first lying-in hospital in Canada was established in Montreal in 1841. When the hospital refused to allow medical students from McGill University (previously called University of McGill College) access to the patients, the professors from McGill founded a second hospital which would fall directly under the control of the professors of midwifery from McGill. According to Archibald Hall (1860), a physician accoucheur and professor of midwifery at McGill, the sole objective was to provide students with the opportunity to work with women during pregnancy and labour. The patients were charity cases (Barrett and Fraser 1943). This would suggest that the women patients were of a lower socio-economic status as they were unable to afford the services of either a midwife or physician. It is most probable that such women were poorly nourished, suffering from related medical problems, and in a condition of health which was not conducive to a problem free labour and delivery. Added to

the condition of the parturient women was the fact that at this time the hospitals were dirty, and the staff lacked knowledge with regard to the spread of infections and their control through aseptic techniques. The extent of the nineteenth century problem in hospital care is illustrated by the statement of a pastor who vowed to ameliorate the condition of the sick poor who "were in their unhealthy rooms, lonely and ill cared for, physically and spiritually neglected" (Seymer 1933: 68). This combination of unhealthy patients and unsanitary environmental conditions resulted in high maternal mortality. The majority of these deaths were attributed to infections.

In his discussion of the maternal mortality rates in the Montreal lying-in hospital in the time from its founding to 1860 when professor Hall (1860) wrote the report, there were seventeen deaths; ten were due to puerperal fever and related convulsions; six from peritonitis and metric infections (inflammation of the uterine musculature); and one from epilepsy complicating labour. Therefore sixteen of the seventeen deaths were infection-related. In Philadelphia and New York, deaths due to puerperal causes were as high as one in forty-five cases (Medical Surgical Science 1875.)

As a result of the high mortality rates, the treatment and prevention of puerperal diseases became the focus of medical attention.

In an attempt to eradicate the problem, physicians sought not only to antiseptically clean the environment (walls, beds, furniture, and floors were scrubbed down with carbolised soap and then mopped with a weak solution of carbolic acid) but the parturient woman as well. In his report on the state of obstetrics, Dr. Gardner (1881) professor at McGill University describes antiseptic midwifery as the method whereby there is a systematic syringing of the vagina before labour, the use of carbolic steam spray during labour, and extra uterine injections after labour (ibid 149). This suggests that in their effort to control the spread of infections, physicians determined that parturient women as well as the environment were pathogenic. This was an important step in the ideological transformation of birthing from a natural to a pathological event.

Nevertheless, mortality rates within lying-in hospitals remained high. Statistics vary but Professor Stadfelt, Director of the Copenhagen Lying-In Hospital and promoter of "antiseptic midwifery" recorded a maternal mortality of one in eighty-seven patients (ibid 149). However, in Canada and outside the hospital, mortality rates appeared to be much lower. Oral histories of the early pioneers indicate their belief in low maternal mortality among rural women who gave birth at home (Smith 1923 and Healy 1923). This comparatively low death rate is confirmed by

the practice of Dr. Walter Burritt of Smith Falls Ontario (Watson 1939) who in the period between 1835 and 1886 assisted at 1828 obstetrical cases. Dr. Burritt recorded a maternal mortality of 3 in 1828 cases; a rate of 1.64 per 1000 cases or 1 death in 609.3 cases. This is a far cry from the 1 death in 114.6 cases outlined by Dr. Hall (1860) for a similar time (1843-1860) in his report on the lying-in hospital operated by the professors of McGill University and Dr. Hall describes her statistics as "a highly favourable ratio" (ibid 51). Dr. Burritt diagnosed the deaths as due to puerperal infection, haemorrhage and convulsive seizures (probably related to toxemia of pregnancy). Both Dr. Hall and Dr. Burritt based their mortality rate on causes directly related to parturition. On the other hand, the maternal mortality rate of Dr. Ross's patients (1852-1877) and as outlined by Zimmerman (1877) is based upon maternal mortality in general. Statistics from Dr. Ross's practice show that he had 22 maternal deaths, a rate of 1 in 214 cases. Of these deaths, only 8 of the 22 were directly related to parturition. This would give a maternal mortality rate of 1 in 588 cases. The remaining deaths were due to such things as typhoid, dysentery, pneumonia etc. Although Dr. Ross's mortality rate was slightly higher than Dr. Burritt's both physicians had a considerably lower rate than that of the lying-in hospital. However, Dr. Ross's data illustrate the difficulty in using statistics from this period. Broad maternal

mortality figures which are not broken down as to causes of death may contain statistics of women who died from causes other than those related to pregnancy.

Physicians associated with the lying-in hospitals often had difficulty accepting the idea that maternal mortality was less in home births. In the article on Dr. Goodell's treatment of puerperal diseases, the writer states "Dr Goodell believes that one of the reasons why statistics of lying-in hospitals can never compete with private practise is that the former is reliable the latter not" (*Medical Surgical Science* 1875). Dr. Goodell's dismissal of the data is indicative of a more serious problem, one which to a certain extent exists within the practice of medicine today. This is the failure of physicians to link specific care interventions (what they do) with the outcomes (the results of the care provided). There is a weakness in assessing explicitly the degree of validity and sufficiency of the evidence linking care structures and processes, to the outcome in general and the health outcome in particular. The practices of these physicians are based on an *unquestioned assumption* of the validity of their practice rather than on any scientific evidence which has related the specific care intervention to the health care outcomes (Williamson 1978). In the past, these unquestioned assumptions were rooted in beliefs which presupposes that class and education were

automatically translated into healing and medical skills. As a result, physicians failed to establish a causal association between their specific obstetrical interventions on patients with certain health conditions and the outcomes which they observed. The fact that they ignored the critical imperatives of epidemiology has never been acknowledged.

Based upon their unquestioned assumptions and observations, physicians drew a conclusion; birthing is a pathological event. Their suggested reasoning (whether conscious or otherwise) may be outlined as follows: lying-in hospitals are operated by professors of medicine and as such offer the highest quality of care. Therefore women who are attended during childbirth in these hospitals receive the best care. However, maternity mortality rates remain high. Because medical services are of the highest quality, these high death rates are not due to care. If they are not due to the quality of care, they then must be due to the pregnancy itself. Therefore it is logical to conclude that pregnancy is a pathological condition. That some physicians accepted this conclusion is evident. For example, in the article on Dr. Goodell's treatment and prevention of puerperal diseases the author writes: "It cannot be too strongly urged that mortality of child-bed is much higher than what is generally stated, and that the ailments arising from it are of a more serious nature, and more frequent, than most medical practitioners suppose" (*Medical*

Surgical Science 1875).

This approach to obstetrics was epitomized by Dr. Joseph B. DeLee in an article entitled "The prophylactic forceps operation" and published in the *American Journal of Obstetrics and Gynecology* in 1920:

It always strikes physicians as well as lay men as bizarre, to call labor an abnormal function, a disease, and yet it is decidedly [sic] a pathological process. Everything, of course, depends on what we define as normal. If a woman falls on a pitch-fork, and drives the handle through her perineum, we call that pathologic-abnormal, but if a large baby is driven through her pelvic floor, we say that it is natural, and therefore normal, ... [If] the fall on the pitchfork, ... [is] pathogenic, [then] in the same sense labor is pathogenic ... and anything pathogenic is pathological and abnormal So frequent are these bad effects, that I have often wondered whether Nature did not deliberately intend women to be used up in the process of reproduction, in a manner analogous to that of the salmon, which dies after spawning (De Vries 1985: 41).

As a result of his belief in the pathology of birthing, DeLee recommended that episiotomies and outlet forceps be routinely and prophylactically used in normal deliveries. He considered that only obstetricians were sufficiently qualified to use prophylactic forceps, and that general practitioners must be brought up to the level of specialists, not obstetrics down to the level of general practitioners (Dixon 1987: 1097). Dr. DeLee's article indicates that by 1920's birthing was understood by some physicians as a pathological event requiring intervention on the part of physicians. This resulted in ideology and intervention being linked in a manner that would influence maternity care until the 1970's, when

beliefs about birthing would once again begin to change.

The transformation of birthing into a pathological event carries with it an important consequence. If birthing is reduced to pathology or risk of pathology, it calls for intervention by medicine. By definition pathogenesis means the origination and development of a disease; medicine as the art of caring for, or assisting in the cure of disease and the care of injured (Taber 1958). It is the function of medicine to care for all conditions associated with disease and injury. Therefore the labelling of childbirth as pathogenic legitimizes medicine's incursion into birthing. The classification of parturition as pathogenic was in the interest of physicians since they saw that it was in accordance with their exclusive authority to diagnose obstetrical patients and therefore they gained control of these women.

Three fundamental ideas are involved in contemporary maternity care; birthing as pathogenesis; hospitalization; and technological intervention. Each aspect of this system is dependent upon the other. Together they create a total obstetrical system. For the system to function unchallenged, each dimension must remain intact. Once one facet is rejected, the system itself can be questioned. Suppose that one aspect of contemporary maternity care is altered and if, for example, home births are substituted for hospital births. Home births carry with them

the corollary of non-intervention. And non-intervention is linked to the belief of birthing as a natural event. Thus, the formula for maternity care is transformed. Birthing as pathogenesis, requiring hospitalisation, and technological intervention is replaced with a birthing ideology which proposes natural childbirth, home births, and non intervention. This transformation carries with it a further consequence. A system of maternity care which is based upon birthing as pathogenesis, hospitalization, and technical intervention, by definition falls under the exclusive authority of medicine. The alternative system, natural childbirth, home birth, and non intervention would rely on the experts in normal pregnancy, in other words midwives. If my analysis is correct, it is understandable why physicians have acted so quickly to prevent home births in Canada.

The reason presented by medical practitioners for their objection to home births is based upon the argument of mother and infant safety. Physicians believe that home deliveries present an unacceptable medical risk to mother and infant. The American College of Obstetricians and Gynecologists claim that out-of-hospital births are 2 to 5 times more dangerous from the standpoint of neonatal mortality (Mehl et al. 1976: 1). This debate over home versus hospital births has been presented in several works; *Report Of The Task Force..* (1987); a research paper by the

Legislature Research Service of the Ontario Government (1986); and an article by Dixon (1987) in the *Canadian Family Physician* journal. I will not repeat their arguments. Rather, I will refer to four papers; two which reject home births and two which support them. These papers illustrate the dimensions of the problem and present an overall view of the hospital versus home birth issue.

What then is meant by mother and infant safety? Many physicians understand safety and risk in terms of the narrowly defined medical outcome. An alternative view conceptualizes it in a broader context. Included within this definition are emotional, psychological and long-term child development factors as well as the physiological outcome. Therefore, decisions about childbirth involve balancing the risks and benefits associated with different models of birthing.

The physicians who are vocally opposed to home births stress that not all complications can be foreseen through even the best screening, and serious problems can arise during labour and delivery. If parturient women are not in the hospital where equipment, facilities, and specialized expertise are located, high morbidity and mortality will occur. Screening itself cannot identify all problems and a number of low risk cases (20-30%) of those deemed as appropriate for home births will develop complications (Legislative Research Service 1986: 3).

Physicians base their conclusion on a study done in a birthing suite, a room designed to create a home-like atmosphere in the hospital. They found that only 41% of their sample of low-risk women were able to complete their labours and deliveries in the location. The remainder developed problems either earlier in their pregnancy or during labour. As a result they were transferred to the traditional labour and delivery room. Because of this research, the authors concluded that low-risk women cannot be predicted beforehand. Therefore birthing cannot be managed successfully at home.

To understand further what is involved in this piece of research, it is necessary to describe the Friedman's curve. If one starts from the view that childbirth is pathological then any deviation from the expected process (or timetable) can indicate a crisis, which requires medical management. In the 1950's Friedman observed women in labour in hospitals in order to calculate the average length of labour and range of variation. He then separated labour into phases and computed their average length and variation.

His next step was an implicit-but unexamined and unproven-assumption that statistical normality can be equated with physiological normality. The problem with such an assumption is that statistically abnormal pregnancies and labour may be perfectly safe and healthy, but are nonetheless medically treated (Legislative Research Service 1986: 15-16)

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Thus, a woman whose labour is outside the statistical range of observed variation will in all probability face medical intervention.

The birthing suite which was studied functioned within the accepted assumptions and procedures of the biomedical model. The study indicates in fact that approximately one half of the transfers from the suite were timetable anomalies (ibid 18). The practices of these physicians which influenced the results of their study are based upon the *unquestioned assumptions* of the validity of their practice rather than on any scientific evidence which has related the specific care intervention to health care outcomes. Therefore women whose labours where outside the statistical range of the observed variation were sent to the traditional labour and delivery rooms. Medical intervention was based on the assumption that physiological normality can be equated with statistical normality.

As discussed previously, the American College of Obstetricians and Gynecologists used data from Oregon collected in the 1970's to show that neonatal mortality rates are twice as high for home as for hospital births. The college asserted that this was only the tip of the iceberg. On the basis of the raw data received from eleven states, the college declared that the risk to a baby's life was 2-5 times greater in out-of-hospital births. In their use of data the college failed to

distinguish planned and prepared births from late miscarriages, premature or precipitous deliveries, and unattended births. All of these births were lumped together in the out-of-hospital category.

A study of home births in California by the Centre for Disease in Atlanta, from 1974 to 1976, illustrates the need for eliminating the confounding variables in site comparisons. The neonatal mortality rate was 3 per 1000 planned home births attended by a midwife; 30 for planned home births without a lay midwife; and 120 for unplanned home births (ibid 10).

These two studies which the physicians have used to support their argument against home births are marked by serious methodological and analytical flaws. There are no control groups; and the conclusions are based on unquestioned assumptions rather than scientific evidence which challenges their validity. The medical profession has failed to assess explicitly the degree of validity and sufficiency of the evidence which they have used to link home births with higher infant and maternal mortality.

The first study I wish to refer to which supports home births was conducted in Ottawa by Dr. Gerd Schneider and midwife Bobbie Soderstrom (1987). The purpose of their study was to describe the outcome, in one family practice, of planned home births attended by a physician and an

experienced birth assistant in a self-selected and subsequently screened population. The information was gathered on the patients from 1976 to 1986. Forty women in the study were assisted in childbirth prior to 1980. Their charts were reviewed and the women were contacted for further information. The data on the remaining women were recorded at the time of birth by the physician or birth attendant.

The initial population was self-selected but later medically screened according to the criteria recommended by the College of Physicians and Surgeons of Ontario. All women who were having babies for the first time were screened out, excepting for twenty-six women who were allowed home births because they had exhibited a strong aversion to hospital care. Home delivery appeared as a reasonable option as they met the other medical criteria.

The population requesting home births was a total of 275. Of these, nine were screened out for medical reasons; three women because they carried twins; one because of a breech presentation; and five women because of prior Cesarean sections. However these five women with previous Cesarean sections gave birth at home, uneventfully, and against medical advice. Ten unplanned home births were precipitous and eight of these were unattended. Of the unattended, four were unplanned home births and four were scheduled for home delivery. The remaining six

unplanned home births were supported by experienced assistants at the time of delivery but because of the rapid labour the mothers opted to stay at home.

Of the 275 requested home births, nine women were screened out for medical reasons before labour; five very early while in labour; and three women for failure to progress. Of the 273 who delivered at home, ten of which were unplanned, two women were transferred to hospital for postpartum hemorrhage and one infant was hospitalized for complications. Therefore 270 home births were completely successful. For this selected population home birth was a reasonable alternative to hospital.

The second study and the one which is usually referred to by the supporters of home births is entitled "Home Birth Versus Hospital Birth Comparisons of Outcomes of Matched Populations" by Mehl et al. (1976). In this research, the authors do a comparison study of 1046 planned (attempted) home deliveries with 1046 planned hospital deliveries with case-control matching for age, individual major risk factors, gestational length, parity, education and socio-economic status, and total risk factor score. Their methodology consisted of data collection of the various combinations of physicians and midwives attending home deliveries in the San Francisco Bay Area and one practice in Madison, Wisconsin. Whenever

possible, diagnostic criteria applied in the chart review were used uniformly for both the home and hospital groups.

Risk factors were grouped according to the Nova Scotia Risk Factor Screening Criteria. For each home assisted patient, a hospital delivered patient was matched according to age, length of gestation, parity, total risk factor score, socio-economic status (usually defined by years of education) and the individual major risk factors. Cases were matched in such a way that the risk scores for women were the same on the day labour began. 98% of the home births were white women as home births appears to be a predominantly middle to upper middle class phenomenon. In general home deliveries were largely non-interventionist.

The researchers list a number of possible confounding variables. Although all the women who participated in the study attended childbirth preparation classes, women planning home births may have been more motivated to learn and practice the material. This in turn may have caused less fear and anxiety, thereby improving outcome. Also, there may have been psychological factors which influenced those who chose home births, and this in turn would effect the outcome of the birth. It was also noted that those couples who planned home births were more aware of nutrition than their counterparts.

The results of the research show that there was no significant

difference in the incidence of foetal intrapartum or neonatal deaths, or in the incidence of neurologically abnormal infants. However, the hospital practitioners used significantly more oxytocin, before and after delivery, more forcep deliveries and had more Cesarean sections. In spite of ninefold greater incidence of episiotomies, women who had planned hospital births sustained significantly more third and fourth-degree cervical lacerations. Analgesia and anesthesia were also used much more frequently in hospital births.

The majority of practitioners within the hospital setting used the criterion of one hour of labour for the second stage. This is based on Friedman's curve. The home practitioners typically accepted any length of second stage just as long as the labour was progressing and there was no sign of foetal distress. The difference in approach is reflected in the increased use of forceps in the hospital because of prolonged second stage.

The hospital group performed more Cesarean sections for such things as first stage labour arrest, cephalopelvic disproportion, and for nonprogressive labour than did the home birth practitioners. The hospital group also had significantly more intrauterine foetal distress, elevated blood pressure during labour, meconium staining, and reported shoulder dystocia. The home group had more bleeding during labour; the hospital,

more postpartum hemorrhages.

Although neonates in the hospital experienced significantly more birth injuries, received significantly more oxygen, and had more respiratory distress lasting twelve hours or more, there were no significant differences in the incidence of the total number of congenital anomalies, congenital heart disease, Down's syndrome, and a number of other conditions associated with the neonate.

Mehl et al. (1976) concluded that according to their data women of a low medical risk who give birth within the hospital setting subject themselves to other risks. This is due to the specific aspects of routine hospital obstetrical care that exists within an aggressive management philosophy for labour. The corollary of this is that low-risk women, who planned delivery at home, and their infants did not suffer significantly because of their choice given the population differences and practitioners differences present in the study.

It is apparent from these four studies that there is as yet no adequately researched piece of scientific evidence which links high infant and maternal morbidity and mortality rates to home births. In fact Mehl et al. in their research show that in their particular study the problem lies within the hospital situation where there is an aggressive management philosophy and an interventionist approach to childbirth.

Tony Dixon (1987) in an article which discusses the home birth controversy offers the following conclusion:

In summary, then, it seems that the imposition of almost universal hospital delivery has not brought all the benefits once thought likely to follow, and that while for some high-risk situations it has indeed been useful, it may have been so at an unforeseen price for many low-risk mothers. The shift to hospital confinement was a social movement that took place at a time when labour and delivery were life and death matters, rather than a scientific movement based on adequate data and well-tested hypotheses. It remains a social rather than a scientific issue, with polarised views expressed in rhetoric rather than reason (ibid 1099).

It is not the primary purpose of this analysis to purport that all low-risk parturient women give birth at home, although I believe they should have the choice. There may be a middle ground such as low-risk birthing units where a low- or non-interventionist approach can be encouraged. However the significance of the previously mentioned studies is in the lack of any scientific evidence to support medicine's claim that home births are unacceptable as they put mother and infant at risk. Therefore the home versus hospital controversy is not a scientific issue; it is a social one. At the heart of this social issue are conflicting philosophies with regard to childbirth. One philosophy understands birthing as a pathological event requiring the hospitalization of women and technical intervention; the other, as a natural event within the home and with non-intervention. The first approach is currently in vogue in

Canada and is supported in general by physicians; the second is the type of care advocated by the women's health movement, midwives, and a small number of physicians. It is this philosophical issue which must be resolved.

Home births have become a symbol of this conflict. For the physicians they are a threat to the present system of obstetrical care which falls under their jurisdiction; for midwives and women in general a necessity if they are to gain control over their practice with normal pregnancy and assistance at childbirth. Home births symbolize the transformation of birthing from a pathological to a natural event and as such carry with them the other dimensions of non-intervention and control by midwives. Therefore home births are central to midwives' claim for autonomy and it is up to women and midwives to promote this issue. What then can they do?

The first objective is public education. Society itself must begin to refocus its understanding of birthing, and midwives, as well as their advocates, must make the public aware of the available research which supports their proposals. The second is through research such as that which was completed by Dr. Gerd Schneider and midwife Bobbi Soderstrom. This type of study not only adds to current knowledge on midwifery, but reinforces the image of midwives as educated competent

women who are able to make a contribution to their field. Finally, midwives and their advocates must attack the political issues which are crucial to their program. The topic of political participation will be discussed in the third section of this chapter.

Midwives as Experts in Normal Pregnancy and Child Birth

If midwives are to become experts in normal pregnancy and childbirth, they must first have defined what is meant by the term *normal*. *The Report Of The Task Force...* (1987) does not tackle the issue of normal pregnancy and childbirth although it leaves it to medicine to delegate medical acts. However since midwifery is concerned with non-interventionist approaches and medical acts may be a part of technological intervention, this does not clarify the situation. The fact that individual physicians will determine whether midwifery care is appropriate for a midwife's client suggests that it will be left to each physician to decide what is normal and what is not. This may result in two problems; one is the possibility of a number of conflicting definitions of *normal*; and two, *normal* is defined by medicine rather than midwifery. Therefore, one of the first tasks that midwives must achieve is the defining of the important concept of *normal pregnancy and childbirth*.

The problems of defining normal childbirth were tackled in 1979 by

the Texas legislature when it introduced "a bill to be entitled an act relating to the regulation of lay midwifery, providing penalties" (De Vries 1985: 64). The bill for the first time in Texas history created a statutory definition of "normal childbirth":

the delivery, at or close to term, of a pregnant woman whose physical examination reveals no abnormality or expected complications and who does not exhibit signs or symptoms of hemorrhage, toxemia, infection, abnormal fetus position, or abnormal presentation (ibid 65).

A revised version of the bill introduced in 1980 restricted the definition of normal childbirth to cases that exhibit " ' no abnormality or expected complications' excluding the more specific references to 'hemorrhage, toxemia, infection, abnormal fetus position or abnormal presentation'" (ibid 67). Although the definition itself may not be acceptable to Canadian midwives, the fact that it was passed in the Texas state legislature points out the need to define "normal childbirth" and to have that definition legitimated by the state.

"Normal childbirth", as defined by the Texas legislature, is limited because it understands "normal" as simply the absence of disease. An alternative perception may view a healthy pregnancy and one which is not healthy as continuous or part of the same continuum. The nursing theorist Imogene King provides a third understanding of health which in turn may be applied to a pregnancy. She perceives it as:

A dynamic life experience of a human being, which implies continuous adjustment to stressors in the internal and external environment through optimum use of one's resources to achieve maximum potential for daily living (Meleis 1985: 233).

King's understanding of health if applied to parturition may read as follows; a normal pregnancy is a dynamic life experience for a female person, which implies continuous adjustment to stressors in the internal and external environment through optimum use of her resources to achieve a maximum potential for daily living for both her and her foetus. Although this is only a suggestion, this type of definition avoids the normal/ abnormal dichotomy in which a normal pregnancy is understood only as the absence hemorrhage, toxemia, infection etc.

Besides defining "normal pregnancy" midwives will also have to outline their scope of practice. Based upon nursing's defined scope of practice, midwifery's scope of practice may be understood as a situationally derived process of midwife and client system interaction which proceeds from the bases of assessment of needs and functions and is designed to optimize the clients functions with strategies related to:

- (1) environmental modification and /or reinforcement;
- (2) reinforced or modified behaviour;
- (3) biophysical care and maintenance;

in required dosage (McGee 1975).

The definitions of "normal pregnancy" and scope of practice presented here are but examples. Midwives may choose to define them differently. The purpose of using these examples is to illustrate two fundamental prerequisites for the establishment of midwifery as an autonomous profession.

Once normal parturition has been defined, the scope of practice outlined, and midwives have been legislated as the experts in the discipline, it will be the function of the midwife to complete the first physical examination of the parturient woman. At this time the midwife will distinguish between normal pregnancy and those with current or foreseeable problems. If the pregnancy is normal, the client will continue under the care of the midwife. If there is evidence of any complication or possibility of complication, the woman will be referred to an obstetrician. With this method, midwives will be responsible for routine pregnancies; obstetricians for cases which clearly fall into the medical domain.

Throughout the pregnancy the midwife will monitor her clients to determine whether they have developed any complications which require referral to obstetricians. Indications for referral should be clearly defined through a cooperative effort between medicine and midwifery. Once all aspects of normal pregnancy fall under the domain of midwifery,

routine birthing decisions will be left to the mothers. Since birthing will be regarded as a natural process, there will be few decisions to make. Like the Dutch midwives who work under the assumption that women know what their bodies are up to Canadian midwives will ensure that their clients are treated as competent human beings who are able to manage the natural process of birthing.

Like the professional institutions associated with medicine, the College of Midwives must strive to be free of external evaluation from other occupations in the division of labour. Freedom from outside control will allow the college to determine what tasks midwives will perform. These tasks will not be delegated by the medical profession, nor will physicians remain responsible for supervising the performance of the acts. Once normal pregnancy and childbirth is defined, the tasks related to the care of the women who fall within this category will be delineated, and administered by the College of Midwives. This will ensure midwifery's autonomy. If midwives wish to become an autonomous profession they and their advocates by necessity, will have to lobby the various provincial governments for this important right. Professional autonomy can only be granted by the state.

Critics of this demand will suggest that midwives do not have the education, knowledge, and experience to make these types of decisions;

only physicians are capable of determining what is a normal pregnancy and childbirth. If the education for midwives is established as outlined by the *The Report Of The Task Force...*(1987), midwives will have had at least four years of university education, or a degree in nursing with a postgraduate diploma of twelve to eighteen months in midwifery. This education is sufficient to prepare them to care for normal parturition. I would point out that at the present time general practitioners are licensed to assist women in childbirth although they usually receive minimal training or clinical experience in obstetrics during medical school and internship. Many begin their practices without having any contact with general practitioners who practice obstetrics. Because these physicians lack role models, they may practise with no secure feeling of competence in obstetrics. This sense of security may be compounded by the relatively small numbers of cases available to them (*Report Of The Task Force ...1987: 69*). Therefore the education and practical experience of midwives will be far more exhaustive than that presently obtained by general practitioners. Midwives will have the necessary knowledge and experience to delegate and supervise all those aspects related to normal parturition.

If midwifery is established in Ontario in the manner that is outlined in the *The Report Of The Task Force ... (1987)* we will have a system of

maternal care in which the general practitioner, who will have had far less education and experience as it relates to normal pregnancy, will be allowed to make decisions with regard to parturient women, that midwives, with their years of education and experience, cannot. It would appear then that the determining factor for decision making as it relates to normal pregnancy and childbirth is not the competency of the care givers but the power of its professional institutions. Through the state, medicine obtained the authority to regulate and supervise the activities of related health care occupations which impinged on medical practice. Through the state, midwifery lost the ability to direct its occupation on its own. Therefore, it is only through the state that midwives will regain jurisdiction over midwifery and the birthing experience.

Midwives, Power, and Politics

As I have previously discussed, there are two political issues which must be confronted if midwives are to be recognized as the preeminent birth attendant in cases normal parturition. The first is that of home births; the second is that of freedom from outside technical evaluation and management by the medical profession.

Legislation is the main political instrument for social change. The passing of laws is a central focus for pressure groups and movements seeking to effect change. The effectiveness of the movements can be

measured by a party or parties' apparent interest and the government's response with new laws which have a bearing on the issue.

A question worth examining is whether social groups such as midwives and their advocates can best promote their goals inside or outside the formal political system. The argument for working within the system is that the ultimate decisions such as those related to the format which will establish midwifery are made within the civil service and by governments and will be ratified or perhaps altered in some small way by parliament. The policies of a government are shaped by attitudes within the political parties and by the party's manifesto, although they often undergo change once the party achieves power. A major problem of trying to work within the power structure to effectively achieve change is that often when a person manages to reach the top, s/he is under great pressure to conform to prevailing standards and attitudes. This has certainly been true with many of the women as well as men politicians (Carter 1988: 187).

On the other hand radical and innovative ideas, for the most part, come from movements operating outside the centres of political power. These groups while generating great energy, challenge existing attitudes and beliefs, and experiment with other ways of tackling social problems and other forms of self-organization. The demand by the consumers for

alternative maternity care, the response of the midwives and the support of this issue by women's groups have had the effect of "humanizing" birthing within the hospital managed obstetrical units. Birthing rooms have been established allowing women to experience childbirth in an atmosphere which resembles the home situation. The midwifery movement has brought about a shift in social awareness which has filtered into the mainstream medical situation promoting some reform.

Highly organized pressure groups can effect specific legislative issues. For example, the women's movement has brought about significant shift in attitudes toward day care and has made some gains in this area. Nevertheless movements do have limitations.

They lack real power, influence, and resources; energy and enthusiasm flag after a while, especially when people find themselves having to fight the same battles again and again and see their victories easily reversed. Moreover, by developing new ideas in enclosed internal debates, movements run the risk of losing touch with majority attitude and social reality, and of becoming sectarian and dogmatic (ibid 187).

After a lengthy examination on the issue of politics and women's rights in Great Britain, Carter (1988) has concluded that the best way to achieve significant political reform is to: (1) build a strong movement to influence the climate of opinion: and (2) to strengthen the representation for the cause within the political system. This of course is achieved by electing supporters of the movement's cause to parliament. I would point

out that it was the physician Sir Thomas Roddick, a member of parliament who campaigned so diligently to have the Canada Medical Act of 1902 passed. In a similar manner it will probably require an advocate of midwifery to ensure that legislation is passed which recognizes home births and midwives as the preeminent birth attendant in normal parturition.

Although some issues gain parliamentary support across all political parties others are not quite so successful. Where wider economic and social issues are at stake, it is usually necessary to gain the support of one political party who will implement the program when it achieves power. Advocates of midwifery may have to take the second route as it can be assumed that those opposed to midwifery will find a party which will take up their cause.

Midwives cannot automatically expect that women elected to parliament or those who have achieved political influence will support their interests. Women who enter politics may identify with a range of political ideas, not necessarily all those supported by the women's movement. Moreover, even though they may wish to espouse the cause of midwives, they are at a disadvantage because of their small minority in an environment unsympathetic to women's issues which have a tendency to be defined as marginal. It is also a fact that some aspiring women

politicians have reacted to being identified primarily with issues associated with women.

Nevertheless, midwives and their advocates must seek to promote their issues inside the formal political arena. Two factors are likely to have an influence upon the readiness of women parliamentarians to support women's interests such as that of midwifery. The first is related to the strength of a movement's cause within the community. Politicians are influenced by the public's attitude. For example in Quebec in 1981, the provincial government took an active interest in institutionalizing midwifery. By 1983 the government had changed its mind. It is not known why this occurred but one suggested reason is that the issue lacked the support and interest of consumer groups. Strong interest in a movement's cause must be demonstrated before a parliamentarian will risk his/her political "neck" in its support.

The second factor is related to the number of women who are elected. If there were a significant increase in the number of women representatives in parliament, women would cease to be an isolated minority. They would be psychologically as well as politically in a better position to promote women's issues. It is suggested that there may be a "critical mass" effect in that a certain level of female representation is needed before women will have the desired effect (ibid 188). Therefore,

to have favourable legislation passed, the advocates of midwifery not only will have to elect a politician to act on their behalf but to ensure that enough women are elected to create a "critical mass" effect in order that female representation is sufficient to provide for the desired ends.

From the previous discussion on the necessary requisites for the establishment of midwifery as an autonomous profession, the political goals for midwives may be outlined as follows:

- (1) the transformation of birthing from a pathological to a natural event. This is achieved partially through a formal acceptance of home births;
- (2) a statutory definition of normal childbirth;
- (3) state intervention on behalf of midwives to free them from outside technical evaluation and supervision by the medical profession;
- (4) and state recognition of midwives as the preeminent authority of normal parturition.

If these goals are achieved midwifery will become an autonomous profession.

Government legislation is the main political instrument for achieving these goals. Based upon our present knowledge of the political system, the following are the major ways to the successful accomplishment of these goals:

- (1) the development of strong support within the community. This

includes social groups which have the political savvy to campaign for favourable legislation;

(2) the inclusion of midwifery's goals within the platform of a political party;

(3) the election to parliament of an individual or individuals who will promote midwifery's cause. Midwives should not assume that all women elected to public office will automatically support women's issues;

(4) and the election of more women to parliament. The greater the number of women, the more likely they are to become involved in women's issues. Such issues will no longer be marginal but mainstream.

Not yet discussed is another means of assisting in the accomplishment of midwifery's goals. This is through the drafting of the parliamentary legislation. Individuals who are knowledgeable on the issues, as well as on the ways and means of formulating parliamentary legislation may provide expert advice on how to frame a midwifery bill. They may play a key role in ensuring that the piece of legislation is articulated in such a manner as to clearly support midwifery's interests. The bill must make certain that midwives have total jurisdiction over their occupation. It is only then that midwives will be able to assume a professional role within the community and health care system.

Towards an Alternative Epistemology and Theories in Midwifery

The Report Of The Task Force ... (1987: 87) raises the concern that midwives may become more competent with technology at the expense of clinical skills. The over-use of technology in obstetrics has been a major concern of those women who reject our present system of maternity care. They fear the iatrogenic consequences of a system of midwifery which relies too heavily on the routine use of technology for normal parturition. According to Mehl et al.'s research (1976) these fears are grounded in reality.

Nevertheless, it is not sufficient to address the problem as simply the over-use of technology. The root of the issue needs to be examined as technology is but one manifestation of a system of obstetrics which is based in science. Fay (1975) states clearly that 'science is linked to the promise of technical control' (ibid 44). Implicit within science is the use of technology. Wherever science is employed, including its use in obstetrics, technical manipulation becomes an integral part of the discipline. Therefore the focus of attention must shift from the narrower facet of technology to the broader problem - that of the use of science as the epistemological basis for midwifery care. In order to ensure that midwives achieve the desired clinical skills, theory for practice must be grounded in something other than science as we presently know it. In

other words midwifery will need to develop alternative theories which will guide practice. These theories, which are referred to as situation-producing theories (Dickoff and James 1986: 103), will guide the actions of the midwives to the production of the desired reality.

Some feminist critics of the methodological use of science tend to delineate the difference between a masculine and a feminine methodology. Proponents of this view indicate that the feminine model is rich with intuition, subjective, personal, contextual material, and description, following the traditional view that women have a greater use of intuitive sense. Mainstream science on the other hand is the male model, rational, objective, and impersonal. This separation of methodology into feminine and masculine approaches has the negative effect of creating "the myth of an alternative mainstream in science with two separate but equal methods" (Parse 1988: 93). This may result in the isolation and denigration of women theorists who are unwilling or unable to compete in mainstream hard science. The mainstream of science would then be confirmed as the rational objective side while the intuitive side may be understood as existing but not essential to the development of the theoretical basis for practice. Instead of this division into "masculine" and "feminine science", scholars such as Parse (1988), and Keller (1985) indicate that the task is to integrate into the mainstream epistemology,

value for intuitive and descriptive dimensions in addition to the rigor of the rational. This involves a reframing of the issue from a gender separation perspective to one in which there is a fundamental change in thinking about the human processes involved in the discovery of information about the reality in which we are emersed (Parse 1988).

In her book *Reflections on Gender and Science*, Keller (1985) offers an alternative to our present methodological approach. She refers to it as *dynamic objectivity*. Objectivity as defined by Keller is "the pursuit of a maximally authentic, and hence maximally reliable, understanding of the world around one-self" (ibid 116). The pursuit is dynamic because it actively draws upon the "commonality between mind and nature" (ibid 116) as the basis for understanding. The focus of dynamic objectivity is in one's connectivity with the world. There is a recognition that the world around us has an independent integrity. Nevertheless, the scientist is always cognizant of the commonality of feeling and experiences (not unlike empathy) which contributes to one's understanding. This, then, is in contrast to static objectivity which is the pursuit of knowledge through the severance of the subject from the object. For those who practise either static or dynamic objectivity the ambition appears the same. However the starting assumption that the researcher has about the nature of the pursuit critically affects the outcome.

"Dynamic-objectivity is thus a pursuit of knowledge that makes use of subjective experience (Piaget calls it consciousness of self) in the interests of more effective objectivity" (ibid 117). Insight is gained through the struggle to disengage self from other. There is a recognition of the difference between self and other as a means of deeper and more articulated kinship. The aim of such activity is not to undo the connections but to establish relations to one's human and natural environment. The perceptual tool used is called " 'allocentric,' or other-centered, perception" (ibid 118). This requires the complete focusing of the researcher's perceptions and experimental faculties upon the object of study in such a manner as to temporarily eclipse the perceiver's egocentric thoughts and strivings with self. This leads to a total absorption in the object before the researcher, and the experiential realization of the kinship between oneself and the other, and is the essence of dynamic objectivity. It is directly opposed to the distancing or severing of subject and object.

Those who function within the realm of science with its technological implications have difficulty stepping outside their paradigmatic view of the world in order to understand the effect of this approach on health care outcomes. Because these workers begin from a particular epistemology, they usually cannot comprehend how their way

of knowing influences their clinical skills. In most cases, there is no attempt to relate epistemology to theories, practices, clinical skills, and finally to health outcome. An understanding of these linkages is necessary in the development of optimal health care practices.

Therefore, in order to clarify the effect of the scientific approach with its use of technology upon a parturient woman, it is necessary to compare it with an alternative approach. This I will do in the remainder of this section with a discussion on ultrasonography, a practice in reproductive technology. The material used in this analysis is taken from the work of a nursing academic, M. Sandelowski (1988).

The goal of all prenatal care is to assist women through pregnancy and childbirth in order that mother and child will have a safe and healthy experience. Included within the concepts of *safe* and *healthy* are emotional and psychological factors, and long term child development, as well as physiological outcomes. There are two epistemological approaches used to achieve this goal. The first is through the mainstream way of knowing; science with its promise of technology and the severing of subject and object. The second is through Keller's (1985) dynamic objectivity; the use of subjective experience in the interest of more effective objectivity. The ambitions of both approaches are the same; to offer quality care during pregnancy and childbirth. However, because of

the different starting assumptions of the researchers about the nature of their pursuit, the outcomes will be critically different.

In dynamic objectivity, subjective experience is used in order to establish more effective objective information. In about the first sixteen to eighteen weeks of pregnancy, a woman perceives for the first time foetal movement. This is referred to as *quickening*. Foetal movement is customarily viewed as the turning point in the establishment of maternal-foetal bonding. Through this subjective experience, the information gained is used in the critical role of differentiating diagnosis and dating of pregnancy. Psychologically, it is viewed as the vital stimulus to maternal embodiment and differentiation of the foetus as well as to a woman's acceptance of her pregnancy as real. Quickening offers women positive confirmation of the pregnancy. Prior to the foetal movement, the pregnancy is often perceived as unreal, and the foetus, if imagined, as formless and lacking in personhood (Sandelowski 1988: 38, 39). Therefore, in terms of dynamic objectivity, subjective experience is used to establish more effective objectivity (Keller 1985: 16).

Science on the other hand implies the use of technology as well as the severing of subject and object. With the advent of diagnostic ultrasonography and its use prior to the sixteenth week of pregnancy, the importance of quickening in the validation of pregnancy and as a stimulus

for maternal-foetal bonding is altered. It is no longer the subjective experience which confirms pregnancy to the mother but modern technology. Some clinicians and researchers suggest that the use of ultrasonography "induces an earlier and more intense bonding of loyalty to the fetus, increased parental valuation of the fetus, and improved maternal behavior and *compliance to the medical regimen* prescribed on behalf of the fetus" (ibid 39 my italics). It is reasoned that ultrasonography converts the maternal fantasies of the foetus into a "real" image and as a result there may be improved maternal behaviour in pregnancy (Note the paternalistic attitude towards parturient women when clinicians suggest the need to improve maternal behaviour and compliance with the medical regime!) These researchers noted that women were pleased with the moving images on the screen and appreciated the extensive explanations they were given about these images. Through science, technology, rather than quickening, confirms the pregnancy. The foetus now is perceived as an image upon the screen. As a result of technology, there is a distancing between foetus and mother, subject and object. Through the use of ultrasonography, seeing is substituted for feeling as the critical sensing modality in foetal awareness. The woman's perception of foetal movement has been transformed from a private feeling experience into a public visual one. It

is no longer exclusively her own.

While visual objects are grasped by the viewer as coming from a distance to what is viewed, touch requires a proximity of feeling to what is felt. While seeing is not necessarily being seen, touching is always being touched and is accordingly a sensory modality requiring interaction (ibid 39).

Ultrasonography results in maternal attachment beginning with a disengagement as the foetus is objectively seen on a screen and not felt as a subjective experience and as a part of the maternal self. Moreover, the ultrasound picture requires an explanation as the image on the screen is not recognizable as a baby. It only becomes a baby after the images have been explained by a clinician or technician.

What is seen on the television screen is made to be consistent with the new obstetric reality medicine is creating. The visual experience of 'blob', in the words of one mother, is defined and translated into the sensation of seeing a baby. With ultrasonography 'parental recognition of the fetal form is now a medical event, occurring beneath the medical canopy' (ibid 39).

This then is a comparison of two epistemological approaches. Such a comparison illustrates how a particular way of knowing effects practices, clinical skills, and health outcomes. In dynamic objectivity, the subjective experiences of quickening are used to confirm pregnancy; in science ultrasonography, technology achieves the same goal. Both approaches begin with the aim of assisting women towards a healthy, safe (in the broadest sense) experience. Dynamic objectivity depends

upon a woman's intimate relationship with the foetus providing data as to the confirmation of pregnancy and dates of pregnancy. Reliance on quickening assists in the development of maternal-foetal bonding. This dependency upon the subjective experience as a source of objectivity increases the woman's confidence in her ability to interpret the information that her body can provide.

On the other hand science with its implicit use of technology leads to a separation of the pregnant woman and her foetus, thus an increase in alienation from the experience of childbirth. Through ultrasonography the foetus is first experienced, not as internal movement within the woman's body, but as an image on the screen which requires interpretation by the clinician or the technician. There is a separation of the subject (mother) from the object (foetus). Technology, such as the use of ultrasonography tends to lead to the women experiencing the machine as becoming incorporated into her body. This results in more dependency by the mother on the machine and less in interpreting the information that her body can provide. Knowledge gained from the parturient woman's subjective experience is relegated increasingly to the realm of ambiguity "while machine generated knowledge is confidently located in the realms of objectivity and certainty" (ibid 41). Moreover, dependency upon the epistemological approach which is rooted in science has the effect of

alienating a mother from her body and foetus, a result which in the long term may be harmful psychologically and emotionally for the mother and for the child's development.

From this discussion it has become apparent, that midwifery will need to delineate the epistemological problems which permeate the present obstetrical system. Once this has been accomplished, the next step will be to develop an alternative approach, and from that the theories and concepts which will guide and shape the mission and the clinical skills of midwives into the desired reality.

Reclaiming The Birthing Experience

It is the purpose of this chapter to offer midwives a general program for reclaiming the birthing experience. As I have previously indicated, it is through midwives regaining their role as principal care givers in normal pregnancy and childbirth that women in turn will have the opportunity to reclaim control of their own birthing experience. From the preceding discussion, it has become apparent, that if the task is to be accomplished, midwives will be required to proceed towards their goal along two different but compatible paths. The first is the political path; the second, an academic one.

First and foremost, midwives will need to form a collectivity which will carefully define their desired goals. From the analysis of the

historical data based upon their felt needs and grievances, I have concluded (and the midwifery collectivity may disagree with this) that midwives and their advocates are mutually calling for:

(1) a transformation of birthing from a pathological to a natural event.

This will be accomplished partially through a formal acceptance of home births;

(2) a statutory definition of normal childbirth;

(3) state intervention on behalf of midwives to free them from technical evaluation and regulation by another profession;

(4) and state recognition as the preeminent birth attendants in normal parturition.

Since state intervention is the apparent means toward legitimation midwives will need to:

(1) develop strong support within the community. This includes developing social groups which will campaign for favourable legislation;

(2) seek the inclusion of midwifery's goals within the platform of a political party;

(3) seek the election to parliament of an individual who will promote midwifery's cause;

(4) and elect more women to parliament as women's issues will no longer remain as marginal but become mainstream. These, then are the primary

political goals. As well as achieving the political goals, midwives will have to;

(5) develop and mount clear effective public education strategies on the relationship of midwifery to society, its utility, and its problems, through television documentaries, newspaper features, and radio interviews; and

(6) design staff development strategies to handle two directions: the current state of maternity care and the future development of the specialty (midwifery) in health sciences.

It is more difficult to offer a program for those who would follow the second path, an academic one. At the present time within Canada there is no academic institution which offers a program in midwifery per se. Therefore it would seem on the surface that there are no academics in midwifery who can look to the epistemological problems of our present obstetrical system in an effort to develop alternative approaches and theories. This in fact is not correct. It has troubled me that the task force for Ontario has chosen not only to persist in presenting this view but in the process has alienated academics in nursing. At the present time, within the field of nursing there are theoreticians who have not only rejected an epistemological approach grounded in science but are developing alternatives to this. Margarite Sandelowski R.N. PhD., for

example, using an alternative approach was able to clearly articulate the problems which result from reproductive technology, and there are others, who have the qualifications and education vital to the development of a Canadian midwifery. If women and midwives are to reclaim the birthing experience they will need to muster all the resources they can (and this includes nursing academics) in the uphill battle for jurisdiction over normal birthing.

On the other hand I would call upon the academics in nursing to assist midwives in their goals. A place to begin may be within the hospital obstetrical wards. Nursing itself has been seen by many as having become too easily co-opted into a system of maternity care which idealizes reproductive technology. In an effort to develop conceptual systems which emphasize holism and connectedness within obstetrical nursing, academics in this field may assist in providing frameworks which can be successfully applied by midwives to normal pregnancy and childbirth.

Obstetrical nurses and midwives are not two different care givers in competition with each other. They are both members of disciplines which seek to provide different types of care and nurturing to parturient women in such a manner as to allow for the development of each woman's human potential. Nurses and midwives complement each other. It is only

through their cooperating together that women will eventually be successful in their bid to reclaim the birthing experience.

Chapter 9

Conclusion

In this concluding chapter, I wish to determine the appropriateness of the critical model of social science for the investigation of midwifery in Canada from 1788 to 1987. Through the use of this model, I have sought to achieve two goals. The first and more immediate is that related to midwifery itself. On behalf of midwives, I have tried to articulate their felt grievances, to provide a vocabulary within which their situation can be conceptualised, to explain why their social conditions are frustrating, and to offer a program which will help them obtain their goals. This I believe I have done in chapter six, seven, and eight.

There is a second goal, one which is broader in scope. Through critical theory, I seek to explain the quasi-causal and functional laws which have assisted in determining the particular midwifery practices that have occurred in Canada in the past two hundred years. Related to this is the understanding of the contradictions in social life which underlie the tensions and conflicts experienced by midwives. To arrive at this explanation, it is necessary to examine the social conditions which have been discussed in each chapter. I refer to gender attitude, the economic status of women, the quality and degree of institutionalization

of medicine, and state intervention into health care. By removing each category from its social context, and by examining it in isolation from the other social conditions it may be possible to discover the quasi-causal and functional laws which explain the midwifery practices, as well as the contradictions in the social life which created in part the tensions and conflicts experienced by midwives.

Gender Attitude and the Economic Status of Women

Gender attitude and the economic status of women are so closely linked that it is difficult to separate the two. For example, in the period between 1788 and 1850, within the lower classes where women were crucial to economic organization, they were perceived as knowledgeable, vigorous, courageous, and, in general, admired. Within this society midwifery was under the supervision of the traditional birth attendant; an elderly woman who had usually had children, was highly respected in the community, and was called upon because of her expertise in her field. On the other hand among the aristocracy where women were not central to the economic organization but important for their ability to produce heirs, they were understood as frail and dependent upon men. This dependency lead to a system of midwifery in which women in childbirth were assisted by male physicians.

From 1850 to 1900 gender attitudes were in transition. In the more

remote areas where women were central to economic production, they remained as admired figures. However, in Upper Canada increased agriculture specialization due to the development of the cash economy and the increased use of farm machinery, as well as compulsory education for children which resulted in a reduction of their economic value in the home production team, had the effect of narrowing and weakening the economic status of rural women. In the developing urban areas working class women laboured as washer women, chars, piece workers or at other menial tasks. Social conditions such as inadequate diet, back breaking work, and disease reduced their productivity. Among middle and upper class women a greater emphasis was placed on women's frailty and their inability to compete in a male society. This was encouraged by physicians, who through the use of 'science' perpetuated an ideology in which girls and women of these classes were instructed to understand themselves as in need of protection. Yet this view of women was not transferred to the lower classes. Within this socio-economic group, women were encouraged to take responsibility for the health of the whole family. As in the previous period, gender attitudes were closely linked to class.

At the same time as women were encouraged to become more dependent upon men, physicians were seeking to absorb more of the

midwifery practices. Nevertheless, in spite of the physicians warnings as to the frailty of their nature, women were becoming involved in movements which encouraged their higher education and even attempted to participate in male professions such as medicine. This resulted in a contradiction between the gender attitude as prescribed by class interests, and the reality of some women's actual participation within society. Midwifery tended to reflect this contradiction. As more women, such as Elizabeth Soley (Kennedy 1982) established busy practices, physicians sought to control their work through licensing.

Between 1900 and 1940 gender attitudes crystallized. At the same time women became more integrated into the economy and their position reflected these crystallized gender attitudes. For example women of the lower classes were incorporated into lower paying "women's work". They were pictured as physically weak and morally corruptible. Middle to upper class women, according to the gender attitudes of the time, were forced to occupy professions which dealt with women's work ie: nursing, teaching, home economics etc. They were also paid lower wages than their male counterparts. As beliefs about women's inferior nature became fixed within society, women became more integrated into lower paying jobs.

At this time physicians were able to almost completely appropriate,

the occupation midwifery. Birthing was transferred from the home to the hospital where it was supervised by physicians. However, there were few tensions between medical practitioners and midwives. This was probably due to the fact that there was in general no contradiction between gender attitude which was accepted by many women who saw themselves as frail and dependent and a system of maternity care under the jurisdiction of male physicians.

From 1940 to 1987 both the economic situation for women, and the attitude towards them was in transition once more. By 1961, 30% of all adult women were in the work force. This is compared to 1901, when it was only 14%. More than one-quarter of all Canadian workers were women (Ostry 1968). Nevertheless, women's salary continued to be lower than that of men as women's average earnings were only slightly better than half their male counterparts (ibid 30). The realization of this dramatic disparity in income, as well as other gender issues triggered a response from women. Whereas in the period from 1900 to 1940 gender attitude appeared to contribute to the poor economic situation for women, in the 1960's, the poor economic situation appeared to contribute to a change in gender attitude. This was the beginning of an all out effort by concerned women to rid themselves of their inferior status. There developed in Canada a strong women's movement.

An integral part of this transitions in beliefs about women, was the rejection by many, of current obstetrical practices. Parturient women, who felt they could no longer cope with a system of maternity care which emphasized technology and deemphasized the woman's role, sought assistance from midwives and physicians in order that they might give birth in their homes. This in turn led to threats of punitive measures from the medical profession. At this time there occurred a contradiction in society, as beliefs that women had about themselves (they were knowledgeable, strong, independent etc,) are in direct opposition to a birthing system which emphasizes their lack of knowledge, frailty, dependency etc. Out of this contradiction tensions and conflicts arose between midwives (and their advocates) and physicians.

From this analysis of gender attitude and the economic status of women as it relates to maternity care it is possible to point out the quasi-causal and functional laws which contributed to particular midwifery practices. There is a direct link between the socio-cultural and economic conditions, and the practices related to childbirth. When women are esteemed, perceived as knowledgeable, independent, vigorous, courageous etc, and society and women understand themselves as such, they are usually assisted in childbirth by female midwives. (Such attitudes appear to be directly linked to women's role in economic

production). On the other hand, when society views women as frail and dependent, and women internalize this ideology of themselves, they are delivered in childbirth by a predominantly male profession of physicians.

Women's perception of themselves influences their choice of birth attendants and the resulting system of maternity care.

Conflict and tension dominate in periods of transition. For example, major conflicts occurred between 1850 and 1900 when medicine was in the process of appropriating midwifery, and in 1940 to 1987 when midwives sought to reappropriate their occupation. At both these times there occurred contradictions in social life. Many women viewed themselves as intelligent, vigorous, and independent. On the other hand medicine was trying to establish, or retain a system of birthing which emphasized the opposite. Contradictions in gender ideology lead to tensions between midwives, women, and physicians.

The Quality and Degree of Institutionalization of Medicine

Prior to 1850 there existed in Canada, several medical sects including allopathy, homeopathy, as well as empiric medicine. In general, practices consisted of blood letting, the use of leaches, emetics, and purgatives as well as herbs and amulets. Because of the questionable effectiveness of the remedies supplied by the medical sects, healing was often left to the women of the family who collected and dried the herbs

used in the treatment of the less serious illnesses.

In 1846, 1847, the government of Upper Canada initiated an Act to incorporate a College of Physicians and Surgeons in Upper Canada. With this act, medicine in Ontario took its first step in the process of institutionalizing medicine. However, midwives were exempted from all licensing procedures. In Lower Canada, a bill passed in 1848 established medical boards, with the power to license midwives. From 1788 to 1850, the public in general had little confidence in the effectiveness of medicine. This added to medicine's lack of any real professional organization until about 1848 thus allowing midwives to function free from medical harassment. Since there appeared to be few contradictions in the social life as it related to the administration of health care, there were also few tensions for midwives.

1850 to 1900 saw major transitions in both the quality of medicine and the establishment of professional organizations for physicians. With the establishment of Colleges for Physicians and Surgeons in every province and territory, the medical profession was able to establish itself as an elite body in control of the various medical specialties. Because of this new power, institutionalized medicine was in a position to make regulations with respect to the admission of students into programs such as midwifery, and could license midwives.

At the same time, physicians, through their use of a scientific methodology, were attempting to improve the quality of maternity care. They participated in major obstetrical related research in surgery (eg. Cesarean section), technology (eg. use of intravenous solutions), and medications (eg. morphine for puerperal convulsions). Nevertheless, maternity mortality rates remained high within the hospital setting (Hall 1860 and Medical Surgical Science 1875).

As a result of these efforts, there occurred contradictions in the social conditions which in turn created tensions and conflicts for midwives. Medicine now had the power to regulate both the education and licensing of midwives. Therefore they tended to refuse licenses to any midwives who had not participated in formal education, supervised by physicians. Traditional birth attendants were soon out of practice.

There was a second contradiction which lead to tension. Physicians in charge of medical schools advocated hospital births. Yet the maternal mortality rates for women who gave birth in hospital were greater than for those who did not (see chapter eight). This in turn created further conflict as midwives and women rejected childbirth in hospitals.

1900 to 1940 saw the stabilization of both the quality of medicine and the physicians' professional organizations in Canada. With the Canada Medical Act of 1902, education and licensing procedures were

systematically regulated in such a manner as to create uniformity across Canada. Maternity care within hospitals improved considerably leading to the eventual decline in maternal and infant morbidity and mortality rates. Because of the power obtained by medical practitioners through their professional organizations, they were now able to oversee the transference of childbirth from the home to the hospital with relatively little disruption to society. Maternity care fell under medical jurisdiction. Since the public now viewed childbirth in hospital as safe, there was little contradiction in what was required of women (childbirth in hospital) and the outcome of that action (safe delivery). As a result midwives (nurse midwives) appeared to have accepted the situation with little difficulty.

From 1940 to 1987 institutionalized medicine retained its power to supervise childbirth. Nevertheless, once more individuals within the public understood hospital birth as less than safe. Women who rejected the present system of maternity care feared iatrogenic disease both to mother and infant because of the over-use of technology. Again, contradictions existed because of the perception of hospital births as not safe, and the demand by the medical profession that women give birth in hospital. This in turn stimulated the growth of lay midwifery, and home births. The medical profession responded with punitive threats. The

results were increased tension and conflict between physicians and midwives.

The analysis of the quality and degree of institutionalization of medicine as it relates to midwifery suggests a quasi-causal and functional 'law'. The institutionalization of an occupation (medicine) results in professional autonomy and self-regulation. If related occupations such as midwifery are not institutionalized a vacuum remains. This then allows the profession (medicine) to either absorb or regulate those tasks once performed by the related occupations. Therefore to become an autonomous profession, an occupation like midwifery must become institutionalized with true self regulating powers.

There is one obvious social contradiction which created tensions for women and midwives in the period between 1850 and 1900 and 1940 and 1987. I refer to women's belief about the safety of the medical practices. In both these instances the medical profession advocated hospital births. Nevertheless, some women viewed them as dangerous to both themselves and their infants. Therefore they searched for midwives who would assist them in home births. This in turn created conflict with physicians. In order to prevent midwives from gaining in popularity, physicians have had midwives charged with practicing medicine without a license. Women

brought to court between 1850 and 1900 withdrew from midwifery. However contemporary midwives, supported by a strong women's movement, have chosen to remain and fight in order to retain their right to work in their chosen occupation.

State Intervention Into Health Care

The final and most effective social condition for the development of midwifery is that of state intervention. The most strategic characteristic of a profession, its autonomy, is owed to its relationship to the sovereign state. It is also the state which maintains for the profession's benefit, the political and formal occupational mechanism.

The first statute of Upper Canada, as it relates to medicine, regulated the licensing of midwives. Such a regulation was seen as inappropriate by the early settlers and the clause to regulate the licensing of midwives was repealed. Successive health acts of 1815, 1818, and 1846-1847 contained clauses which exempted midwives from licensing. It can be concluded that the state had not only the power to license midwives but could also withdraw such legislation when it was sufficiently opposed by the public.

In the period between 1865 and 1906 all provincial governments passed medical professional acts which allowed for the establishment of professional organizations with the power of self regulation. These

organizations had authority over education and licensing. As well as jurisdiction over their own profession, physicians were given the right to delegate and supervise medical acts of related occupations. When individuals, such as midwives, were deemed to be practising medicine without a license, a police and court system was called into action. Once medicine was granted authority over itself and related occupations, it could leave enforcement of its powers to state mechanisms in the exercising of its medical hegemony.

Nevertheless the state also responds to public pressure. In the late 1970's, rejection of the present obstetrical system by some women, was brought to its attention. Members of well organized women's groups lobbied for the return of midwives. When a jury inquiry into the death of an infant born at home recommended that midwifery be legalized in the province of Ontario, the Minister of Health appointed a task force to look into the establishment of midwives in Ontario. In the fall of 1987, their report was submitted to the government. However, the Ontario government has yet to take any action in putting into effect the task force's recommendations.

In analysing the previous social conditions and their relationship to midwifery, I have tried to discover the quasi-causal, and functional laws which have assisted in the development of the occupation. To use the

terminology of "quasi-causal" and "functional laws" in reference to state intervention is inappropriate. In reality, it is the state law which transforms an occupation into a profession. It is only through the state that the profession of medicine became self regulatory ie: free of technical evaluation and management by other occupations. And it will only be through the state that midwifery will be granted the same rights. In the end it is the sovereign state which grants an occupation its most treasured characteristic, that of professional autonomy.

Through the study of midwifery in Canada from 1788 to 1987, it has been possible to discover the quasi-causal and functional laws which have influenced midwifery's position within society over the past two-hundred years. Based upon this information, I may now describe the ideal social condition which would lead to the establishment of midwifery today. They are as follows:

- 1) a positive gender attitude accepted by both society and women in which women are perceived as intelligent, independent, and vigorous. Gender attitudes which portray women as inferior beings both mentally and physically lead to a birthing system under the supervision of a predominantly male profession;
- 2) improved economic conditions for women. Gender attitudes are most often, but not necessarily, linked to the economic status of women. For

example within toiler society, women who were central to economic production, were in general admired. Women must be understood as important in the economic development of society;

3) doubts by women, about the efficacy of the prevailing system of maternity care. As a result of these doubts women will seek an alternative system, one which emphasizes natural childbirth, and midwifery care;

4) an established College of Midwives with self-regulating powers;

5) and state intervention in order to establish an autonomous profession of midwives.

Since the ideal social conditions usually never exist, midwives must seek and support the most effective one. In this case, it is state intervention on behalf of midwives, in order to establish midwifery as an truly autonomous profession.

Conclusion

The critical model of social science envisages a conceptual approach which not only speaks to the actors which are being studied but also attempts to provide a means whereby they can resolve their problems. Thereby the "*truth is ... judged partially on the basis of whether or not the satisfactions which it promises are forthcoming*" (Fay 1975:108 original italics). From this statement it follows, that the

social actors for whom the researcher seeks to provide an understanding of their situation actually help to determine the truth of the theories discussed, by their reactions to them. According to the critical model as outlined by Fay, one criterion of truth is the response which the actors make to the claim. The actors who are affected by the purported truth have a central and determining role to play.

Based upon my qualifications as a social scientist, and guided by my own experiences within the health care system, I have sought to present an analysis of midwifery which would not only help to explain the reasons for the present predicament but which would offer guidelines for the resolving of the problems at hand. However, this work will be validated partially in terms of the response of the social actors, women in general and midwives, to whom the theoretical claim is made. If in fact it offers a way out of their untenable situation ("and is therefore a true theory") (ibid 109) is determined by those who may or may not act on its principles. The decisive criticism of it as a theory, is its acceptance (or rejection) by the people to whom it is addressed.

Appendix 1: A Chronicle of Midwifery in Central Europe, England, and Canada

	Central Europe	England	Canada
Present			1987 - Task Force Report on Midwifery, Ontario.
1900 -		1902 - National scheme for regulation of midwifery - midwifery legitimated as a profession.	1902 - Canada Medical Act 1906 - All provinces pass legislation which brings midwifery under the control of physicians.
1800 -	1800 - National schemes put into effect for the regulation and licensing of midwives - midwifery legitimated as a profession.	1818 - Thousands of midwives to educated in Scotland. 1780 - Few educated in England - decline in the licensing of midwives by ecclesiastic authorities.	1849 - Midwives in Lower Canada, to Montreal, Quebec, and Three 1848 - Rivers require licenses. 1847 - Women continued to be to exempt from licensing in Upper Canada. 1815 - Women exempted from midwifery licensing in Upper Canada 1795 - Statute of Upper Canada required licensing of midwives. 1788 - Statute required the licensing of midwives in Quebec City and Montreal in Lower Canada
1700 -	1700 - Witch trials end.	1700 - Witch trials end.	
1600 -	1631 - Hôtel Dieu Hospital in Paris established first education program for female midwives.		
1500 -	1500 - Regulation of midwifery by municipalities, Germany and Netherlands. 1452 - First municipal system of midwifery regulation in Regensburg.	1512 - Act giving responsibility of licensing midwives to ecclesiastic authorities.	
1400 -	1400 - Witch trials - Beginning of campaign against women healers - male doctors gained monopoly over practices for upper class except obstetrics which remained under women.		
1300 -	1300 - Development of Barber-Surgeon Guilds - medical profession established under control of church- - physicians university educated. Men and women acted as physicians.		

Appendix 2

Brickman (1983) writes that in New York:

In 1916, with about 40 percent of births in midwives' hands, only 22 percent of the city's deaths from puerperal sepsis could be traced to their deliveries. Physicians, who reported approximately 60 percent of the city's births, bore responsibility for 69 percent of deaths from puerperal septicemia (ibid 73).

In Providence Rhode Island, in an area where midwives worked with city officials, their infant mortality rate fell to seventy-seven (per one thousand live births) as compared to one hundred and seventeen for the rest of the city. In 1913 Newark's Division of Child Hygiene established a program in which midwives delivered fifty percent of the city's babies.

Maternal mortality in Newark dropped steadily, to compare favorably with other larger cities. In 1914 it stood at 5.3 per 1,000 births; by 1915 the rate fell to 3.6 and in 1916 it was 2.2. In 1916 in Boston, where the midwife was illegal, the maternal mortality rate remained at 6.5 (ibid 74).

Appendix 3

The original printing was in 1910, copyright by The Carnegie Foundation For The Advancement Of Teaching.

Appendix 4

The first major national government thrust to develop better health care for Canadians occurred in 1945. At that time the federal government offered to pay to the provinces 60% of health services (Hall 1982:3).

Failure to agree on a transfer of taxes caused the health services to be postponed.

In 1957 the federal government under pressure from several of the provinces enacted *The Hospital Insurance and Diagnostic Services Act*. This, along with the *Medical Care Act* of 1966 freed Canadians from the financial burdens of illness and enabled almost all people in Canada to obtain good quality medical care.

Appendix 5

The Midwifery Task Force of Ontario is composed of individuals, other than midwives, who lobby for the acceptance of midwifery in Ontario. This organization should not be confused with the special task force appointed by the Minister of Health, Murrey Elston, to make recommendations on educational standards for midwives and the regulation of practice.

Appendix 6

The jury in the McLaughlin-Harris case made the following recommendations:

The Health Disciplines act should be rewritten to incorporate 'specific descriptions of what the practice of midwifery is and ... strict penalties for practice outside the Act.'
 Midwifery should initially be included as a specialty practice under the College of Nurses of Ontario ... After five years a new independent college of midwives should be established.
 An international standard of midwifery training should be established by the International Federation of Obstetricians and Gynecologists and the International Confederation of Midwives. It should be taught at accredited post-secondary institutions, involving at least two years' midwifery training and at least one

year of general nursing.

Licensed midwives should be given hospital privileges in maternity wards.

Ontario Health Insurance Plan coverage should be extended to include midwives.

Malpractice insurance should be made compulsory for midwives.

Birthing centers should be established at hospitals.

Ontario's health care system should give parents the option of choosing a home birth.

The College of Physicians and Surgeons should establish safety standards for home births and doctors should be protected from censure by their colleagues if they attend births (Besharah 1985: 11)

Appendix 7

According to R. A. Tulurialik and D. Pelly (1986) and M. A. Ungalaaq (1985), the following are the normal childbirth practices among the Inuit: Pregnant women are taken care of and instructed by their mother or mother-in-laws. Once labour begins the parturient woman lies down in the igloo. If she is uncomfortable she walks around. Birthing may occur when a woman is either squatting or lying down. If the woman squats a small depression is made in the bed to receive the baby. The water bags are often broken with a fingernail and the nail has to be a bit jagged in order to tear the bag correctly. In order to prevent swelling of the "bottom", Inuit women are told to alternate activity with lying down.

During child birth, the woman is helped by her relatives and told to remain absolutely still as birthing "is a very intense thing and is taken seriously" (Ungalaaq 1985: 2). Once the baby is born, his/her mouth is cleaned out with sucking or using one's forefinger. The cord is cut rather long, and allowed to dry. If the placenta is slow in being passed it is pulled gently and slowly.

According to Tulurialik and Pelly (1986), it is most important that the elder's opinions are always heeded. "The elders are important to young

couples having children. They give help and advice".

Appendix 8

Deaton (1986: 37) writes: "Although assisting home births is illegal in all Canadian Provinces, Statistics Canada says there were some 8 000 home births nationwide between 1975 and 1980". I spoke by telephone with Mr. Surinder Wadhera, Program Manager for Vital Statistics. He stated that such a figure could have been arrived at by inference. If 99% of all births occurred in hospital, the figure of 8 000 home births could be obtained by calculating 1 % of the total births for that period.

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