THE MIDWIFE'S TALE: OLD WISDOM AND A NEW CHALLENGE TO THE CONTROL OF REPRODUCTION

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I. INTRODUCTION

Reproductive rights for women remain elusive and contested. All over the world poor women continue to be denied access to even basic health care and information. Privileged women also face the dehumanizing effects of a fetal rights campaign which successfully "fetishizes the fetus,"[1] as women's demands for reproductive choice[2] are balanced against the separately constituted interests of fathers and the state in the production and protection of the ultimate innocent third party—the fetus.[3]

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[1] The insight that recognized the construction of the fetus as a fetish in the politics of reproduction comes from the work of Rosalind Pollack Petchesky. For a discussion of the ultra right's deliberate use of the artificial construct—the image of the disembodied fetus—as a political tool, see Rosalind Pollack Petchesky, Abortion and a Woman's Choice: The State, Sexuality & Reproductive Freedom xiv (2d ed. 1990). Petchesky considered the ideological force of the image in an earlier work, Rosalind Pollack Petchesky, Fetal Images: The Power of Visual Culture in the Politics of Reproduction, in Reproductive Technologies: Gender, Motherhood and Medicine 57 (Michelle Stanworth ed., 1987).

[2] See infra notes 24–26 and accompanying text.

[3] Shelley Gavigan in her discussion of "foetal personhood" notes that the pregnant woman is increasingly cast as an adversary to a separately constituted "foetal person": "The foetus is presented as helpless and vulnerable, the most innocent of innocent victims." Shelley A.M. Gavigan, Beyond *Morgentaler*: The Legal Regulation of Reproduction, in The Politics of Abortion 117, 130–33 (Janine Brodie et al. eds., 1992). This separate constitution of the fetus in law and in public discourse is shadowed and marked by scientific advances in the understanding of fetal life. In Canada, a Royal Commission Inquiry into new reproductive technologies has characterized feminists who are concerned by the implications of this technology as being "anti-technology" and as depriving infertile women of choice. See Jamie Cameron, Fighting Infertility: Please Respect My Choice, Globe & Mail, Nov. 5, 1990, at A13 (caption: "Women unable to have children without medical help run into arguments about designer babies and tinkering with the mystery of life. But it's a physical problem and should be fixed the same way we fix problems with kidneys and

This paper considers an aspect of the struggle for reproductive rights that has received relatively little attention but merits more: the story of midwives. Midwives are the unsung and undervalued women who deliver a significant percentage of all babies born in the world today, and are recognized by the World Health Organization of the United Nations (WHO) as the most appropriate caregivers in normal childbirth,[4] regardless of the availability of (primarily) male physicians.[5] Even in jurisdictions where they are recognized, such as the United Kingdom, midwives are struggling to preserve their autonomy and their role as supporters and advocates for women in childbirth and reproduction, and are frequently relegated to a place as second best to the preferred services of an obstetrician.[6] In other jurisdictions midwives must fight for the right to practice at all, and along with the women who seek their services, are held to the margins of the alternative health care movement.[7] In the United States they are recog-

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livers."); Susan Pigg, Probing High-tech Baby Making: Commission Examining Mistakes, Miracles, Toronto Star, Sept. 12, 1990, at A23. The other side of this technology criminalizes poor and minority women for "fetal abuse." See Doctor Seeks Crackdown on Boozing Mother-to-be, Toronto Star, July 20, 1992, at A4. The same technology permits sex-selection and overt devaluing of female fetuses. See Rod Mickleburgh, MD to Defend Fetus Sex Test, Globe & Mail, Nov. 15, 1990, at A8; Linda Hossie, Gender by Choice, and Guess Which One? Boys are Preferred as New Technologies Let Parents Pick Sex, Globe & Mail, Aug. 14, 1992, at A1 (detailing the success of and controversy around a company called Gametrics Ltd., based in Alzeda, Montana, which markets sex-selection services through sperm separation all over the world, and noting that boys are preferred everywhere, including in the United States).

[4] This statistic, and the WHO endorsement, is frequently cited in midwifery literature. See, e.g., Sheila Kitzinger, Why Women Need Midwives, in The Midwife Challenge 1, 9 (Sheila Kitzinger ed., 1988) (stating that 75% of all babies born in third-world countries are delivered by midwives).

[5] Id.

[6] British midwives face enormous pressures both as working women and as midwives. See infra notes 91–108 and accompanying text. For a discussion of the dilemma faced by British midwives as described by a member of the British Association of Radical Midwives, see Janet Jennings, Who Controls Childbirth?, 12 Radical Sci. J. 9 (1982). For a more current discussion, see Caroline Flint, On the Brink: Midwifery in Great Britain, in The Midwife Challenge, supra note 4, at 22, 22–39. For a detailed analysis of the control mechanisms in place, see Dianne L. Martin, The Control of Reproduction: Law, Medicine and Women; Midwives, Subjects and Agents: A Study in Social Control (1987) (unpublished LL.M. thesis, London School of Economics, on file with the *Columbia Journal of Gender and Law*).

[7] The marginalization of midwives in the developed world is being resisted in grass root campaigns as the newsletters of midwifery associations attest. See, e.g., Joan Donley, Midwives' Dilemma, The Alberta Midwifery Taskforce and Alberta Association of Midwives Newsletter (March, 1991); see also Germaine Greer, Sex and Destiny: The Politics of Human Fertility (1984). For a theoretical discussion focusing on the United States, see Sheryl Burt Ruzek, The Women's Health Movement: Feminist Alternatives to Medical Control (1978).

nized in only a few states as fully autonomous caregivers,[8] while in Canada they went underground, all but disappearing until the resurgence of the women's health movement and government concern about skyrocketing health costs sparked a midwifery renaissance.[9]

At the risk of attempting too large a task, this paper tells the midwife's tale, noting the class and gender bias that mark each chapter of that story and suggesting that midwifery offers women an important ally in the reproductive rights movement. The position of midwives is presented as a lens through which to view the relationships between law, patriarchy, and medicine in the control of women's reproductive powers.[10] Consideration of the discourse around the contemporary "midwifery dilemma"[11] itself is offered as a more precise tool for understanding the relationship of tactical struggles to questions of class and gender.

Both the term and the discourse associated with the concept "patriarchy" are used in this paper, although, as Carol Smart has noted in considering terms such as "sexism," its widespread use in feminist writings from different perspectives renders it somewhat problematic.[12] In this paper "patriarchy" is used to denote both ungeneralized structures and practices

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[8] For a recent analysis of the American situation, see Irene H. Butter & Bonnie J. Kay, State Laws and the Practice of Lay Midwifery, 78 Am. J. Pub. Health 1161 (1988).

[9] Four of Canada's ten provinces are examining the introduction of midwifery. Ontario has passed interim legislation, will conduct examinations soon in a "grandmother" provision for practicing midwives, and will open a College of Midwifery in 1993. See infra notes 123-26 and accompanying text. For a discussion of the earlier position in Canada, see Brian E. Burtch, Community Midwifery and State Measures: The New Midwifery in British Columbia, 10 Contemp. Crises 399 (1986).

[10] This was the approach I took in my LL.M. thesis, Martin, supra note 6. The critical references to "medicine" throughout the paper are meant to describe the positions of the essentially conservative establishments (associations and colleges) which govern the profession. All over the world, concerned, humane, and progressive physicians struggle alongside women against the attitudes and practices described in this paper. Moreover, it is important to remember that the case that ultimately defeated the criminalization of abortion in Canada, did so in the context of Dr. Henry Morgentaler's crusade for abortion rights for women. Dr. Morgentaler offered himself for criminal prosecution and spent months in jail in defiance of a law that he saw as discriminatory and demeaning to women. Morgentaler v. The Queen [1988] 1 S.C.R. 30 (S. Ct. Can.). For a discussion of the Canadian law on abortion, see Gavigan, supra note 3. For a discussion of how "patriarchy" is used in this article, see infra notes 12-13, 46-52 and accompanying text.

[11] The "dilemma" as it is considered in this paper centers on the tension between recognition as the "experts in normal childbirth" (the WHO position and that supported by most midwives) and the personal and institutional costs associated with undervaluing and marginalizing midwives, as discussed in Kitzinger, supra note 4.

[12] Carol Smart, The Woman of Legal Discourse, 1 Soc. & Legal Stud. 29, 31-33 (1992).

of male domination and, more precisely, the anthropological meaning of masculine-determined child-parent relationships. Indeed, this paper relates both meanings causally.[13] Class, in the broad sociological sense of socio-economic place, is identified as being as central to understanding the story as gender is, both historically and in contemporary terms, since class loyalties are often stronger than gender loyalties.[14]

The role of law is considered primarily with regard to the legal challenges facing midwives who seek to practice independently from medical domination. These challenges range from the use of professional discipline procedures in jurisdictions where midwives are recognized, to criminal charges and inquests in jurisdictions where they are not. Those challenges are an integral part of the midwife's story as they have frequently served to force midwives to make a choice between security and autonomy, between integration into the male-dominated mainstream of health care through legal recognition and professionalization, and continued marginalization through reform initiatives or a-legal independence. This paper attempts to illustrate both the gender and the class bias underlying that choice, while suggesting that the concept of choice poses its own dilemma.

Framing the issue as simply a choice between professionalization (itself a contested construct[15]) and marginalization, whether in telling the story of midwifery's past, or in addressing contemporary tactics, obscures issues of class and gender bias and further marginalizes midwifery. That is, the portrayal of the midwifery debate as important either as a matter of choice for the improvement of middle-class (primarily white) women's birth experience, or as a solution to the needs of poor women, does not touch the

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[13] This causal relationship is fairly commonly relied on in feminist writings about reproduction. See, e.g., Barbara Katz Rothman, Recreating Motherhood: Ideology and Technology in a Patriarchal Society (1989). The author begins with a consideration of patriarchy in an anthropological sense and develops that definition into a critique of male domination. For an analysis of the relationship between the patriarchal state and women in Denmark, see Drude Dahlerup, Confusing Concepts—Confusing Reality: A Theoretical Discussion of the Patriarchal State, in Women and the State: The Shifting Boundaries of Public and Private 93, 110–13 (Anne Showstack Sassoon ed., 1987); see also infra notes 47–50 and accompanying text for Mary O'Brien's synthesis of these ideas.

[14] In a critical discussion of the indoctrination of physicians Martin Shapiro cites Vicente Navarro, Women in Health Care, 292 New Eng. J. Med. 398 (1975), in his description of the distinction, which he sees as central. Martin Shapiro, M.D., Getting Doctored: Critical Reflections on Becoming a Doctor 109–11 (1987).

[15] Barbara Katz Rothman uses the term in its sociological sense in Childbirth Management and Medical Monopoly, in Women, Biology, and Public Policy 117, 117 (Virginia Sapiro ed., 1985). See also Terrence J. Johnson, Professions and Power 19–38 (1972).

core issues of access to health services and fundamental freedom over reproduction for all women.[16] The choice model suggests that while it may be pleasant (but certainly not essential) to have the assistance of a skilled and sympathetic woman attendant during childbirth, nothing more than personal preference is involved.[17] The picture of the midwife as an alternative suggests that she possesses second-class skills and is a second-class doctor,[18] acceptable for the care of poor or third-world women, implicitly promotes medicine as the superior model of care. Both images marginalize (and divide) the women who turn to midwives as much as they diminish midwifery itself.

Although the historical trend all over the world has been to marginalize midwifery and midwifery skills,[19] that process manifests itself somewhat differently around the world depending on many factors. For example, although Canada and the United Kingdom have both long provided universal health care to their citizens, the position of midwifery is very different in the two countries. The United Kingdom has recognized and regulated midwives as an independent health care profession since 1902, and they are numerous if underutilized there, while Canada today has no recognized profession of midwifery, although changes are pending in a number of provinces.

The United States continues to resist the provision of universal

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[16] The analysis of legal issues surrounding midwifery, and the restrictions imposed on midwives, frequently posit the issue as one of "quality of birth." See, e.g., Gail A. Robinson, Midwifery and Malpractice Insurance: A Profession Fights for Survival, 134 U. Pa. L. Rev. 1001, 1003 (1986) (adding to the choice rationale the importance of midwives to American women with no other access to health services); Dale Walker, Note, A Matter of the Quality of Birth: Mothers and Midwives Shackled by the Medical Establishment and Pennsylvania Law, 23 Duq. L. Rev. 171, 171 (1984) (identifying the question with respect to Pennsylvania as one of individual freedom and choice, noting in her introduction that "[t]he criminalization or strait jacket regulation of midwifery has had the effect of severely limiting choice of birth setting and birth attendant in many states.").

[17] Descriptions of midwives as "labor coaches" who are a useful "addition" to the medical team are common. See Louise Brown, Delivering Support: Expectant Moms Who Hire Women to Coach Them Through Labour Experience Shorter, Drug-free Childbirth Researchers Say, Toronto Star, May 28, 1991, at F1. The context of this story was the announcement of the establishment of an independent profession.

[18] This depiction has been an effective device in marginalizing midwives for the past three hundred years, and continues today. See infra notes 19, 45, 58-87 and accompanying text.

[19] For the broad strokes of the history of midwifery, see Jean Towler & Joan Bramall, Midwives in History and Society (1986). For a more critical analysis, see Mary Chamberlain, Old Wives' Tales: Their History, Remedies, and Spells (1981); Jean Donnison, Midwives and Medical Men: A History of Inter-professional Rivalries and Women's Rights (1977); see also infra notes 58-87 and accompanying text.

healthcare,[20] but is similar to Canada (although not nearly so completely resistant) in its fainthearted acceptance of midwifery.[21] In jurisdictions like the United States, where access to health services is substantially determined by wealth and the interests of private insurers, the market determines the place of midwives. For example, by denying midwives medical negligence insurance (directly or indirectly through unaffordable premiums), or limiting access to hospital and back-up medical care, the medical establishment effectively holds midwives to the margins.[22] In countries like Canada and Great Britain, with universal health care systems, the state assumes that role and uses the policy advice of the medical establishment as a basis for a "best interests" regime.[23]

It is also worth noting that there are significant differences in abortion rights for women in these three countries as well, although the differences do not parallel the position of midwives any more directly than the health care delivery schemes do. The experience of American women currently witnessing a weakening of the protection for abortion rights guaranteed in *Roe v. Wade*[24] is a pattern that has not been followed in Canada. However, the fetal "rights" debate is not over in either Canada, or the United Kingdom. In *Morgentaler v. The Queen*,[25] the Supreme Court of Canada ruled unconstitutional the provisions of the Criminal Code that criminalized all abortions not authorized by a hospital-based therapeutic abortion committee and recognized a "state interest" in fetal life. That interest has a durable pedigree. MacNaghten's pronouncement, "[T]he law of this land has always held human life to be sacred, and the protection that the law gives to human life it extends also to the unborn child in the womb,"[26] opened the way to recovery for damages and presaged the current rash of fetal protection cases throughout the common law world. However, in the context of the midwife's story, these differences mean little, as in all three

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[20] The lack of universal health care was once again a concern in the United States as an issue in the 1992 Presidential election campaign, and as such, prompted popular media discussion. See, e.g., Peg Byron, The Health Insurance Conspiracy, How Doctors, Insurers, and Hospitals Have Left Us in Critical Condition, Ms., Sept./Oct. 1992, at 40-45.

[21] See Butter & Kay, supra note 8.

[22] Robinson, supra note 16; Walker, supra note 16, at 176-82.

[23] See infra notes 34, 36, 63 and accompanying text.

[24] 410 U.S. 113 (1973). The weakening was evident in cases like Webster v. Reproductive Health Serv., 492 U.S. 490 (1989), and in the compromise decision in Planned Parenthood v. Casey, 112 S. Ct. 2791 (1992).

[25] [1988] 1 S.C.R. 30 (S. Ct. Can.). The leading case on fetal life in Canada is, ironically, a midwifery case. The Queen v. Sullivan [1991] 1 S.C.R. 489 (S. Ct. Can.). For a discussion of this case, see infra note 121.

[26] R. v. Bourne [1938] 3 ALL E.R. 615, 620 (Cent. Crim. Ct., Eng.).

countries, women's traditional ally and advocate in reproductive matters has been relegated to peripheral status. It is also clear that state recognition has not been enough in most cases for women to preserve the midwife's autonomy nor to resist the technological revolution in childbirth that so dominates women's reproductive lives. In part, this is reflective of a wider issue, an issue with deep historical roots.

In this paper the multiple factors that have diminished midwifery are addressed as they have occurred in three jurisdictions: Canada, the United Kingdom, and the United States. The first section briefly describes the important differences between medicine and midwifery as a backdrop to a discussion of the discourse and tactics that challenge midwives and their supporters everywhere. The second section surveys the history and historiography of the decline of woman-centered, woman-attended childbirth and presents that story as foreshadowing the contemporary debate. Finally, the contemporary struggle for recognition and the professionalization debate are considered. The challenges facing midwives in Britain, where they are numerous and theoretically acknowledged as autonomous health professionals, are examined as a contrast to the situation in Ontario, where model midwifery legislation is pending. The conclusions to be drawn are few and tentative, except as cautions, as the tactical demands of the moment must not be judged solely from the safety of hindsight and theory. However, as it is equally unwise to lose sight of the lessons of history or the insights of theory, the conclusions that end this chapter of the midwife's story are offered in a spirit of solidarity.

II. MIDWIFERY: WOMEN'S WISDOM

In beginning the project of locating midwifery within the reproductive rights struggle, and of questioning the discourse that frames the issue as one of professional recognition, it is important to understand how the midwifery model addresses issues of reproductive health. The literature critiquing the medicalization of birth is extensive[27] and the following discussion is meant

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[27] One of the most comprehensive discussions is found in the exhaustive report of the taskforce which led to the development of interim midwifery legislation in Ontario. Mary Eberts et al., Report of the Task Force on The Implementation of Midwifery in Ontario (1987). See also Ann Oakley, The Captured Womb: A History of the Medical Care of Pregnant Women (1986) (an important book tracing the growing hegemony of medicalized birth); Robinson, supra note 16; Barbara Katz Rothman, In Labor: Women and Power in the Birthplace (1982) (connecting women's loss of power over birthing process to a male-dominated medical hierarchy); Deborah A. Sullivan & Rose Weitz, Labor Pains: Modern Midwives and Home Birth 23–59 (1988) (linking the debate over place of birth with the increasing number of women opting for midwife-attended woman-centered home births and avoiding the medical establishment in hospital);

to serve only as context for the balance of the paper.

Midwifery at its best is a holistic and woman-centered system of practices and theory, premised on accepting, celebrating, and supporting women. Midwives, whose training and approach are not based on a medical model,[28] come to understand reproduction as a continuum: sexuality, fertility, pregnancy, birth, and the postpartum period are not separate subjects, separate specialties to midwives. Pregnancy is not an illness; labor and birth are not inherently dangerous. Moreover, women are seen in their contexts, as social actors, not as well- (or ill-) functioning body parts or objects for study.

This ethic is translated into midwifery practice. Midwifery standards of practice and codes of ethics highlight a commitment to continuity of care, informed choice (in contrast to consent), support, and non-interference unless absolutely necessary. All of these distinctions are fundamental to midwifery.[29] The definition of midwife created by WHO, and widely accepted as appropriate, illustrates the ideal scope of practice for midwives:

> [S]he 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 preventative 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.[30]

The difference between medicine and midwifery on the question of intrusive intervention is illustrative. It is literally one of "burden of proof." The midwifery model, which does not reject the benefits of medical solutions to medical problems, insists on proof that they are needed.[31] The medical model, which asserts that "childbirth is only normal in retrospect," presumes that there will be problems, and that intervention will be necessary. Medicine trains practitioners to abstain from intervention only

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Walker, supra note 16.

[28] Both Kitzinger, supra note 4, and Oakley, supra note 27, make this distinction central to their respective theses.

[29] See Caroline Flint, Sensitive Midwifery (1986) (providing an inspirational guide to midwifery practice and values); see also Jennings, supra note 6.

[30] Quoted in Kitzinger, supra note 4, at ix. This definition is relied on, for example, in Britain. See United Kingdom Central Council for Nursing, Midwifery and Health Visiting, A Midwife's Code of Practice for Midwives Practising in the United Kingdom 1 (1st ed. May 1986). The definition has also been incorporated in Ontario's proposed legislation.

[31] See supra note 29.

upon proof that it is not needed.[32]

The reasons for these fundamental differences are to be found in the underlying constructs of these two philosophies. Doctors are trained to think in terms of pathology, to find something wrong and then to do something about it. This is even more the case with surgeons, who are trained to cut.[33] The medical specialty that deals with women's reproductive "function" is that of obstetrics and gynecology. Gynecology is a surgical specialty. The obstetrician is thus half-surgeon, and he[34] controls the procedures and protocols surrounding pregnancy and birth. Although eighty percent of all births are normal,[35] i.e., manifesting no condition that would call for medical intervention, the approach to them is determined by specialists in the pathological.

One of the results of this approach is an ever-increasing use of medical/surgical intervention in the reproductive process. The so-called "cascade of intervention" may start with a false positive diagnosis of abnormality, perhaps identified by ultrasound. It will lead either to an induction of labor, and the greater use of painkilling drugs frequently associated with induced labor, and/or to electronic fetal heart monitoring, which has its own false positive rate as well as a negative impact on the effectiveness of the labor due to the resulting maternal immobility necessary for this practice.

The domino of intervention may also be started without a diagnosis of abnormality, as is the case with obstetricians committed to the philosophy of "active management of labor." This school of thought rests on the thesis that no labor should go on for longer than twelve hours, as labor is dangerous to fetuses. The "cure" for delayed labor is more drugs and a

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[32] See infra note 38 and accompanying text.

[33] For a description of the aggressive language used by surgeons about their work, see Shapiro, supra note 14, at 175. For a discussion by a medical historian tracing the development of the modern heroic doctor trained to inspect the 'passive patient' and identify a pathology, see Edward Shorter, Bedside Manners: The Troubled History of Doctors and Patients 75-139 (1985). For a recent illustration of how these attitudes translate into practice, see Lisa Priest, Doctors 'Locker Room' Talk Censured, Toronto Star, Aug. 15, 1992, at A11 (reporting that a doctor was ordered to appear before the College of Physicians and Surgeons for a comment made to the husband of a woman in labor that "men were lining up for his services" because of his skill at repairing episiotomies, as he could "make virgins of their wives" and for a comment made to a colleague in the delivery room that "the penis rules the world").

[34] See Oakley, supra note 27, at 251-74. Oakley directly relates male domination of the specialty to masculinist domination of the contemporary approach to birth.

[35] Dr. M. Wagner, Chief of Maternal & Child Health, Northern Region WHO, testimony before Coroner Dr. J.G. Young, McLaughlin-Harris Inquest (Toronto, June 24-July 17, 1985) [hereinafter McLaughlin-Harris Inquest], cited in Martin, supra note 6, at 28 n.64.

significantly higher incidence of Cesarean sections, which in turn leads to a higher incidence of infant respiratory distress syndrome quite apart from the effect on the mother of major surgery.[36] The language used in the literature is illustrative of the ethic: "active management" of "performance" in labor, "improvements in management," and "management of spontaneous labor."[37]

This attitude is also reflected in the purely institutional requirements of hospitals, which are slow to change and which rely on written procedures and protocols to ensure uniformity and efficiency of care. A classic example of the routinization of a useless procedure and its longevity, is the routine shaving of the perineum. This practice was introduced at the turn of the century to reduce infection and was proven valueless in a controlled study in the 1920s; yet it is still practiced in more than fifty percent of Canadian hospitals in the 1980s.[38] Other routine procedures, such as the lithotomy position for delivery, with the laboring woman strapped on her back with her legs in stirrups, have an even more doubtful heritage. It is not merely a quaint piece of historical trivia that the ubiquitous and dangerously ineffective supine position for birthing entered our world because of Louis XIV's insistence on being able to see the emergence of "his" children from his mistresses' bodies.[39]

Some of these procedures may be positively dangerous to mother or baby; others not yet identified as dangerous nonetheless make the process frightening, dehumanizing, or alienating.[40] The procedures all reflect a technological hegemony that is patriarchal in the sense of male domination

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[36] Id., cited in Martin, supra note 6, at 28 n.65; Rothman, supra note 27, at 259-65; Walker, supra note 16, at 176-81. The routine use of high-tech interventions, criticized by women and midwives for decades, has been the subject of considerable study recently. The medical establishment is now validating the criticism and receiving relatively wide popular coverage. See Paul Taylor, Childbirth Procedure Questioned: Episiotomies May Do More Harm than Good, Globe & Mail, July 7, 1992, at A1 (describing a study led by Dr. Michael Klein of McGill University in Montreal, and published in the June 1992 issue of the *Online Journal of Current Clinical Trials*, which shows that there is "strong evidence that episiotomies should not be performed routinely"); see also Gene Allen, MDs Urged to Reduce Caesarean Operations: Method Still Used in 20% of Births, Globe & Mail, July 17, 1991, at A5; Matt Maychak, Caesarean Rate Too High Province Told, Toronto Star, July 17, 1991, at A12.

[37] D.D. Boyle et al., An Assessment of Active Management of Primigravid Labour, 149 Irish J. Med. Sci. 465, 465 (1981).

[38] Institute of Child Health Exhibit, in McLaughlin-Harris Inquest, supra note 35, cited in Martin, supra note 6, at 29 n.68; see also supra note 37 (for the discrediting of routine episiotomies and other forms of intervention).

[39] Walker, supra note 16, at 179.

[40] Greer, supra note 7, at 11-15, 20-21.

of the processes of reproduction. That this mechanism is truly hegemonic is evidenced in the reality that in western culture the birth of a child has been transformed from a woman-centered physiological event into a medical problem to be solved with efficiency, rationality, and technology.[41] At the same time, the scientific hunger for data, for information to advance the "battle" against illness and death, blinds medicine to the value of other models, and indeed serves other goals.[42]

In sharp contrast, the midwifery ethic recognizes pregnancy and birth as neither inherently dangerous, nor inherently a matter for medicine. The paradigm that provides the basis for a model of reproductive health is one in which the midwife, as the expert in normal pregnancy and childbirth, cares for the woman throughout, while the physician, as the expert in the pathological, serves as the back up.[43] The reality, of course, is that this model is rarely approximated, let alone achieved.[44] The reality is that women's bodies have been medicalized, and the advocates of integration and normalcy devalued.[45]

The role that the precepts and constructs of masculine science have played in the struggle for reproductive rights has produced a considerable body of feminist analysis which locates the story of midwifery within critiques of patriarchy, both as a socio-sexual concept and as a political construct.[46] Central to that body of work are the powerful insights of feminist sociologist Mary O'Brien, herself a former midwife. O'Brien argues that male domination of women arises from male recognition of the fact that paternity is an alienated state that rests on historical reasoning; that

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[41] See supra notes 34-40 and accompanying text; infra note 56.

[42] Id; see also Rothman, supra note 27, at 259-74. Continued experimentation on poor women and third-world women, and the introduction of dangerous drugs and procedures have only slightly abated in the face of horrendous (and costly) errors such as the thalidomide debacle.

[43] See supra note 30 and accompanying text.

[44] It is a model that is difficult to advance. See supra note 37 and accompanying text.

[45] The response of Quebec doctors to a proposal to legalize midwifery illustrates the depth the scorn can reach. Augustin Roy, president of the 16,500-member Quebec Corporation of Physicians, responded to the proposal by saying: "You might as well make prostitution legal. More people are asking for prostitutes than midwives." His colleague, Clement Richer, president of the Quebec Federation of General Practitioners, was equally dismissive: "It's like letting an apprentice pilot take charge of a 747 loaded with passengers." The rejoinder of Helene Cornellier, president of the 60-member Quebec Alliance of Practising Midwives, was sharp. She pointed out: "Pregnancy is not an illness and childbirth is not a medical procedure. Doctors who think so are living in the Middle Ages." Andre Picard, Quebec MDs Spurn Legalizing Midwifery, Globe & Mail, May 11, 1989, at A10.

[46] See supra notes 12-13; infra note 56.

an act of sexual intercourse is related to the birth of a new human being from the body of the woman with whom intercourse was performed nine months earlier.[47] The alienation is reflected in legal maxims such as *mater semper certa est* (motherhood is always certain) and *pateris est quem nuptiae demonstrant* (fatherhood must be proven). It is manifested in the full panoply of laws and institutions which preserve male privilege and control generally. She poses the issue of control over matters of reproduction as a deliberate effort engaged in by men both to preserve their freedom from the burdens of reproduction and to "resist the alienation of men from reproductive process."[48] O'Brien argues that the result of this fight by men for control over women's reproductive power has been the creation of a patriarchal hegemony that serves to "engineer consent to their interpretations of gender and knowledge."[49] That consent creates a distorting lens to perceptions of gender relations and dominates understanding of the relationships of reproductive labor.[50]

This analysis locates the issue of control over reproduction as a struggle over knowledge: knowledge concerning reproduction, knowledge constituting reproduction, and knowledge controlling reproduction. Barbara Rothman offers a similar analysis and observes that about matters of reproduction, others may have beliefs, "but we believe medicine has the facts."[51] The power of this medical hegemony, which is rooted in patriarchal (in all senses) relations governing reproduction is manifested in a presumption that medical "truths" are prima facie "true." It can be difficult to unpack that belief system and Rothman reminds us that "obstetrical knowledge, like all knowledge, comes from somewhere; it has

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[47] Mary O'Brien, Hegemony and Superstructure: A Feminist Critique of Neo-Marxism, in The Politics of Diversity: Feminism, Marxism and Nationalism 255 (Roberta Hamilton & Michele Barrett eds., 1986).

[48] Id. at 263. In an earlier work O'Brien is even more explicit.

> Marriage in its primeval form is not a contract between a man and a woman, but a treaty among men, a mutual back scratching that restores integrity to male reproductive consciousness. Male potency is an amalgam of the power to appropriate, supported by the socially bestowed right to do so, and dependent on suspicious cooperation between men.

Mary O'Brien, Feminist Theory and Dialectical Logic, in Feminist Theory: A Critique of Ideology 99, 109 (Nannerl O. Keohane et al. eds., 1982).

[49] O'Brien, supra note 47, at 263.

[50] O'Brien points out that "[i]t is odd indeed that we still have to argue that reproduction is a form of knowledge with profound epistemological significance for women and men, and the fact that the argument must be made is itself a massive triumph for patriarchal hegemonic practice." O'Brien, supra note 47, at 263.

[51] Rothman, supra note 13, at 173.

a social, historical, and political context. Medicine does not exist as something 'pure,' free of culture or free of ideology."[52] Midwifery, by offering a different paradigm, assists in challenges to a view of women and reproduction that has served to deny reproductive autonomy. The medical and midwifery models represent in this sense two different ways of "seeing" which have had and continue to have profound social and political implications.[53]

III. THE DECLINE OF MIDWIFERY AND THE RISE OF MEDICINE

This privileging of male medical knowledge and the resulting second class status of midwifery knowledge in matters of women's reproductive health is a story of the past three hundred years, a relatively recent development in human history. Women have been "with woman"[54] before, during, and after childbirth for thousands of years. For most of human history childbirth has been exclusively a female preserve, a matter for midwives. However, the roots of the current devaluing of midwifery are firmly rooted in that so-called golden age. Until the rise to dominance of the medical model, in Western society at least, from the earliest recorded times, the site of male control over reproduction has been the control of midwifery—first by the church and later by science and the state.[55] That story is considered in this paper both because it illuminates the present, and because its telling and its historiography have helped to shape the contemporary debate into one over who offers the best in scientific skill and expertise in reproductive health matters.[56]

The Church was the institutional organ that controlled midwives

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[52] Rothman, supra note 15, at 122; see also Helen Roberts, The Patient Patients: Women and Their Doctors (1985) (illustrating how the control of knowledge wields power over women, particularly when women are patients).

[53] Philosopher-historian Michel Foucault has identified this dichotomy most clearly. "There is, therefore, a spontaneous and deeply rooted convergence between the requirements of political ideology and those of *medical technology*. . . . which turn knowledge into social privilege." Michel Foucault, The Birth of the Clinic: An Archaeology of Medical Perception 38 (1976).

[54] The old Anglo-Saxon term "midwife" simply means "with woman." Kitzinger, supra note 4, at 1.

[55] See supra notes 6, 18.

[56] See infra notes 86–89 and accompanying text. This celebration of science has been recognized and critiqued fairly widely as masculinist, a male denial of alternative (e.g. women's) ways of seeing and being. See Brian Easlea, Science and Sexual Oppression: Patriarchy's Confrontation with Women and Nature (1981); Carolyn Merchant, The Death of Nature: Women, Ecology & the Scientific Revolution (1980).

throughout the medieval period, when the reproductive power of women was associated with their supposedly dangerously sexual, sinful natures, and men owned their women's capacity to produce children.[57] Although respected and influential figures, midwives were also seen as potential witches.[58] Childbirth was frightening and dangerous,[59] and very much women's business. Over time both the rationale and the mode of control changed. By the beginning of the twentieth century, the state and the medical profession controlled midwives. Women were no longer seen as rampantly sexual, but instead were portrayed as having no sexual appetites.[60] Rape was no longer theft of reproductive capacity, but rather a crime of morality, and reproduction was a matter of state interest, with women the conduit of new generations, whether of workers or of leaders.[61] Women and midwives were not only incapable of reversing this trend, but indeed contributed to the new faith in science. They felt that as

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[57] Chamberlain, supra note 19, at 31-66. Moreover, rape was seen as theft. Constance Backhouse, Nineteenth Century Canadian Rape Law 1800-92, in Two Essays in the History of Canadian Law 200, 201-04 (David H. Flaherty ed., 1983); Lorenne M.G. Clarke & Debra J. Lewis, Rape: The Price of Coercive Sexuality 110-24 (1977).

[58] For a strong argument for the midwife-as-witch thesis, see Barbara Ehrenreich & Dierdre English, Witches, Midwives & Nurses: A History of Women Healers (1973). According to *The Malleus Maleficarum* (The Hammer of the Witches), the handbook for medieval inquisitors, midwife witches are the greatest threat to the Catholic Church. The Malleus Maleficarum of Heinrich Kramer and James Specher 66 (Rev. Montague Summers trans., 1971). Isabel McAslan details the deep misogyny of that document and the bizarre and horrible "tests" for locating witches that were in use. Citing primarily to Mary Daly and Adrienne Rich she also documents the brutal obstetrics practiced in 18th and 19th century Britain and North America, including the removal of ovaries and clitorodectomies performed to "cure" "hysterical" or "unnatural" women. Isabel McAslan, Pornography or Misogyny? Fear and the Absurd, in The Anatomy of Gender: Women's Struggle for the Body 37 (Dawn H. Currie & Valerie Raoul eds., 1992). Although the ongoing efforts to contain women healers is undisputed, the midwife-as-witch thesis has been criticized by some as ahistoric. See, e.g., Margaret Connor Versluyen, Old Wives' Tales? Women Healers in British History, in Rewriting Nursing History 175, 191-93 (Celia Davis ed., 1980). Within one hundred years of the first Church-approved study of medicine, women were specifically forbidden to study medicine or to enter the many new universities. Midwives and herbal women continued their work, of course, but were increasingly regarded as being potential handmaidens of the devil. Successful medical practices that were not church approved could only be successful through the devil's interventions. Women healers, who were not permitted to receive the Church's sanction for their practices, and who, as women, were morally weaker and more subject to his influences, thus had to be closely controlled.

[59] Antonia Fraser, The Weaker Vessel 445-63 (1984) (describing women's lot in 17th century England); Edward Shorter, A History of Women's Bodies 35-97 (1982).

[60] Ruzek, supra note 7, at 69-70; Backhouse, supra note 57, at 229-30.

[61] Jane Lewis, The Politics of Motherhood 78 (1980).

women of all classes turned to medicine for pain relief and greater safety in childbirth, promotion and power for midwives would increase. Midwives, who were primarily middle-class, linked their rise with that of the male/medical structure.[62]

The turning point, if any, for midwives was the late eighteenth and early nineteenth centuries, when the trend away from the female, the natural, and the irrational gained its ascendancy.[63] Midwives were closely associated with the care of poor and working-class women, and through that association were successfully portrayed as providers of second-class care. At the same time, the medical profession, as it was emerging, associated itself with the interest of the ruling classes to ensure a viable workforce and a stable economy. Those policies served (and reflected) their own interests well.[64] The process was gradual and multi-layered. For example, as the subject "bad mother" was introduced into social policy discourse, almost inevitably concerning poor or working-class women,[65] midwives were

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[62] This is amply demonstrated in the histories that stress intra-professional rivalry between midwives and physicians. See Donnison, supra note 19, at 177–89.

[63] Historian Mary Chamberlain recognizes that the process of the diminution of the midwife voice was a power struggle, and identifies the economic and class dimension historically with the development of capitalism. "A hierarchy of knowledge became established which paralleled the social hierarchies. Certain forms of knowledge were identified with class and gender. Medical science became male, bourgeois science." Chamberlain, supra note 19, at 146–47.

[64] For a treatment of this, see Juanne Nancarrow Clarke, Health, Illness, and Medicine in Canada 277-79 (1990). For an analysis of the infusion of scientific justifications into state police policy and legitimation, see Roger Smith, Trial by Medicine: Insanity & Responsibility in Victorian Trials (1981). In the contemporary context, see Dorothy E. Chunn & Robert J. Menzies, Gender, Madness and Crime: The Reproduction of Patriarchal and Class Relations in a Psychiatric Court Clinic, 1 J. Hum. Just. 33, 37 (1990). The alliance is every bit as marked in the control of reproduction. See, e.g., Shelley Gavigan, Women and Abortion in Canada: What's Law Got to Do with It?, in Feminism and Political Economy: Women's Work, Women's Struggles 263 (Heather Jon Maroney & Meg Luxton eds., 1986).

[65] Carol Smart uses the term in her explanation of law as a "gendering strategy" and points to the Infanticide Act of 1623 as marking the beginning of this strategy. Smart, supra note 12, at 37–41. Smart also points to the use of the death penalty for mothers who kill their bastard children. (The same statute imposed penalties and restrictions on the midwives who assisted these women.) Smart does not touch on the equally significant role of instruments of (what she and Foucault would call) discipline, such as decisions of the Poor Law Commissioners. For example, an 1834 decision of the Poor Law Commissioners urged that any penalties and charges levied on the fathers of illegitimate children be repealed so that bastard children would remain "what Providence appears to have ordained that it should be, a burthen on its mother, and, where she cannot maintain it, on her parents. The shame of the offence will not be destroyed by its being the means of income and marriage." Brenda M. Hoggett & David S. Pearl, The Family, Law and Society: Cases and Materials 401 (2d ed. 1987). The Poor Law Commissioners did not reverse their position until ten years later when

associated with her. Physicians, on the other hand, gained ascendancy as "modern," "expert," and "better," and encroached more and more on the obstetrical care of respectable women of all classes, and added the term "midwifery" to the definition of their practice.[66]

During this period, medical doctrine of all sorts was augmented for the first time with empirical knowledge obtained in the pauper infirmaries and, most effectively, the lying-in wards of the great London charity hospitals. Rarely has the reality of stark need more conveniently coincided with class interests than in the raw material offered to inquiring and humane physicians in the way of growing hordes of rural poor pouring into the cities, cut off from traditional supports and vulnerable to death and starvation on the streets.[67] Pregnant working-class women, separated from traditional supports, were driven into the hospitals, and physicians, for the first time, developed practices and theories about pregnancy and birth from an experiential foundation. They were able to test their knowledge with examination and care of real patients, and their understanding grew.

The application of the new science in charity hospitals expanded medical knowledge, but also increased the authority of the medical practitioners, giving them access to additional knowledge by providing empirical experience. This new science shifted from reliance on the patients' subjective experience of problems (which remains important to midwifery) to knowledge acquired through a physical examination, therefore permitting the physician to tell the patient what she was feeling.[68] Moreover, the policies of the lying-in wards ensured that the physicians would "win the battle" against death in childbirth by denying care to the so-called immoral women who were in poor health and could not be readily "cured" of their pregnancy.[69]

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they recommended that women be given the right to sue the fathers of their illegitimate children in civil court. Id. at 402.

[66] In many jurisdictions, the practice of medicine continues to be expressed as "medicine and midwifery," testament to the enduring quality of the role and the need that doctors felt to use legislated definitions to assist in removing midwives from the practice of midwifery. In Canada, in provinces using this definition, prosecutions for practicing medicine without a license have been periodically brought against midwives for the past one hundred years. See infra notes 78–84 and 130 and accompanying text.

[67] Chamberlain, supra note 19, at 84–93.

[68] Foucault, supra note 53, at 39–42. Edward Shorter, who advances a misogynist analysis in the guise of sympathy and a call for better doctoring, places the change in medical authority as being consolidated in the last 40 years. Shorter, supra note 33, at 62–67, 109, 128; see also Judith Walzer Leavitt, "Science" Enters the Birthing Room: Obstetrics in America Since the Eighteenth Century, 70 J. of Am. Hist. 281, 281–304 (1983).

[69] Margaret Connor Versluysen, Midwives, Medical Men and "Poor Women Labouring of Child": Lying-in Hospitals in Eighteenth Century London, in Women,

Many factors combined to diminish midwifery and to transfer control over reproduction to masculine science. At the same time that the emerging medical profession engaged in a struggle for professional recognition,[70] economic and social forces produced an unprecedented state interest in health, reproduction, and social engineering in which medical science served as the expert voice. Perhaps the most significant of these was the prevailing nineteenth century belief that poverty was a condition of moral laxity and was susceptible to a scientific remedy, a "cure" as it were.[71] That perception paved the way for the creation of hierarchical health and social services bureaucracies designed with that goal in mind.[72] Medical authority over those exhibiting this moral failing was unquestioned, as it was soon to be unquestioned in regard to female fertility and reproduction more generally.[73]

In this climate of thought, the nineteenth century midwife was portrayed as a drunken incompetent slattern by everyone from Charles Dickens to contemporary medical historians.[74] This picture was supported by the doubtful status of all matters obstetrical.[75] Also, midwives were associated with immoral (poor) women. For example, the diet for pauper pregnant women in the poor house infirmaries was called deterrent gruel (so they wouldn't want to come back); pauper women's attendants in the wards were women of very low status, often paupers themselves.[76] Whether justified or not,[77] legislators accepted the picture of ignorance, incompe-

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Health & Reproduction 18, 18–19, 22 (Helen Roberts ed., 1981).

[70] See Johnson, supra note 15, at 45 (defining professionalization as the acquisition of power); William Ray Arney, Power and the Profession of Obstetrics 39–49 (1982); see also supra note 15 and accompanying text.

[71] See supra note 59, 69.

[72] Ruth G. Hodgkinson, The Origins of the National Health Service (1967). This massive work provides a collection of the documents, reports, and papers that trace not only the origins of the National Health Service, but also, unwittingly, the "birth" of doctors as the experts of the welfare state. That process in Canada has been illustrated and analyzed by Juanne Nancarrow Clarke. See Clarke, supra note 64, at 179–91.

[73] See supra notes 34, 41 and accompanying text.

[74] This image is a common one, almost an icon, particularly among medical historians. See Towler & Bramall, supra note 19; Nancy Schrom Dye, History of Childbirth in America, 6 Signs 97, 102 (1980).

[75] Throughout this period, midwives continued to perform their traditional extended function with the women left to their care, to dispense birth control information, and to perform abortions. Doctors initially avoided the abortion issue since it did not improve their status. Kristin Luker, Abortion & The Politics of Motherhood 41–45 (1985). Today in many parts of the world, abortion services are associated with midwives. See generally Greer, supra note 7.

[76] Hodgkinson, supra note 72; Chamberlain, supra note 19, at 106–11 (mentioning deterrent gruel at 109).

[77] Significant numbers of non-pauper women in the 19th century continued to rely

tence, and anarchy used by medical men against licensing for midwives. In the United States and Canada, midwifery almost disappeared; in Great Britain it was severely restricted.[78]

The forces that operated in Canada and the United States to suppress midwifery and to advance doctors as the sole appropriate birth attendant were similar to those that were effective in the United Kingdom. The rise of the medical profession, the scientific revolution, and a growing state interest in fertility and perinatal health were significant on both sides of the Atlantic, and both class and gender bias figure in the campaign waged by doctors against midwives well into the twentieth century. The language used by doctors writing for women's magazines as late as the 1930s openly allies male medical science with altruistic, objective truth, and implicitly demeans alternative visions. Dr. John McCullough, for example, describing himself as writing "frankly" about midwifery in the popular Canadian women's magazine *Chatelaine* in 1931, posits the high maternal death rate as the important issue, without ever touching on the actual competition for business that was still a reality.[79] The maternal deathrate in Canada, 6 per 1,000 living births, was lower than that of the United States but was much higher than Sweden's where midwifery is universal (2.94 in 1926, 2.78 in 1927, 3.30 in 1928, and 3.40 in 1929 per 1000 living births).[80]

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on the local midwife rather than risk the local hospital. Moreover, mortality rates were considerably lower for these women than for those who had their babies in hospitals, lying-in wards, and Poor Law infirmaries largely because of much reduced risk of infection at home without instruments. Arguably the care was much better and safer, less interventionist, more patient, and much less stressful. See supra note 75.

[78] In Britain, the 1902 Midwives Act reflected an acceptance of all of these stereotypes about midwives which continue to the present. The British legislation focused on the pauper hospital attendants, and regulated everything from clothing to living habits to midwifery skills. Donnison, supra note 19, at 177-80; see also infra notes 79-86 and accompanying text.

[79] According to Dr. McCullough:

> In the entire field of public health and medical practice there is no more engrossing subject nor one of higher importance to the national character of our people than the preservation of the mother . . . . but of all our resources the sons and daughters of the great pioneer mothers of Canada take the first rank. Their character, their health, their very existence depend on the mother.

John W.S. McCullough, Should Canada Have Midwives?, The Chatelaine 13 (Oct. 1931).

[80] Id. at 13. Physicians' efforts to eradicate midwifery and other homeopathic and naturopathic healers took a predictable path and ostensibly had been resolved by the middle of the 19th century with the passing of a new Medical Act in 1865. This Act prohibited anyone but a practitioner licensed under the Act from legally recovering any charges for any medical advice, medicine or operation provided, or from holding themselves out as licensed practitioners. While it did not directly prohibit midwives

The primary reason advanced to explain the low mortality rate of countries such as Sweden and the Netherlands which have midwifery as part of the health service is racist jingoism, blithely offered up as part of the physician's role as moral decision maker.[81] The offered solution, of course, is not the substitution of midwife for doctor, but pre- and postnatal care and education of the mother, all under male medical supervision. This answer suffices for almost forty years, not only because it is medicine's voice, but because it serves other interests equally well. Women are portrayed as incompetent childbearers and birth attendants, in contrast with male medical expertise.[82] The alliance of medicine's expert voice, with state interests in the promotion of familial ideology[83] is enduring and longstanding.[84]

The history of medicine's rise to dominance over knowledge about women's reproductive power has sometimes been expressed in linear economic terms. That is, doctors worked to discredit midwives because they needed the fees from obstetrical services, and in providing obstetrical services communities could not afford the "luxury" of midwives.[85] While

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from assisting at birth, it made it illegal for them to charge for their services.

[81] Dr. McCullough opines that Canada "must deal with almost all races of the world striving to make a living and to reproduce in an alien climate and under unusual conditions." Id. at 13. He particularizes his racism with examples, including:

> Intermarriage between different races is a factor in difficult labor. . . . Foreign peoples vary in their attitude toward the physician. The midwife could not be expected to have any better success with these types of peoples than the doctor. Continental people at home are much better disciplined than our mixed population. They obey the laws and rules of their own country and are inclined to abuse the wider privileges of this free country.

Id. at 13.

[82] McCullough, supra note 79, at 53. For a critical analysis of the class and gender bias that served both professional and political interests, see Clarke, supra note 64, at 224–48.

[83] Clarke, supra note 64, at 205–06. The law is frequently complicit in this process and the engagement of psychiatry in the criminal justice milieu is perhaps its most overt expression. See Chunn & Menzies, supra note 64.

[84] On a micro level, the efforts of middle-class feminist reformers ultimately contributed to the same result. For example, the role for nurses and midwives in their relationship with hospital hierarchy was put in place more than 100 years ago in the Nightingale Code: "If you see anything which you believe to be prejudicial to the well-being of your patients, it is your duty to report it forthwith to your immediate superior and then meddle no further therein." Dr. Herbert Barrie, Ethical Decisions, 18 Midwife Health Visitor & Community Nurse 480, 482 (1982).

[85] The economic issue was expressed overtly in Canada in the days before midwives were driven completely underground. It continues today in various forms. See Jutta Mason, Midwifery in Canada, in The Midwife Challenge, supra note 4, at 98, 108–29.

economic interests were at work, medicine's dominion was (and is) waged in ideological terms. The safety of infants and the frailty and incompetence of women are posed as challenges to science. Ignorant, dirty, lower-class women midwives are compared unfavorably to educated, upper/middle-class male doctors. As women's fear and mistrust of their own bodies increase, so does their need for and reliance on male physicians.

The story has even more frequently been told as one of a straightforward competition between professions, sometimes a competition between genders, using liberal concepts of progress and change. The description becomes the analysis and represents a historiography that collapses class and gender issues and cedes the terrain to the experts, as the story unfolds of class-neutral male physicians coming to a position of preeminence over equally class-neutral (and simply less qualified) women midwives.[86] That description must be placed in a wider context, one that rejects the historical characterization of the midwife and her role within the community as simply being analogous to that of professional physicians, only female.[87] There is more operating here than the achievement of one set of interests (medicine) at the expense of another (midwifery), or even the triumph of a scientific worldview over a naturalistic one. The constructs and paradigms of science are gendered, and in that sense the reason that the men of medical science control reproduction today is as much a product of the patriarchal imperative described by Mary O'Brien[88] as it is of a mythically neutral and objective science, and as much a matter of class as a matter of gender. Indeed, it is important to see these historical changes as results, rather than as causes. The failure to do so romanticizes midwifery,[89] essentializes women with no recognition of particularity of class and race,[90] and distorts tactics and strategy. Consideration of the

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[86] See Kitzinger, supra note 4 (noting that studies reveal the decline of midwifery as attributable to the emergence of a male-dominated medical profession and while critical of much of that work, she identifies the challenge as primarily gender based); see also Lesley Biggs, The Case of the Missing Midwives: A History of Midwifery in Ontario from 1795-1900, 75 Ontario Hist. 21 (1973). Biggs concludes that the displacement of the midwife can be better understood in terms of this competition than as an ideological struggle or as scientific advancement. Id. at 33.

[87] Barbara Katz Rothman identifies the authority of that version. "[W]hen we look backward, midwifery seems to us like a branch of medicine, and the midwife an untrained forerunner of the obstetrician." Rothman, supra note 27, at 51.

[88] See supra notes 47-50 and accompanying text.

[89] In Canada, although this argument is not uniquely Canadian, the trend is to glamorize the history of midwifery and to cast midwives into the sisterly role of "neighbor women" acting in and through an unspoken but shared "birth culture." For a historical examination of the "neighbor woman" midwife, see Cecilia Benoit, Traditional Midwifery Practice: Limits of Occupational Autonomy, 26 Can. Rev. Soc. & Anthropology 633 (1989); see also Burtch, supra note 9.

[90] This essentialism has become an important challenge to what has been identified

lived lives of British midwives illustrates that particularity, and sharpens the questions around legal recognition in Canada.

IV. THE CONTEMPORARY DEBATE: UNITED KINGDOM, UNITED STATES, AND CANADA

United Kingdom: Regulated Integrated Midwifery

Although midwives in the United Kingdom achieved the legal status and recognition that Canadian and (most) American midwives did not, the majority of British midwives today are employed in hospitals where policies and procedures are essentially determined by the consultant obstetrician, where their midwifery skills are eroded by substantial time spent in nursing activities, and by the tendency of doctors, particularly junior ones, to either repeat or themselves perform the type of examination and procedure that should be part of a midwife's usual role.[91] The hierarchical medical model of nursing supervision has been adopted for midwives[92] and their work defined, restrictively, as one of the caring professions.[93]

Although this subservient role has theoretically been changed, and midwives in Britain are recognized as independent professionals,[94] the reality is that midwives struggle under the same double burden that most

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as white, middle-class feminism. See bell hooks, Talking Back: Thinking Feminist, Thinking Black (1989); Marlee Kline, Race, Racism, and Feminist Legal Theory, 12 Harv. Women's L.J. 115 (1989).

[91] Sarah Robinson, Career Intentions of Newly Qualified Midwives, 2 Midwifery 25 (1986); Sarah Robinson, Normal Maternity Care: Whose Responsibility?, 92 Brit. J. Obstetrics & Gynecology 1, 1-3 (1985) (discussing the increasing involvement of medical staff in management of normal maternity care leading to the restriction of the midwife's role).

[92] For a description of the impact of the nursing supervision model (itself an offshoot of medical hierarchy), see E.A. Bent, The Growth and Development of Midwifery, in Nursing, Midwifery and Health Visiting Since 1900 180, 180-95 (Peter Allan & Moya Jolley eds., 1982).

[93] "The aim is to assist, and/or enable people as patients, clients or relatives to meet their physical, psychological and social needs. Thus, caring for people is their business; they are educated and trained in ways of undertaking this function." Allan & Jolley, supra note 92, at 17.

[94] She is described as a "practitioner who has the capacity to challenge, the honesty to ask why, the empathy to care, the skill to perform competently and the determination not to be put down," all as a result of the new legislation. Failure to live up to this standard means that she is "rejecting honesty, tolerating the intolerable, contributing to the abuse of colleagues, accelerating a deterioration of standards and reneging on personal professional accountability." Reginald H. Pyne, The UKCC Code of Conduct, 82 Nursing Times 510, 511 (1986).

working women face, and have little autonomy or power over their work. The British midwife is the supposed expert in normal birth, committed to the ancient wisdom of Hippocrates in regard to routine procedures, *primam non nocere* (first do no harm),[95] yet she is expected to follow procedures established by hospital obstetric consultants about anything from the routine artificial rupture of membranes,[96] routine use of syntometrine[97] in the third stage of labor,[98] and when to do vaginal examinations during the course of labor,[99] to how to take a blood sample.[100] She is meant to be fully accountable to patients and to her professional body for her own practice, but is not permitted to ever be wrong in the exercise of judgment, a judgment which must arise in the context of the procedures which govern in the hospital where she works.[101] For example, midwives preside as maternity nurses over increasingly mechanized births, becoming so used to depressed fetal heart rates in women on their backs connected to intravenous (IV) units tied to Electronic Fetal Heart monitors, paralyzed from the

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[95] Association of Radical Midwives, Newsletter, Spring 1987, at 15, cited in Martin, supra note 6, at 32 n.76.

[96] The uterine membrane is ruptured to produce a "breaking of the waters" or release of amniotic fluid when it has not occurred naturally during labor to accelerate a delayed or slow labor, but when done routinely, that is, without a diagnosed reason, the increased risk of infection, for example, outweighs the value of the procedure. A midwife was sanctioned, however, for not following hospital rules requiring the procedure. Proceedings Against White, Testimony before the UKCC Professional Conduct Committee (May 21, 1987) (author's personal notes, on file with author), cited in Martin, supra note 6, at 32 n.77.

[97] Syntometrine is a drug which increases the strength and duration of contractions of the uterus. As with most drugs, side effects are possible, and its routine use is difficult to justify. Association of Radical Midwives, supra note 95, cited in Martin, supra note 6, at 32 n.78.

[98] Labor is generally understood as having three stages: the first involves the onset of contractions; the second stage is the active pushing stage leading to the birth; and the third stage describes the expulsion of the placenta after the birth of the baby.

[99] Proceeding Against Lee, Transcript of the UKCC Professional Conduct Committee (Nov. 15, 1984), cited in Martin, supra note 6, at 33 n.79.

[100] Proceedings Against McCormack, Transcript of the UKCC Professional Conduct Committee (July 25, 1985), cited in Martin, supra note 6, at 33 n.80.

[101] Indeed, as recently as 1983, the Royal College of Obstetricians and Gynaecologists declared that they "cannot accept responsibility that within either the Specialist Maternity Units or the GP units it is the midwife's responsibility for all normal deliveries. The ultimate responsibility must rest with the consultant within his unit or with the GP under whose care the patient is booked." Quoted in Wendy Savage, A Savage Enquiry: Who Controls Childbirth? 133 (1986) (describing the ordeal of a woman-centered obstetrician, Wendy Savage, working with poor and immigrant women, against whom, ironically, the above proposition was used, and providing a stark illustration of the class and gender issues that are the underpinnings of the medical "best interests" rationale); see also supra note 6.

waist down with epidurals, that they may miss fetal distress. In some health areas if they complain about procedures or refuse to intervene routinely they face employment disciplinary proceedings for disobeying a doctor, or refusing to follow a rule when it is not in the patient's interest; however, midwives may also face discipline for *not* disobeying.[102]

The class position of British midwives cannot be ignored. Over ninety percent of midwives practicing in the United Kingdom do so as relatively low-paid employees with the National Health Service[103] where the first line of control is at the employee level. Midwives in this regime are first working women. Within hospital hierarchy, they are policy implementors, not policy makers, initially reporting to the first-level supervisor, the Nursing Officer, who in turn reports to a Supervisor of Midwives for a health area.[104] An employment model operates with investigations of conduct of a purely employee-like character (i.e., tardiness) merging with complaints about, and investigations into, the employee's performance as a midwife. The dual nature of the midwife manager's role as professional colleague and advisor as well as employment manager has the potential for abuse, misuse, and misunderstanding, particularly in view of the manager's power to temporarily suspend a midwife from employment and to set in motion the power of the Local Health Authority to suspend her right to practice pending a final determination by the statutory body.[105] The midwife can appeal the local decision through the regional and district levels of the National Health Service, or to an Industrial Tribunal,[106] but until the professional disciplinary process has been completed, it is quite possible that she could remain under statutory suspension for a year or more and then finally be exonerated. Professional discipline and employee discipline are obviously not intended to be the same thing, but the only guarantee that they are not rests on the fairness and competence of management and/or the energy and willingness of the midwife to pursue legal remedies. The link between professional conduct and purely management decisions to discipline remains somewhat unclear. The result is that

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[102] All of these "standard" hospital procedures, from the use of the lithotomy position for delivery (mother on back, feet in stirrups), to the routine use of the IV and Electronic Fetal Monitoring, have been associated with poor outcomes for mother and baby. See supra notes 27, 38, 39 and accompanying text. For an illustration of the dilemma for the midwife, see Proceeding Against Lee, supra note 99.

[103] Eng. Nat'l Board for Nurses, Midwives & Health Visitors, Ann. Rep. (1985), cited in Martin, supra note 6, at 34 n.85.

[104] Flint, supra note 29, at 193-96.

[105] Flint, supra note 29, at 197-99.

[106] Minutes of Professional Conduct Committee, English Nat'l Board, (Mar.-Nov., 1985), cited in Martin, supra note 6, at 35 n.90.

the "difficult" employee, who may be an excellent midwife, was and is more vulnerable to discipline at either level than the mediocre midwife who merely "toes the line."[107] The stage for this impossible position was set two hundred years ago by the mechanisms enshrined in the legislation that created the profession.[108] The position of midwives in the United Kingdom today sharply illustrates the dilemma facing North American midwives and their supporters.

Midwives in Canada and the United States: A Calling Without a Voice

The bureaucratized, oppressed midwife working in a state-regulated regime that expresses the will of the medical establishment is the specter that haunts midwives in both Canada and the United States who are seeking and considering the wisdom of state recognition. It is reality for midwives in the American states that recognize nurse-midwives, whose position as employees looms large in their lives. The experience in the states in which "community midwifery" (referred to as "lay midwifery" in U.S. legislation, in distinction from "nurse-midwifery"[109]) is legally recognized has been

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[107] Martin, supra note 6, at 35-36.

[108] The test of what constitutes professional misconduct for a midwife is extremely strict, is defined as "conduct unworthy of a . . . midwife" and is determined by the members of the Professional Conduct Committee. Nurses, Midwives and Health Visitors (Professional Conduct) Rules, S.I. § 1(2)(i) (1983). The composition of the Committee has changed dramatically from 1902, when the members of the Central Midwives Board established by the 1902 Act were not even required to be midwives (although four were), to the 1979 legislation which for the first time ensured that a majority of the members of the Midwifery Committee of the UK Central Council for Nursing, Midwifery and Health Visiting were practicing midwives and that midwives were dominant in deciding questions of midwifery misconduct. Nurses, Midwives and Health Visitors Act, 1979, ch. 36, § 4(1) (Eng.). In 1915, conduct "unworthy" of a midwife encompassed her personal life and morals as well as her competence, an unlikely standard today. Stock v. Central Midwives Board [1915] 3 K.B. 756 (Eng. C.A.) (at issue was the cohabitation of the midwife with a man not her husband). However, a single inadvertent act, a sole error of judgment, or a breach of hospital procedure can and does constitute professional misconduct; it is a standard of perfection. In contrast, the test for medical practitioners is a pattern of conduct demonstrating incompetence to the extent that a "consultant could be personally responsible for mistakes without his competence necessarily being called into question." Savage, supra note 101, at 189.

[109] Vicki Van Wagner, With Women: Community Midwifery in Ontario (1991) (unpublished Master's Thesis, York University). Van Wagner prefers the more accurately descriptive term "community midwife" and rejects the earlier "lay midwife" to describe midwives who fit the WHO definition, and who almost universally attend women at home births as well as acting as "labour coaches" at hospital births (to gain admission). For an autobiographical description of the enormous difficulties facing

equally bleak. For many of these midwives, their community practices, usually comprised of a mixture of very poor women with no other maternity-care options and privileged, well-educated women challenging traditional medical practices around birth, are dependent on physician approval. This dependence has resulted in closely circumscribed practices, and abusive and insulting restrictions on everything from birth registration to ongoing "fitness to practice" testing.[110] In fact, state regulation in the United States has produced conditions not unlike the situation in countries which have a longstanding recognition of midwifery.[111]

By claiming for itself the moral and expert high ground, medicine has dominated the public debate and has made itself the arbiter of the public interest in an almost impermeable hegemony.[112] However, medical hegemony has not gone unchallenged by women reacting to the medicalization of birth in any of the three countries.[113] In the resurgence of interest in home birth in the 1970s for example, some women decided that changing doctors and hospitals was not worth the effort, or was not possible and went "underground" with a midwife in attendance to have their babies.[114] That

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midwives in the United States under both systems, see Penny Armstrong & Sheryl Feldman, A Midwife's Story (1986).

[110] For a survey of the restrictions imposed on midwives in the United States, see Butter & Kay, supra note 8; see also Robinson, supra note 16; Walker, supra note 16.

[111] For an analysis of the use of the professional conduct regime in the United Kingdom, see Martin, supra note 6.

[112] For example, Maureen Baker, writing for the Library of Parliament, notwithstanding her clear sympathy to midwifery for Canada, simply states, "As long as physicians retain their current dominant role in the health care system, any changes to this system will come on physicians' terms." Maureen Baker, Midwifery: A New Status 25 (1989) (available at the Library of Parliament, Ottowa and on file with the *Columbia Journal of Gender and Law*). Equally explicit in asserting physician acceptance as the sine qua non of recognition is Kristin E. McIntosh, Regulation of Midwives as Home Birth Attendants, 30 B.C. L. Rev. 477 (1989).

[113] The women's health movement has had an impact in all three countries. In Britain the "Association of Radical Midwives" was formed to challenge medical hegemony and to support midwives struggling to regain their autonomy. All over the United States, in part arising out of the critical need of poor women for any maternity care at all, particularly in New York City, Louisiana, and parts of Washington, California, and Massachusetts, community midwives established themselves and began the battle for legal recognition. These forces were much slower to take root in Canada; there was no obvious lack of maternity care and no core of working midwives to radicalize. See Mason, supra note 85.

[114] Despite attempts to segregate place of birth from birth attendant, the two are closely connected in jurisdictions where midwives attempt to practice independently. See Sullivan & Weitz, supra note 27; McIntosh, supra note 112. The collapsing together of midwifery and home birth continues in Ontario even in the face of pending legalization. For example, a recent article purporting to be about midwifery is in fact an endorsement of home birth. See Wendy Powell & Douglas Powell, Midwifery: The

alliance of women (seen in the women's health movement, for example) supported midwives who were striving to reclaim the midwifery ethic and to put considerable pressure on state and medical establishments.[115] At the same time, by casting the issue as one of opposition to an establishment, and as a matter of individual choice, this movement has also provided the basis of resistance to the question of professionalization for midwives.[116]

State Recognition: The Canadian Compromise

In Canada, the medical establishment recognized that place of birth had become a direct challenge to its dominance and proprietorship.[117] To the medical establishment, place of birth could no longer be a matter of parental choice, but rather came to be defined as a medically significant question of safety and responsibility. Once again the medical association allied itself with the "public interest" and with state power. In Ontario, for example, they made exceptionally effective use of the coroner's inquest, an

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Evidence in Favour Grows, Toronto Star, Sept. 3, 1992, at A21. The Powells cite Cesarean section rates, the recent trial challenging the routine use of episiotomies (a surgical incision in the vagina to enlarge the birth passage), and physician dominance to support midwife attended home birth. Criticism of midwifery also focuses on place of birth. David Shoalts, Ontario First Province to Recognize Midwifery as Profession, Globe & Mail, Nov. 22, 1991, at A5. In the article, covering the third reading of the new legislation on November 20, 1991, Andre Lalonde for the Society of Obstetricians and Gynecologists of Canada focused his criticism on independence and place of birth. "'Every province in the country has had deaths from home births. We're not against midwives, but we think there has to be a team approach. *There's got to be someone in charge of these people* . . . . We're all for midwives, provided they are integrated with a medical team.'" (emphasis added); see also Alanna Mitchell, Never Mind the Lousy Experience—It's Life that Counts, Globe & Mail, May 2, 1991, at Feedback (expressing strong support for reliance on medical technology in birth, and suggesting that home birth, midwifery, and natural childbirth (all part of the same phenomenon according to Mitchell) reflect a selfish desire for a "spiritually heightened" experience).

[115] Sullivan & Weitz, supra note 27 (providing a general review of the literature on the debate and safety statistics around home birth, and the movement of educated and middle-class women to midwifery services). Vicki Van Wagner has also studied this phenomenon. See Vicki Van Wagner, Women Organizing for Midwifery in Ontario, 17 Resources for Feminist Res. 115 (1988). For a discussion bearing witness to the strength of the movement in the United Kingdom, see Flint, supra note 6, at 22-39; Jennings, supra note 6, at 13.

[116] The concern around professionalization is identified in Butter & Kay, supra note 8.

[117] The debate has been public and vocal. For the view of the Quebec medical establishment, see Globe & Mail, Apr. 29, 1992, at A7. The article quotes a Manitoba Provincial Court Judge as finding in the inquest report that Darlene Birch and Marla Gross (both midwives) "'lacked the knowledge, expertise and skill to recognize and deal with the complications which arose'" during the birth of twins at the home of Lorna Cameron. One twin was stillborn. The reply has been equally strong.

instrument almost exclusively within their control.[118] By focusing the legal and public debate around instances of infant death, medicine attempted to maintain preeminence in matters of safety by locating midwife-attended births in the sphere of the exceptional and hazardous. The particular focus was on home births, widely portrayed by the medical community as unsafe, in spite of the evidence to the contrary.[119]

In Ontario, the largest province in the country, now on the verge of implementing ground-breaking midwifery legislation, the blatant, even brutal, use of the legal institution of an inquest in 1985[120] might have succeeded in its attempt to prevent the recognition of midwifery in Ontario but for widespread support from women, both individually and in groups, and the determination of the midwives and the parents involved. The prosecution's right to stop the inquest at any time and to bring criminal charges,[121] coupled with blind reliance on scientific expertise which is often inherently illogical,[122] was intended to discredit independent midwifery in general and home birth in particular. Instead of criminal charges against the midwives, however, or recommendations for a closely controlled practice, the verdict was strongly in favor of an independent midwifery profession and acknowledged that parents had the right to choose both attendant and place of birth. The inquest led to the establishment of a task force to inquire into the implementation of independent midwifery in

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[118] Coroners Act, R.S.O. Ontario, 1990.

[119] See supra note 114; Sullivan & Weitz, supra note 27, at 112-32.

[120] McLaughlin-Harris Inquest, supra note 35. The inquest seemed to have been intended to tarnish independent midwifery and home birth. The organizing efforts of the Association of Ontario Midwives, and its involvement in a sophisticated legal strategy, which included expert witnesses from WHO and the United States, probably contributed to the failure of the attempt.

[121] Coroner's Act, 1988, ch.13, § 16(1)(a) (Can.). Although criminal charges were threatened in the McLaughlin-Harris inquest, supra note 35, they have not been successful in Canada in recent years. Criminal charges were brought in British Columbia, in another midwife-assisted home birth. The trial judge's conclusion was that the relevant standard of care for determining negligence was that of a "medical practitioner." R. v. Sullivan, 55 C.R.3d 48 (B.C. County Ct., 1986) (acquittal entered, The Queen v. Sullivan, [1991] 1 S.C.R. 489 (Sup.Ct. Can.)). The issue before the Supreme Court was the legal status of the fetus; the Crown argued that the midwives could be guilty of causing bodily harm to the fetus in the process of its being born, thus granting "personhood" to the unborn. The opposite conclusion was reached in Nova Scotia in 1983, when criminal negligence charges were brought against midwives attending a home birth. The midwives were discharged after the preliminary inquiry, having established that they were competent midwives, and that their approach, although not shared by much of the medical community, had been excellent midwifery. R. v. Carpenter, unreported judgment (Prov.Ct., Crim. Div., Halifax, Nova Scotia, Nov. 25, 1983).

[122] Supra notes 36-38 and accompanying text.

Ontario, which released its ground-breaking report two years later. *The Report of the Task Force on the Implementation of Midwifery in Ontario*, released in September 1987, appears to represent a victory for the supporters of independent midwifery and woman-centered childbirth. Legislation has been passed implementing the Task Force's recommendations, and an interim Midwifery Advisory Council has been established to assist in the development of a College of Midwives.[123]

In the face of the determination of medical opposition, the Ontario legislation, An Act Respecting the Regulation of the Profession of Midwifery ("The Midwifery Act"),[124] represents an impressive attempt to establish an autonomous sphere of practice for community midwives. The scope of authorized practice is that recognized by WHO, with specific authorization for performing and repairing episiotomies and tears, administering drugs by injection or inhalation, conducting vaginal examinations in the course of managing labor, and conducting spontaneous normal vaginal deliveries.[125] The College of Midwives, including its Executive Committee, Complaints Committee, and Quality Assurance Committee, does include non-midwives appointed by the government (in a manner similar to other health professions) but midwives hold a substantial majority on all governing committees.[126] The Midwifery Act represents one of the strongest statements of legislative support for an autonomous profession of midwifery anywhere in the world.

The result is in many ways a victory for women, but to determine how significant a victory one must ask, once again, whether women and midwives can harness the state's interest in fertility and health on their own terms in the face of the dominant role the patriarchal medical hegemony plays in setting the agenda. The experience in Britain and the United States documents the enormous difficulty facing women and midwives who challenge the patriarchal imperative to control reproduction. On the other hand, the cost of fighting legal battles is extraordinary, both in personal and in economic terms, and ending the prosecutions has been recognized as one of

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[123] The bill, which would make Ontario the first province in Canada to formally recognize midwives, was introduced on April 2, 1991 (Alberta and Quebec have only pilot projects). Matt Maychak, Ontario Plans Licensing for Midwives, Toronto Star, Apr. 3, 1991, at A11. The Michener Institute announced a midwifery preregistration program with a call for applications for registration from practicing midwives with two years of active practice of midwifery in Ontario. Globe & Mail, Dec. 16, 1991, at D1; Shoalts, supra note 114 (covering the third reading of the legislation, Nov. 20, 1991).

[124] The Midwifery Act received a first reading June 6, 1990, went to Committee, and had a second reading in May, 1991. It has now passed with a third reading, supra note 114.

[125] The Midwifery Act, §3-4 (1990) (Ontario).

[126] Id. §§ 6-14.

the benefits of state regulation.[127] Insisting that midwives remain unregulated and "underground" in order to preserve their "purity"[128] condemns dedicated women to marginalized and exhausting lives and ensures that midwifery services will remain available only to an elite group of women who are "in the know" about alternative health services, or to women in isolated communities that are unattractive to doctors, which sends a message that they are receiving second-class care.[129] Absent legislation, there is no doubt that the prosecutions would continue, particularly as midwifery gains credibility with the public and with legislators, as the Ontario pattern of the use of legal strategies to discredit midwifery is a constant across the country.[130]

Moreover, lessons about state regulation in the United States have limited relevance in the Canadian context as health-care debates in Canada have an additional dimension arising out of the medicare scheme, and currently turn on questions of cost effectiveness, "skyrocketing health care budgets," and the need to curb doctors' fees and demands.[131] It is not surprising in this context that government has shown itself increasingly willing to listen to midwives and their supporters, even in the face of vigorous medical opposition to the introduction of an independent profession of midwifery. The argument that attracts government is that midwifery care is less costly than medical care and every bit as safe, if not more so.[132] Canada's system of state-run medical insurance is both expensive

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[127] This benefit has certainly been recognized in the American context. Butter & Kay, supra note 8, at 1168. In Canada, the excuse commonly offered for the calling of an inquest is that midwives are unregulated and the Coroner's duty demands an inquiry. Presumably, legal recognition and thus regulation would remove that weapon. See Burtch, supra note 9.

[128] See Mason, supra note 85, at 124–25.

[129] Mary McIntosh, Feminism and Social Policy, 1 Critical Soc. Pol'y 32 (1981) (discussing this issue from the perspective of women's struggles with the state and state-sponsored services and concluding that "purity" is a result of inward-looking and ultimately apolitical structures).

[130] In the face of pending legislation, as recently as June 1991, inquests continued to be called in Ontario, and are pending in Manitoba where a midwife attended home births. Inquests have been held recently in Quebec, contemporaneously with proposed legislation to study midwifery within the framework of eight pilot projects. Bill 4 received Royal Assent June 22, 1990 in the face of extraordinary physician opposition. See Picard, supra note 45, at A10. Midwives were charged in Alberta in the first prosecutions for practicing medicine without a license in many years, arousing both public interest and sympathy. See Rod Mickleburgh, Case Renews Long-standing Debate: Alberta Midwife Who Helped Deliver a Healthy Baby Is Charged with Practising Medicine Without a License in First Such Case Recalled, Globe & Mail, Nov. 13, 1990, at A1. The charges were stayed in Provincial Court on June 5, 1991, on the basis that practicing midwifery is *not* the practice of medicine.

[131] Baker, supra note 112, at 5.

[132] Baker, supra note 112, at 6; see also Van Wagner, supra note 109 and studies

and extremely popular, and government has interests other than the medical profession to consider. At the same time, although there is no doubt about the preeminent position in terms of status and prestige that medicine holds in the hierarchy of health-care providers in Canada (as in the United States and Britain), Ontario midwives are establishing themselves in a climate wherein working women are at least theoretically equal, in sharp contrast to the class and gender bias that established midwifery regulation in the United Kingdom. It is on these interests that midwives and their supporters rely. The response of the dominant voices in the medical profession has now been limited to reminding government of its need to win their support, a move from total opposition to midwifery to a reluctant acceptance of a possible addition to their world.[133]

V. CONCLUSION

There remain a number of issues of substantial importance, all of which could continue to impose a heavy burden on the members of the Ontario Association of Midwives, the organization which has been central to the struggle for recognition of midwifery in that province. Any one of these issues could, in hindsight, represent the fatal compromise between principle and possibility. For example, nothing in the proposed legislation would oust the power of the coroner to call an inquest (which is available against all other professions). Although the unregulated nature of midwifery provided the public-interest justification for the earlier inquests, it is by no means clear that the existence of regulation will end coroner interest. In this context, it is important to remember that the legislation authorizing "lay" midwifery in the American states, where it exists, was also the product of extraordinary effort and represented compromises that appeared appropriate or inevitable at the time in response to different

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cited therein.

[133] The medical profession has many allies. Louise Brown, medical columnist (and supporter) for the Toronto Star, writing in Ontario in 1991, on the eve of statutory recognition of independent midwifery, is still able to write about "labor coaches" as a useful "addition" to obstetrics with only one passing mention of the "M" word; and make a clear statement that these labor coaches do nothing "medical." She attributes the rather startlingly impressive results of "labor coach" support in labor to "psychological" factors. She reports on satisfaction and outcome in a University of Toronto controlled study of 103 women, half with "labour coaches," half without. The results might have given Dr. Hilliard pause in 1950; deliveries with no labor coach were twice as likely to need an epidural or painkiller, and three times as likely to have an episiotomy or suffer vaginal tearing. The results replicate a Houston study of 600 women; 8% with a labor coach required a Cesarean versus 18% without; 8% with a labor coach required forceps versus 26% without; and the average length of labor was 7.4 hours with a labor coach versus 9.4 without. Brown, supra note 17.

questions about relationships with the state.[134] The Ontario Act does not contain any of the obvious weaknesses of the American statutes, particularly physician domination;[135] however, the struggle is by no means over. Issues around funding, training, medical backup, hospital support and access, and inter-professional conflict remain to be addressed. At each stage of the development of the "new" profession, midwives will be faced with absorbing and using what the medical model has to offer, reassuring hostile or uninformed doctors and nurses, and supporting their clients in the process, all while remaining true to their own tradition and norms. It is no wonder that some would prefer to remain out of this treacherous mainstream.[136]

The prevailing argument, that licensure and professionalization comprise the only route that will preserve midwifery and extend midwifery services to all women, itself raises intriguing and important questions about how this might be achieved in the face of the tremendous forces of patriarchy that medicine, the law, and, in the final analysis, the state, have arrayed against it.[137] However, it is the apparent enormity of the struggle which contains the key to its solution. Midwifery in this context is a feminist issue; not an add-on at the margins of the struggle for reproductive autonomy, but a theory and a practice that can act as a catalyst for bringing women together across lines of class, difference, and race. The lessons to be learned from the midwife's tale can and should be applied to broader questions.

The marginalization of the struggles of midwives ultimately serves the

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[134] The question of state initiatives has been critiqued in regard to wife assault and legal services. See Laureen Snider, Legal Aid, Reform, and the Welfare State, in The Social Basis of Law: Critical Readings in the Sociology of Law 169 (Stephen Brickley & Elizabeth Comack eds., 1986); Gillian A. Walker, Family Violence and the Women's Movement (1990); see also Dawn Currie, Battered Women and the State: From the Failure of Theory to a Theory of Failure, 1 J. of Hum. Just. 77 (1990) (analyzing the literature and proposing new approaches).

[135] See generally Butter & Kay, supra note 8; Baker, supra note 112, 17-20 for examples, such as physician-created entrance examinations, physician-controlled insurance requirements, and the like.

[136] Mason, supra note 85.

[137] See Wayne Roberts, Midwives Move into Modern Medical Mainstream: New Birthing Profession Pushes Choice, Not Holistic Hardline, Now Magazine, Aug. 13-19, 1992, at 21; Von Wagner, supra note 115. Von Wagner herself is concerned about funding under the new scheme and focuses on the as yet unresolved issue of funding for the newly recognized midwifery service. Midwives are fighting for funding to go to community-based collectives that specialize in continuity of care. Dr. Krieger, the "grandfather of midwifery," is fighting for birthing centers in Ontario. Both point out the cost savings over physician/hospital-based care, while the government spokespersons remain noncommittal.

hetero-patriarchal hegemony identified by Mary O'Brien.[138] The structures that have alienated women from their reproductive capacity, fetishized the fetus, and characterized women as enemies of their born and unborn children are the very structures that have successfully relegated midwives to peripheral status all over the world. At the same time, the diminishing of midwives' voices has separated women from a critical advocate and ally while advancing the ideology that alienates women from their own bodies. Patriarchal ideology has thus been served, carving the single issue of reproductive autonomy into several issues, paralleling and advancing an overall strategy of division and dominance. Birth control and abortion become different issues from birth attendant and choice; infertility and reproductive technology are rendered different from one another. Within this division, class and race are isolated from gender, and issues of quality of care are isolated from those addressing access to any care at all. The corollary is the segmentation of "woman" into a series of functions, each attended by its own discourse, its own experts, and its own place.

I suggest that part of the process of reintegration is the preservation and advancement of women's traditional ally and advocate in reproduction, the midwife. The midwifery commitment to women as whole beings, connected to and through whole communities, exposes the dangerous fallacy of patriarchal medicine's insistence on splintering women into reproductive parts, and offers a real alternative. At the same time, the example of the creativity and tenacity of Ontario midwives and their supporters in not only surviving, but flourishing in the face of concerted opposition, offers a model to all activists. Commitment to feminist principles of sharing and questioning, courage in the face of abuse and aggression, and connection to age-old wisdom represent an ideal prescription for change.

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[138] O'Brien, supra note 47 and accompanying text.