RELUCTANT RE-DEFINITION: MEDICAL DOMINANCE AND THE REPRESENTATION OF MIDWIFERY IN CMAJ, 1967-1997

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ABSTRACT

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This thesis is an investigation of the medical representation of midwifery in the *Canadian Medical Association Journal* from 1967 to 1997. The recent changes in the status of midwifery in Ontario, Canada inform the presentation of the findings. The theoretical framework for the thesis is social constructionist and as such assumes the medical knowledge, scientific information and illness categories in the journal to be socially constructed by the claims making activities of medicine. A description of the formal characteristics of the representations provides a structural framework for the more in-depth claims making analysis. The themes and patterns of the representation of midwifery that emerged in the journal are consistent with the theoretical model of professional dominance as developed by E Freidson. These findings generally reflect the reluctance of mainstream medicine to accept midwifery as an autonomous profession.

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Chapter I : Introduction

My interest in midwifery goes back to my undergraduate days when the topic was introduced in a sociology course. It overlaps with my interests in alternative health care more generally and the struggles that many marginalized groups of practitioners have encountered with mainstream medicine.

However, my involvement with midwifery goes beyond the academic world. For the birth of my daughter, six years ago, I had a midwife attended home birth. This was prior to the legislation in Ontario which legalized midwifery. I was quite impressed with their standards of care, protocols and the midwife's level of training. My home birth experience was very positive - one which has left me quite biased in favour of midwifery care. What struck me as well, were the reactions my choice unleashed. Friends and family thought I was nothing less than "crazy", taking unnecessary "risks" and that the midwives were not trained and would not "know what to do".

As I began to think in a more scholarly way about midwifery, my own experiences of midwifery care, combined with the literature on midwifery stood in stark contrast to the reactions to my choice of this form of care. I began to wonder to what extent the changes in legislation might affect the opinions of those who regarded midwifery with such fear and suspicion.

Initially I considered looking into public views of midwifery. From a preliminary investigation, there seemed to be close links between public and medical views of midwifery. As I pursued this idea further I focused more and more on the representation of midwifery by the medical profession. Eventually, I wondered if physicians, a group

with a strong tradition of resistance to midwifery, may have reconsidered their views on midwifery in light of its recent rise in popularity and its new found respectability. This led me to the study presented in this thesis, a systematic analysis of the representation of midwifery in a Canadian medical journal.

I was next faced with the decision of which medical journal to analyse. Perhaps the most obvious choice was an obstetrics journal as this is the group of physicians most directly impacted by the increased interest in midwifery. However, I chose the *Canadian Medical Association Journal* instead of the more specialized one because I wanted to get a sense of the debate among physicians of all kinds, rather than limiting the perspective to that of the obstetrician. Historically, the first conflicts over pregnancy and childbirth between medicine and midwives involved the general practitioner, not the obstetrician. Both general practitioners and specialists subscribe to CMAJ and, so it seemed to offer the most potential for an analysis of medical representation of midwifery.

My concerns in this thesis are to identify first, how midwifery has been represented in the medical literature and second, if the representation has changed since midwifery attained legal status in Ontario. I have tracked representations of midwifery in the *Canadian Medical Association Journal* through the years 1967-1997. More specifically, I identify characteristics, themes and patterns which emerged in the medical views of midwifery throughout this thirty year span.

The overarching theoretical framework for my thesis consists of an interactionist or interpretive perspective. From this perspective the meanings of events, situations and conditions are not objective and fixed, but continually constructed by social actors as

they struggle to make sense of their world and their lives. Often these meanings are contested. In the case of my thesis, the objects of definitional debate are pregnancy and childbirth as natural, and midwifery as an appropriate response to women's birthing needs. The medical profession has traditionally constructed pregnancy and childbirth as medical events requiring the intervention of a doctor. Midwives were seen as incompetent and dangerous. Recent developments, however have forced the profession to react with an alternative view. It is within this context that I examine their representations of midwifery. I conceive of the medical profession as a group of social actors immersed in a definitional contest over the appropriate meaning of, and response to, childbirth. I explain my theoretical framework more fully in chapter two.

Through my analysis I demonstrate that while the medical representations of midwives were varied and at times even positive, there are indications that physicians remain reluctant in their acceptance of autonomous midwifery, in spite of the 1993 legislation in Ontario which legalized midwifery. I explain this reluctance in relation to medicine's historical representations of midwifery and the professional dominance medicine once enjoyed but now appears to be losing to competing groups of health care practitioners.

1.1 - Organization of thesis

In Chapter II, I describe the historical decline and near elimination of midwifery as a result of medicine's monopoly over childbirth and pregnancy. Central to this history are the tensions between midwifery and medicine. These tensions also inform the more current tensions surrounding the definition of childbirth and pregnancy as medical

conditions, as well as the status of midwifery. I also describe the recent resurgence of interest in midwifery which began in the 1960s and continues today. The height of this resurgence in Ontario is signalled by the 1993 legislation which legalised midwifery.

In Chapter III, I explain more fully the theoretical framework used in my thesis. I outline Freidson's (1970) model of professional dominance and describe the process of "medicalization". Both of these theoretical concepts are interpretive in nature, assuming that medical knowledge and illnesses are subjectively constructed by social actors.

Next, in Chapter IV, I describe my methodological framework which also draws upon a constructionist or interpretive perspective. The literature which informs the "claims-making analysis" approach is discussed as it has been utilised within the field of sociology. I also provide a description of the *Canadian Medical Association Journal* in order to contextualize the source of the medical representations considered in my thesis.

In the following Chapters (V, VII and VIII) I present the findings of my research which consist of the representations of midwifery found in the journal between 1967 and 1997. The historical events surrounding the implementation of midwifery in Ontario provide the basis for these chapter divisions. I describe the formal characteristics and themes which emerged during each time period. I summarize the findings of each period as well as for the entire thirty years. Chapter V includes the years 1967-1985, the years prior to Ontario's announcement of the intention to legalise midwifery. Chapter VI includes the years 1986-1992. This period represents a transitional time in Ontario, following the announcement of the intention to legalize midwifery but preceding the passage of the new legislation. Chapter VII covers the years 1993-1997. This period

coincides with the passage of the Ontario legislation in 1993 which legalized midwifery and continues through the implementation and post implementation period. Also in chapter VII I summarize the findings over the thirty year period.

In Chapter VIII, I link the findings presented in Chapters V, VI and VIII to the theoretical literature on medical dominance and midwifery. I also summarize the trends or patterning in the tone, rhetoric and themes of the claims about midwifery in the journal and speculate about the direction the medical discourse on midwifery is likely to take. Finally, I consider the implications of these findings in terms of the future of relations between midwifery and medicine.

Chapter II: The History of Midwifery: Medical Dominance, Decline and Resurgence

Introduction

This chapter deals with the history of midwifery in North America in a general sense, providing an overview of its decline and subsequent resurgence. I explain how, in the latter part of the 19th century an emerging medical profession medicalized childbirth, discouraged the use of midwifery, appropriated control over pregnancy and childbirth and established a medical monopoly in this area. I also explain why through the 1960's there was heightened interest in midwifery and how this led to changes in its legal status. Special attention will be paid to the development of the "new midwifery" in Ontario and the recent legislative changes there.

2.1 - Early Midwifery

Until the 18th and 19th centuries childbirth was conceptualized as a part of life, attended by neighbouring women who had experience assisting other birthing women and often had children of their own. These women were the early midwives and their role in childbirth was captured by what they were called. Versluysen (1981:23) states that: "The old Anglo-Saxon word 'midwife', meaning together or with ('mid'), and women ('wife'), neatly expressed the sex of the practitioner and the essentially informal communal nature of traditional child-birth management." Bourgeault (1997:1) also, describes early midwifery in a Canadian context as a situation where neighbouring women, experienced in childbirth acted as midwives and were the primary birth attendants.

For birthing women and the midwives who acted as birth attendants, childbirth was a part of life, an event which took place in the home with the aid of familiar women, (Clarke 1990:273). This childbirth culture was very much the norm across North America as well as globally until quite recently. It was not until the middle of the last century that practices of childbirth and childbirth attendants took a dramatic shift towards a medical model.

As I will illustrate in this chapter, this type of midwifery practice was effectively eliminated throughout most of Canada and the United States early in this century. First physicians replaced midwives as the appropriate birth attendant and then, the hospital replaced the home as the appropriate location to give birth.

At the time, medicine was radically different from what we know it as today. Health care was pluralistic. Many different types of practitioners existed in competition with one another. For example, homeopaths, herbalists, osteopaths as well as the early allopathic practitioners all competed for the same clients. Childbirth was not part of the medical agenda for any of these groups.

The professionalization of medicine began around the mid-1800's with the formation of medical associations by the allopaths. Eventually they gained a monopoly and eliminated their competition. As part of their process of professionalization doctors became interested in acquiring control over pregnancy and childbirth. The midwife became a source of competition for the emerging medical profession. In order to secure pregnancy and childbirth into the medical domain doctors launched a campaign to eliminate midwives. Their political campaign against midwifery portrayed pregnancy and

childbirth as dangerous and the midwife as incompetent and a danger as well.

2.2 - The Medicalization of Childbirth and Decline of Midwifery

There are many factors which facilitated the shift from the community midwife to medical practitioner as birth attendant. The status of physicians and their efforts to elevate their trade into a profession are of primary importance as were the claims made about midwifery by the medical community of the time. As part of this process, power, knowledge and occupational territory were central issues in how community midwifery was lost.

Physicians in North America modelled themselves after the elite "gentlemen" who practised medicine in Europe and Britain. As such they were interested in establishing medicine not just as another occupation, but as a powerful and prestigious profession. They wanted to distinguish themselves from the other medical practitioners of the time, as well as dissociate themselves from those of a lower status such as the barber-surgeon. In order to do so, physicians needed to define the territory of their occupation and to secure the exclusive right to their occupational territory. The power of men to claim this territory as well as to secure the training and education, and to set their own standards was not easily challenged at that point in history.

When doctors in North America began to aspire to become professionals, childbirth developed into an area of intense competition (Wertz, 1986). It was during the late 1800's and early 1900's that allopathic medicine in North America was interested in securing a client base by including the birth process under its "professional" domain. Birth represented not only the gateway to life but a method of securing and retaining

clients (Oakley & Mitchell 1978:33; Ontario Task Force 1987:207/208).

However, the development of medicine as a profession was not based in either experience or rational theory. In fact, medicine as such had no real proof of its efficiency or superiority to midwifery in childbirth practices:

> "...the progression from popular birth culture to modern obstetrics took place during a time when, for more than three decades, medical birth in a hospital was statistically more dangerous than birth accomplished at home in the traditional manner". (Ontario Task Force 1987:198)

Most accounts of the decline of midwifery in North America highlight gender, power, knowledge and claims by the medical community about midwifery and childbirth As Ann Oakley notes:

> "The main change in the social and medical management of childbirth in the last century has been the transition from a structure of control located in a community of untrained women, to one based on a profession of formally trained men." (Oakley & Mitchell:1978:18)

Ehrenreich & English (1978:33,34) highlight the epistemological shift towards scientific knowledge and the control of women, rather than the rationalization and pursuit of "progress" as the main mechanism behind the change in birth culture.

Medical training was precarious, and cultural values played a role in preventing experiential learning in the area of childbirth for medical men. When formal medical training was established in North America medical students were not allowed, because of traditional feminine modesty, to witness child birth. It is perhaps not so surprising then, that the community midwives, with their training based in personal experience and attendance at many neighbourhood births had more and better training in childbirth attendance than did the aspiring doctors of the time. Referring to medical students,

Drachman (1981:71) notes that it was often the case that a medical student could graduate from medical training without ever attending a birth.

Some medical historians (Versluysen 1981:30) place an emphasis on technological innovation suggesting that the invention of forceps was responsible for the professionalization of obstetrics and the displacement of midwives by doctors. Technology and more generally medical interventions certainly did play an important role in the shift from popular to medical conceptualizations of birth. But the technological innovations are better thought of as part of the strategy to promote the danger of births without medical attendants rather than as explanations for the shift as pointed out in the important Ontario Task Force Study: "...these new techniques were not available from neighbour women, who came to be portrayed as dangerously unequipped." (Ontario Task Force 1987:206). They were part of the strategy to discredit midwives.

The decline of traditional or popular birth culture in early North America was the result of many factors occurring within a changing society. Such factors include an increase in industrialization; a decrease in the confidence of women about their ability to give birth without medical intervention, the use of middle class feminine "modesty" to justify not educating young women about the birthing process and "innovation" as indicative of progress and modernity.

As such, a strategy involving direct evidence of superior skills and techniques of medicine over midwifery was not possible. I suggest there were two main aspects to reforming birth from a community to a medical event. The first was part of the

professionalization of medicine, dramatically illustrated by Ehrenreich & English (1978:79); "The general reform strategy, then, had to be to ignore the sea of incompetence that was turn-of-the century regular medical practice, and to focus on medical education.....The specific reform strategy was of course to add *science* to medical education."

A second, although related aspect involved a shift in perceptions about birth and pregnancy in order to secure a place for medical men as birth attendants. Pregnant women and other members of society had to be persuaded that birth and pregnancy were medical events to be managed only by medically trained men (Scully 1994:28). Part of this campaign would involve the discrediting of midwives. Medical representations of pregnancy, childbirth and midwives became an important strategy in the medicalization of both and, the decline of midwifery.

An important element in this conversion was the articles and booklets about childbirth which were widely distributed and published in popular women's magazines. They drew attention to the many dangers which awaited the pregnant woman and her unborn child at the time of birth. In addition, public health nurses in the 1920's campaigned, literally from door to door promoting medical child birth. Pamphlets were distributed instructing pregnant women to see a physician immediately. The pamphlets also stated that midwifery was illegal and directed women not to consult them, (Task Force 1987:214). The role of the "nurse as propagandist" (Task Force 1987:212) was of substantial importance in promoting the idea of birth as a medical event. Since employment in nursing was scarce, nurses felt it was to their advantage to promote the

medical model which, in turn, would alleviate their own near desperate situation.

There are strong links historically to be found between territorial claims by physicians/obstetricians and attempts to discredit midwifery care through attacks on character rather than more "rational" attacks on the actual practice of midwifery. As Oakley &Mitchell point out, "There was a strong tendency on the part of the male doctor to regard midwifery as an inferior, dirty, feminine, poor relation of 'proper' medicine"(1978:33). Jordanova (1989:32) illustrates that these views of midwives were not new, "Eighteenth-century writings by male practitioners commonly implied that midwives were dangerous and ignorant by comparison with surgeons and physicians."

Other writings also substantiate this trend, detailing earlier, negative portrayals of midwifery by several prominent physicians in Europe including the Chamberlains (inventors of the forceps). Not only were these representations of midwifery taken seriously at the time but they have had a lasting impact in that the authors of these images of midwifery have "...been eulogized by historians of medicine...." (Merchant 1980:154).

The medical community were not the only source of negative and stereotypical representations of midwives, and as mentioned earlier, the midwife occupied a precarious cultural perch in the 19th and early 20th century.

> "The other less-flattering representation of the midwife is one which was propounded by Victorian writers such as Dickens, that of a dirty, drunken old woman. This image is very powerful, and remained in the constructed image of midwifery until very recently. It was the background to demands by the medical profession that they be given the legitimate control of birth and to the aspiration to professional status by the newly-formed Midwives Institute. It was a portrayal which had to be eradicated by the attainment of public respectability." Hunt

(1995:23)

Lupton (1994) has argued that there are powerful associations between women and nature and similarly between men and culture. Such cultural constructs of femininity as well as the overall status of women in 19th century North America impacted the fate of midwifery as well as the fate of medicine. Nature was not the only thing closely related to femininity. Irrationality and dependence also have strong ties to our historic constructs of femininity. These associations were particularly powerful when women took on the role of midwife or mother (Lupton 1994:69/70). Oakley & Mitchell (1978:33) also characterize midwives as susceptible to feminine stereotypes of the time because of their exclusively female clientele. This caused suspicion on the part of male academics of the time.

Hunt expands on the connections between the midwife and questionable feminine characteristics:

> "Historically, the identity of the midwife as a woman dealing in the private and therefore 'mysterious' female world of birth has always occupied an ambiguous and contradictory cultural space. On the one hand, she was a skilled, knowledgable and paid female worker....whilst on the other hand, the world in which she operated was a hidden one of taboo, male exclusion and ignorance. It was a world surrounded by rumour and superstition, within which the 'wise woman' occupied a position of limited power and authority." (Hunt 1995:22)

It is with an understanding of the "cultural space" occupied by midwives that we gain some insight into how the midwife appeared as a potential threat to larger, more "rational" and male forces in society.

Scholar Ann Oakley characterizes the derogatory nature of early medical representations of midwifery as containing several underlying assumptions. They are:

> "Midwives are ignorant and dirty, therefore their practice is dangerous. Even trained midwives are incompetent. Midwives are especially unscientific because they care for women and children's health generally. Men know more about obstetrics than anyone else. Obstetrics is a science." (Oakley 1993:66)

These assumptions appear to underlie many of the cultural and medical representations of early midwifery.

According to Clarke (1990:274) and Schiebinger (1989:110) there was a class dimension related to the intensity with which the medical establishment opposed midwifery. There was less medical opposition to the midwife's treatment of the poor than there was to their treatment of the middle class. Doctors seemed to mind less about the midwife's "interference" with poor and ethnic women except when these women were needed to train obstetricians (Scully 1994:34).

2.3 - Criticisms of the medicalization of pregnancy and childbirth

The conversion of birth into a medical event was not without its critics. Some medical men were critical of the new ideology which accompanied the development of medicine. This debate is most evident in the development of obstetrics and gynaecology as a medical specialization which emerged in the 1920's. In this early period, ob/gyn was divided among "radicals' and "conservatives" of the time. The debate is interesting because the radical position advocated high rates of surgical and other medical interventions while the conservative position is exemplified in the following quotations:

> "The basic error has crept into the obstetric field that pregnancy and labour are pathologic entities, that childbearing is a disease, a surgical malady which must be terminated by some spectacular procedure...." and, "Many critics (of radicals) emphasized the danger of intervening, while others expressed the fear, first mentioned by DeLee himself, that interventions could too easily be used by physicians to serve their own interests by shortening labors and thus saving

time."(Summey & Hurst 1986a:139)

As they developed and promoted their early technologically enhanced skills, doctors were criticized even by other doctors as having their own interests, rather than the birthing woman's interest at heart. Critics referred to the over-use of procedures, appropriate when needed to save a women's life, in order to entrench their importance and the necessity of the ob/gyn speciality (Sully 1994:30). Midwives themselves were not oblivious to the tactics of the doctors, nor were they ignorant to the potential harm the new technology could bring to pregnant women. They opposed "instrument-aided" childbirth unsuccessfully (Ibid.1994:28). As the popular view of birth as a normal life even and was being usurped by the medical view of pregnancy and childbirth, it became more common for women to give birth in hospital.

Thus, early conservatives aligned themselves towards a male-midwifery model (obstetrics) with a more naturalized approach to birth. Radicals aligned themselves with gynaecology's focus on pathology and surgical interventions. The debate between the conservatives and radicals died down and in 1932 obstetrics officially redefined itself in a markedly medicalized approach to childbirth and pregnancy, emphasizing danger and the necessity of medical interventions (Summey & Hurst 1986a:141). As the two fields of gynaecology and obstetrics merged, the medicalization of pregnancy and the birth process became more and more entrenched within the system and lead to it becoming the dominant view of birth (Summey & Hurst 1986a:142).

2.4 - From Home to Hospital

The shift from home to hospital was not accompanied by a decrease in maternal

mortality rates. Ironically, hospital birth presented more dangers to the expectant mother than did a midwife attended home birth (Evenson 1982:316). Childbed fever was an unwelcome addition to the medicalization of childbirth in North America and in Europe during the nineteenth century (Scully 1994:30/31). This epidemic was not easily remedied and, even into the early twentieth century the maternal mortality rates were still quite high. In England, as late as 1937 there were reports which indicated that hospital birth was not safer than birthing at home (Hunt 1995:10).

Interestingly, Scully (1994:31) notes that medical journals of the time (approximately 1910) were including articles which claimed the dirty, ignorant and incompetent midwife to be responsible for maternal mortality from childbed fever. In a similar manner, Evenson (1982:318) referring to Litoff's 1978 work, notes that in spite of lower maternal mortality rates in the 1930's in the USA, that "Medical journals touted the 'midwifery problem,' suggesting the urgency of eliminating them to 'protect' America's mothers and children." This identification of the midwife as the cause of childbed fever rather than the physician's failure to wash between autopsies and attending births was a powerful tool in entrenching fear of the practice of midwifery. This campaign by medical associations of the time was especially important because birthing women in the late 19th century were aware of the dangers associated with the lying in hospitals attended mainly by physicians.

The contradictions between the claims made by the medical establishment about the incompetencies of midwives and the actual practice of midwifery as well as the statistics on lying-in hospitals did not go unnoticed. The following quotation from Scully

(1994:32) underscores the irony of the physicians' claims of the midwife's ignorance and incompetencies: an article by the American Association for the Study and Prevention of Infant Mortality from a 1912 publication of the American Journal of Obstetrics "If the [woman-] midwife does better work untrained than the general practitioner, what type of work would she do after six months or one year of medical training?"

The influence of the medical response to midwifery was quite extensive as medicine promoted itself into professional status. It went beyond the successful lobbying of government and the entry restrictions to its education programs to having its campaign supported in the media of the time. For example, Clarke (1990:274) notes that "The Globe newspaper opposed a medical monopoly of childbirth until 1895, when a bill to reinstate licensing of midwives was vehemently defeated in the legislature. At this juncture The Globe reversed its position."

And so, both pregnancy and the birth process were perceived more and more as medical events, and the derogatory medical opinion of midwifery developed into public opinion. What we now recognize as the medical establishment including general practitioners and obstetricians succeeded in transforming the perception of birth as a natural process into its perception as a medical condition requiring treatment by a medical "expert". With the popularization of the medical view of birth and pregnancy came the decline and marginalization of midwifery.

Perhaps then, it is not surprising that in spite of the prevalence of childbed fever and the dangers of instrument-aided childbirth, the shift to hospital as the preferred location to give birth continued. Over a span of thirty years (1900-1930) in the United

States, midwife attended home births dropped from 50% in 1900 to virtual non-existence, excepting rural and poor populations (Evenson 1982:315).

With the campaign to medicalize childbirth and shift the desirable birth attendant from midwife to physician a success, there only remained to bring the rest of the homebirth mothers to the hospital. This was a comparatively simple but not unremarkable task, especially since medicine still had no real proof of superiority to the midwife's skills.

These changes in birthing practices were not restricted to North America. Although the midwife did not disappear in Britain to the extent she did in North America, Britain nonetheless experienced major changes in this area:

> "The resiting of childbirth which took place from the late nineteenth century and accelerated during the twentieth century mirrored economic and social change and fundamentally altered professional and popular images of childbirth and motherhood. Childbirth moved from the hidden all-female sphere, where the presence of men was taboo, into the open medicalised sphere where men were present and in control. This altered the social experience of childbirth for succeeding generations of women both as mothers and as midwives." (Hunt 1995:4)

To re-iterate, the medicalization of childbirth along with the demise of the midwife was not based in rational theory. Similarly, the shift from home to hospital was not accomplished through proof of lower mortality rates. These changes then, from midwife to physician and, from home to hospital were not reflections of inevitable progress, but a political accomplishment.

The loss of midwifery care occurred in spite of their attempts to organize and include themselves in the newly flourishing medical industry. As medical schools and

associations were created, midwives were denied the opportunities to organize themselves as a profession or to upgrade their skills through formal education (Schiebinger 1989:105-109). Officially, midwives directed their requests to governments, however, the rejections (supported by the government through legislation) were from the governing bodies of the new medical establishment. Unsuccessful attempts were also made by British midwives to apply to the newly formed medical training establishments. The main obstacle for midwives in this arena was the fact that women were not permitted to attend these educational institutions (Merchant 1980:152).

During the 1940's & 1950's the aggressive ideology of early "radicals" became mainstream within the field and interventions increased dramatically (Summey & Hurst 1986a:106-109). During this period there was such a high demand for obstetric services that the return of the midwife was suggested from within the field of medicine as a remedy for the "manpower shortage".

The use of a variety of interventions including episiotomies, cesarean sections, twilight sleep, epidural anaesthetics to name just a few, increased. Often a single intervention led to further intervention and/or monitoring (Katz Rothman 1983:265). More and more, the pregnant woman was a passive rather than active participant in the birth of her child. There was a general lack of input and control by women and their partners. These developments continued to the point where they began to generate controversies.

2.5 - The status of midwifery

In Ontario doctors successfully lobbied (Ontario Task Force 1987:207) to have

female midwives excluded from the Medical Act of 1857. This left those women wishing to practice midwifery open to prosecution for practising medicine without a license. As a result, the few midwives who continued to practice, rarely in urban areas, and of lesser concern to the medical profession in rural areas, did so under constant threat of prosecution.

In Canada (Burgin, 1994:1), midwifery was either officially illegal according to provincial legislation or was unrecognized and therefore was of alegal status. Because health care in Canada is a provincial matter, each province eventually had different legislation in place with regards to the status of midwifery. In the United States as well, the status of midwifery varied from state to state (Evenson 1982). Midwifery in Ontario was "alegal".

2.6 - The Rebirth of Midwifery

By the 1960's and 1970's the socio-political climate of North America had changed. Establishments of all kinds - medicine among them - were being challenged. There were indications that doctors would no longer be able to define the terms of childbirth. Across the United States and Canada birthing women and their families began to question the need for high intervention. Their concerns were fuelled by studies showing excessively high cesarean and episiotomy rates. These studies suggested that medical interventions were used primarily to benefit the doctor rather than as a necessity for the patient. In addition, and increasingly so, feminist and consumer movements challenged the impersonal hospital environment.

The dissatisfaction with medical births led to the emergence of an underground

home birth movement. This movement developed across North America and Canada. Along with this challenge to the necessity of a hospital birth came a redefinition of pregnancy and childbirth. Similar to pre-medicalization childbirth views, the new definition focused on the normalcy of birth and pregnancy as a natural life events. Part and parcel of the resurgence in interest in natural birth and midwifery was the feminist movement which advocated the concept of transferring control of women's heath care into the hands of women (Bourgeault 1997:2).

This movement demanding more control and a more natural birth was not limited to Canada, nor did it begin there. Describing the upsurge of interest in midwifery in the late 1970's and early 1980's Burgin (1994:1) states that "Parallelling events within the United States of two decades ago, a grassroots consumer movement has recently arisen throughout Canada, stronger in some provinces than in others, giving voice to consumer demands for options not previously available to them except in the underground home birth movement."

In response, medicine did not launch an attack on midwives. Instead it re-asserted the dangers of birth and the need for medical attention. Even more significantly, they responded to the criticisms by co-opting those who were beginning to offer women the birthing experiences they sought.

Summey & Hurst (1986a:136/137) characterize medicine's response to the challenging climate of the 1960's and 1970's as defensive, "Once again the profession asserted its own importance by emphasizing high risk aspects of women's reproductive system, and by moving toward increased specialization." Evenson's (1982:319) findings

are consistent with this characterization. She notes that "Physicians generally maintain a pathology oriented view of birth, emphasizing the risks and dangers which require institutionalized care and subordination of the midwife to physician control."

Beyond affirming the need for medical supervision, medicine launched no concerted or organized campaign against midwifery at this time. The lay-midwives who began to emerge during these years were largely ignored as they practised mainly in rural areas which were understaffed by physicians (Evenson 1982:326). American obstetric journals do not directly mention the pressure they are under from the women's movement and there was little published which reflected the feminist analysis of how women's health care was delivered at the time (Summey & Hurst 1986b:116).

However, some writers such as Burt Rusek (1980) and Summey & Hurst (1986a) have characterized medical responses to criticisms of the interventionist approach and demands for a more naturalized approach to childbirth came as a form of co-optation. For example, Burt Rusek (1980:336) says that if more repressive measures (in response to external pressures) fail, medicine will act to co-opt programs in order to maintain control over the condition or activity.

2.7 - The New Midwifery in Ontario

In Ontario, as elsewhere, there have always been practising midwives, most notably in rural areas, despite the effort to eliminate midwifery entirely. The 1960's and 1970's, however, witnessed a resurgence in interest in midwifery in urban areas among a middle class clientele.

Although they were without legislation, practising midwives were however,

organised, trained and to varying degrees, regulated. There were informal mechanisms of regulation such as personal recommendations from previous "consumers" and slightly more formally, the informed choice agreement. Training consisted of a combination of experiential learning, self-directed reading, apprenticeship, attending many births, correspondence courses, and occasionally, courses taken outside of Canada. Prior to legislation, there was a fee for service form of payment schedule, usually with a sliding scale for fees (Bourgeault 1997).

With the 1857 legislation untouched, Ontario midwives in the 1980s remained "alegal". Midwives were in a vulnerable position because of their legal status. As such they practised "underground", so to speak, and sometimes this resulted in being charged with criminal offenses. The instances where individual midwives were charged with practising medicine without a license, criminal negligence or even homicide served to reinforce the vulnerable status of midwives. Almost exclusively, the source of the charges was the medical profession (Bourgeault 1997:3/4). As a result, midwives turned to more "sophisticated patterns of political actions" (ibid. 1997:4).

By the 1980's, there were a sufficient number of midwives to create an organization Bourgeault (1997:8-10) outlines the development of the Ontario Association of Midwives, (OAM) officially formed in 1981. The OAM became the major organization of practising midwives, and eventually became the primary vehicle for the representation of "midwives' professional interests". There was also sufficient consumer interest in midwifery for the Midwifery Task Force of Ontario, (MTFO) a consumer advocacy and support group, to be created. Its role was to promote the

legalization of midwifery.

The main catalyst which began the push for the change in legislation for midwives occurred when the Health Professions Legislation Review (HPLR) contacted the OAM to inquire into the possibility of midwifery being included in the upcoming legislation. In response to this request the OAM, the Ontario Nurse Midwives Association (ONMA) and the MTFO joined forces and became the Midwifery Coalition. In 1983, the Midwifery Coalition submitted a proposal to the HPLR for midwifery to be included in the new legislation as a self-regulating health profession (Bourgeault 1997:9-12).

In 1986, the Ontario government announced the intention to legalize midwifery. During the period between the 1986 announcement and the December 1993 passage of legislation, the Ontario government created committees to study midwifery practices and establish the form that the new midwifery in Ontario would take. During this time the HPLR allowed other interested groups such as nursing and medical associations to comment on the submission by the Midwifery coalition. Their submission was strong enough to withstand this process and, in 1989, the HPLR recommended that midwifery be included in the new legislation as a self-regulating profession. In 1993, Ontario had the distinction of becoming the first province in Canada to legalize midwifery as an autonomous "profession". And so the fate of midwifery in Ontario has come full circle.

With its newly gained status, midwifery in Ontario has undergone a multifaceted transformation. Midwives now have hospital privileges, and are funded through the Ministry of Health. Training has shifted from an informal, community based

apprenticeship model to a three year university degree program (Bourgeault 1997:20). However, some aspects of midwifery care in Ontario have not changed. For example, women seeking the care of a midwifery do not need a referral from a physician. Midwives have also maintained their community based offices where most visits with their clients occur.

2.8 - Reflections on the history of medicine and midwifery

> "Canada is a dramatic example of the exclusion of midwifery from health care systems. Despite its size and international stature, it was one of the eight countries of the world where midwifery was not recognized legally." (Page 1995:227)

This type of statement was often used by supporters of midwifery in Ontario and other provinces. Although it is no longer an accurate reflection of the status of midwifery in Canada it does reflect the importance of the 1993 legislation change in Ontario. The interest in midwifery has only grown across Canada and several other provinces have announced their intention to have legislation for midwifery.

Despite the changes in legislation across the country and the corresponding public support for midwifery some medical opposition to midwifery remains both in Canada and the United States. Challenges to the midwife's training and competence continue, especially in areas where legislation is under review. There is some evidence (Evenson 1982) from the United States that relations between midwives and doctors who work together in a hospital setting are strained. Evenson (1982:318) cites a recent example of medical dominance over nurse- midwifery care in spite of an impressive standard of care, along with low neonatal mortality and morbidity rates. In this case, permanent

funding for a successful pilot project using nurse-midwifery care was successfully opposed by the California Medical Association.

The success of the submission by the Midwifery Coalition and the resulting change in status of midwifery which followed from the new legislation has dramatically changed the shape of midwifery, as well as maternity care in Ontario. Prior to these changes, medicine, namely physicians and their associations, had total control over maternity care. As a result of the new legislation, physicians and their associations have been forced into a new working relationship with midwives with a corresponding structural changes in health care administration. This new situation raises questions about the extent to which medicine has changed its view of midwifery, which in the past has been quite negative.

Chapter III: Theoretical Perspective: Interactionist and Interpretive

My analysis of the medical representations of midwifery as represented in the *Canadian Medical Association Journal* is informed by an inter-related set of theoretical perspectives and ideas. I briefly described the interactionist perspective in my introductory comments. In this chapter I discuss the perspective more fully and consider how it has been applied more directly in the study of professions and health care. I explain the concept of professional or medical dominance as developed by Eliot Freidson (1970). In addition to Freidson's model I discuss the related concept of medicalization as developed by Conrad and Schneider (1985).

3.1 - Symbolic Interactionism and Constructionism

At the most abstract level, symbolic interactionism represents a perspective in sociology that places emphasis on agency and meaning. This approach contrasts dramatically with the more structural or objectivist approaches which assume that objective conditions and structures hold ontological priority over meaning and agency. From the recognition of meaning as primary, the focus becomes a consideration of how meaning is constructed. Interactionists assume that the meanings we construct for ourselves are the basis for our actions. As such it follows that the study of these meanings will give us greater understanding of the social world we live in. George H. Mead, recognized as the founder of the symbolic interactionist school of thought, began his work as a critical response to the dominant functionalist approach of the time and focused on the primacy of the interpretation and construction of meaning by social

actors.

These abstract premises about the nature of social action have been applied in many more substantive areas of sociology, including social problems. In the study of social problems, symbolic interactionism has contributed to the development of the constructionist perspective. Rather than treating social problems as objective conditions in society that are problematic, constructionism concerns itself with the claims-making process by which conditions come to be seen, or defined as problematic. Constructionists define social problems as a process of claims-making activities (Best 1989: xviii). Best describes the claims making approach: "In this view, social problems are not conditions; conditions are merely the subjects of claims." and, "Claims-makers shape our sense of just what the problem is." This focus on the process rather than the objective condition allows for the underscoring of what "social problems" have in common, namely the claims making process behind them (Best 1989:xix).

The empirical literature that constructionism has generated focuses on different aspects of the process. For example, Best (1989:21-37) considers the role of statistics in the claims making activities surrounding the emergence of "missing children" as a social problem. Based on his analysis, Best identifies three characteristics of the use of statistics by claims makers. They include the use of "big numbers" as they are more dramatic and the use of "official statistics" because they carry more weight and are assumed to be accurate. The last characteristic combines the two: "big official numbers are best of all." In another study, Johnson (Best 1989:5-17) focuses on the power of the media to elicit emotional responses as he considers the role of "horror stories" in the construction of

child abuse as a social problem. He argues that the use of horror stories, like the use of statistics in the previous study, play an important role in the defining of the social problem.

Similarly, other areas within sociology have been re-invigorated by interpretive approaches towards the construction and interpretation of meaning. Parallel shifts in the field of medical sociology (Brown 1996:89), in the study of social problems (Best 1989), and in the professions literature (Pawluch 1997:136) have occurred with a tendency to move away from objectivist studies. As a result, there is a growing body of diverse literature within sociology which utilises interactionist or constructionist assumptions in shaping its research direction. Brown (1996:89) summarizes this shift within medical sociology: "The critique of the medical model has led many sociologists to develop a *social construction of illness* (emphasis in original) perspective which posits that health matters are like other social problems in that they may exist for a long time before they are perceived as problems". To distinguish this new thrust in medical sociology Freidson tells us that these types of inquires are concerned with the "etiology of meaning" (Conrad and Schneider 1985:28), rather than the "etiology of illness" as such.

Pawluch (1996) uses a claims making approach to consider the profession of paediatrics. In describing her study of paediatrics she says, "The new pediatrics underscores first, the extent to which claims making around social problems can become enmeshed with professional concerns, and, therefore, points out the need to look at claims making in the context of professional development."(Pawluch 1996:136).

Similarly, the process of medicalization can become intertwined with the expansion and or defence of medicine's occupational boundaries. Pawluch (1996:133) notes that "constructionists" observations about medicalization are consistent with those of sociologists of medicine who point out that the trend toward medicalization has not been restricted simply to problematic behaviours. As such, the process of medicalization is not limited to "problematic behaviours". Conrad and Schneider (1980:29) refer to Ivan Illich's (1976) work entitled "Medical Nemesis" in which he describes this tendency as "medicalization of life". The medicalization of pregnancy and childbirth are prime examples of this process.

The combination of the interactionist assumptions inherent in the claims making approach along with its focus on how meaning is constructed lends itself well to the examination of representations of midwifery in the *Canadian Medical Association Journal*. The theoretical models of Freidson and Conrad and Schneider complement the claims making approach in that they too focus on the constructions of meaning within a medical context. I will now elaborate on some of the assumptions of the constructionist perspective as they relate to the representation of midwifery.

3.2 - Claims-making Analysis

I have chosen to draw upon the "claims-making" literature to frame my study. This perspective has both theoretical and methodological dimensions. Claims-making analysis arose (Best 1989) from criticisms of objectivist studies of social problems which had not produced a unifying foundation for a theory of social problems. In addition, objectivist studies did not recognize the essentially subjective nature of the recognition of

social problems. In contrast, Best (1989:xvi) notes the centrality of the subjective element to a claims-making analysis when he writes: "Social problems are what people view as social problems."

Claims-making analysis focuses on the activities of claims-makers rather than "objective" social conditions. While the social constructionist lens was developed in the social problems literature it is also applicable to other subject matter such as the professions or, social movements (Pawluch 1996). The claims-making framework applied to the examination of a professional journal can provide information which would likely have been difficult to access otherwise. Pawluch (1996:143) discusses the fruitfulness of examining the professional literature to gain insight into, not only the claims making process, but "The image that pediatricians hope to promote as the new pediatrics evolved, and the rhetoric they used to justify their new roles and interests, were also reflected in their own literature" (referring to pediatrics).

3.3 - Social Construction of Illness and the Social Construction of Medical Knowledge

My use of the terms "illness" and "knowledge" is consistent with the interactionist definitions of these terms. Neither are viewed as objective realities which necessarily reflect either a condition or the "truth" of a situation. H Laurence Ross notes that there is not necessarily an obvious connection between the defining of social problems (or illnesses) and the status of the condition. He states that:

> "The constructionist view of social problems emphasizes the looseness of the connection between the "objective" social conditions and their definition and treatment as social problems. To be sure, problems often are constructed following a critical change in some condition;.....However, problem claims can emerge in the absence of crises, indeed even despite demonstrable improvement

in objective conditions." (Best 1989:177)

This is true too of the defining of illnesses in that an increase in claims making activity is not necessarily reflective of a growing number of cases or new information in the area of concern.

From the social constructionist perspective there is a difference between the bio-physical condition which affects the body and the social designation of that condition as illness. Culture and history play a role in when or if a bio-physical condition will become defined as an illness. Freidson (1970a) points out that the power to define what constitutes illness typically resides in the medical profession. Particularly with reference to "medicalization" the defining of a condition as an illness involves both politics and "morality". These issues will be further developed in the discussion of medicalization which appears later in this chapter.

Jordan points to the connections between the power structures of a society or an occupation and the assigned label of authoritative knowledge. She states that "The power of authoritative knowledge is not that it is correct but that it counts."(Davis-Floyd and Sargent 1997:58). She also talks about how the construction of knowledge becomes "naturalized" and "consensually constructed". Conrad and Schneider (1985) refer to the work of Berger and Luckman when they also note the tendency for knowledge to become naturalized.

3.4 - Professional Dominance

Influenced by symbolic interactionism, but also conflict theory, Freidson assumes power differences among individuals and among groups within a given society. One

arena where power plays itself out is in the occupational sphere, where certain occupations have the power to have themselves recognized as professionals and benefit from the status and prerogatives attached to that label. Unlike the earlier professions literature which understood professions in terms of a set of objective traits, Freidson regarded "professions" as characterized by the power and status they hold. The occupations known as professions are not, therefore, distinct from other occupations because of their content or knowledge base, their sense of altruism and other traits identified in the literature as "distinctive", but because they successfully persuaded the state to regard them as different and hence deserving of the privileges which go along with the title. In this way, the conceptualization of the profession for Freidson remains consistent with an interactionist stance.

Freidson (1970) develops the model of professional dominance based upon the practice of medicine in the United States. Initially, his goal was to establish empirical support for a theoretical model, something which the professions literature of the day lacked. In addition, he wanted to (ibid.1970:82) "...clarify both the sociological characteristics of the medical profession" as well as highlight issues relevant to the sociological study of professions.

Power, is the multidimensional core upon which Freidson bases his model of professional dominance. Coburn (Coburn et al 1983, Coburn & Biggs 1986) summarizes Freidson's model as consisting of four distinct dimensions. These dimensions may be read as the various forms professional dominance takes. They include control over clients, control over other health care workers, control over the contents and conditions

of work and control over health policy.

The crux of professional dominance, according to Freidson, is occupational power as defined through its relationship with the state. The state for Freidson (1970:83) is the "ultimate source of power and authority in modern society." This relationship involves the granting of a monopoly, by the state, to an occupation. Freidson presents this as an accomplishment of the American medicine in the late 19th century. The claims making activities of medicine at this time were successful in that the state did grant a monopoly to mainstream medicine. Its professional association acted as a stabilizing factor in the maintenance of the power and autonomy which flowed from the occupational monopoly of medicine, (Coburn et al 1983:407).

The monopoly gained carried with it dominance over other medical occupations. Within the health care sphere, all other health care occupations became subordinate to physicians. This power is also extended to the occupational training of medical students. Physicians have set the curriculum and standards as well as the entry criteria to medical school.

Freidson (1970:98) identifies the value of independence as an important element which underpins the professional dominance model which is manifest in the power to define content and the power of self-regulation. As such, the value of independence or freedom to practice without interference is central to the concept of medical dominance.

The power of a profession to control the content of its work is the area closely linked with the process of medicalization. Medicalization can be defined as the process by which a condition or behaviour is defined as a medical problem. The medicalization

process will be defined in more detail later in this chapter. Within the context of medicine, the power to control the contents of its work means that physicians and their associations have the power to define conditions and behaviours as medical problems. Once something has been defined as a medical problem, medicine then has the authority to also define the remedy.

David Coburn has written extensively on medical dominance within a Canadian context. Coburn et al (1983) and Coburn et al (1986) have argued that there has been a decline in medical dominance in the Canadian system due to increasing state involvement in health care as well as by increasing pressure to "rationalize" its health care policies. They state (Coburn et al 1986:1045) that "Overall then, medicine, while still dominant, is decidedly on the defensive." In a solo article Coburn (1988:109) argues that there has indeed been a decline in medical dominance in Canada. More recently, Coburn (1997) co-authored an article which again focuses on the changing relationship between the state and medicine in Ontario which concludes that there is considerable evidence for the decline of medical dominance (Coburn et al 1997:18).

Coburn's analysis of the decline of medical dominance permits an explanation of the passage of the midwifery legislation in Ontario. Freidson's model does not explain how a group such as midwives, historically incapable of penetrating the dominance of medicine could successfully manoeuvre their way into a medically dominated system of health care. In the past, medicine has had a great influence on and cooperation from the state in maintaining the freedom to control the contents of its work as well as health care policy. The status of midwifery then, was dependent upon the state's perceptions, which

in turn was controlled by medicine.

In more recent years, the state has pressured medicine to "rationalize" its practices. In addition, the state has promoted a polyvocal evaluation processes which include "consumers" and alternative health practitioners. As a result, medical dominance has declined. For midwifery, this was an opportunity to present its case to a group of legislators which were not solely composed of physicians.

3.5 - The process of Medicalization

In providing a context to the analysis of medical power, Conrad and Schneider (1985) identify the church and medicine in addition to the state as agencies of social control. All three of these institutions have had the role of defining and controlling "deviant" behaviours. However, the state and the church have relinquished some of their jurisdiction as agents of social control. Over time, deviance conceptualizations have moved away from moral and legal definitions towards medicalized definitions. As such, much of what we consider to be "deviance" has shifted "from badness to sickness". Medicine is thus seen as increasing in its power and scope to define and control "deviance" in the post-industrial era, (Conrad and Schneider 1985:28).

Conrad and Schneider's (1985) assumptions about power are parallel to Freidson's in that they adopt a critical sociology perspective. They (Conrad and Schneider 1985:17) state that the power to define and construct reality is unequally distributed and is based on the structure of power in society. The concept of medicalization is directly related to Freidson's references to a profession's power to control the contents of its practice. Medicalization focuses on the process by which

medicine expands its field of practice. This expansion process has connotations of morality and politics. Medicalization redefines deviant behaviour.

According to Freidson (1970:252) medicine is characterized as expansive in nature: "Medicine, then, is oriented to seeking out and finding illness, which is to say that it seeks to create social meanings of illness where that meaning or interpretation was lacking before." It is in the medicalization process that the power to define and construct is most evident in Freidson's model. This expansion is not limited by a rational link between the condition or behaviour being redefined and the knowledge and treatment basis of medicine. Freidson (1970b) is referred to by Conrad and Schneider (1980:14) on this point: "This expansion of medicine, especially into the realm of social problems and human behaviour, frequently has taken medicine beyond its proven technical competence."

Both Freidson (1970:252) and Conrad and Schneider (1985:23) talk about the physician as "moral entrepreneur". The moral entrepreneur concept originates from the work of Howard Becker (1963):

> "Becker notes that the claims of most moral crusaders have humanitarian overtones; they truly think that they know what is good both for themselves and other people. But the crusader or crusading group is also often a self-interested participant in the (deviance)-defining process. The crusader (or the group) is not only crusading for a moral change in social rules, but there also may be a hidden agenda which is of equal or greater import and not immediately obvious."(Conrad and Schneider 1985:22).

Public facts, which are in themselves a construction, are utilized in the political process of medicalization. In this sense, the neutrality of medical-scientific information is questioned as it is a product, that may reflect a hidden agenda or "latent" content. For

example, the use of scientific evidence to "prove" the dangers of childbirth is also a strategy to discredit midwifery. According to Conrad and Schneider (1980:26), "This perspective is particularly appropriate when "scientific evidence" is presented by an agency or organization in support of their deviance designation or to refute the claims of others."

Science is a particularly powerful tool in claims making because of the authority it enjoys in contemporary society. The combination of medical-scientific public facts are not easily challenged as our society tends to view science as the "ultimate arbitrator of reality". In addition, there is what Conrad and Schneider (1985:28) call the hegemony of medical definitions whereby the dominance of medicine is entrenched as an "acceptance of medical authority as the "final" reality and a diminishing of other potential realties." Referring back to Freidson's model of professional dominance, we see that medicine has an advantage in that it can create and legitimate these conceptual definitions which support their interests when compared to the defining power of a marginalized occupation (Conrad and Schneider 1980:25).

To summarize, the theoretical perspective outlined in this chapter allows us to regard physicians as social actors, or a category of claims makers who regard midwifery as problematic. The medical dominance model is applied to the medical profession in Canada where, as in the United States, physicians have been successful in their claims to persuade others, including the state and society, that they deserve special privileges such as self-policing, power in recruitment and training, monopoly over certain procedures and activities, (access to drugs and hospitals) and domination over other health care

providers. Pregnancy along with a number of other conditions, not necessarily problematic, has been medicalized through a complicated political and moral process early in the twentieth century (although the process started much earlier). As we see from Coburn's work, medical dominance and medicalization have been challenged through state intervention and the process of rationalization, leaving opportunities for previously marginalized groups, such as midwives, to gain entry into the health care sphere. The question remains, however, if or how medical views of midwifery have been altered in light of these changes.

Chapter IV: Methodology

In this section I describe the methodology used in this analysis. I analysed the formal characteristics (place, author, length, tone, date) of midwifery representations in *Canadian Medical Association Journal* and I also analysed the themes and meanings in the representations. I describe these two approaches as different "lenses" used in a complementary fashion. More generally, my methodology resembles a content analysis. In a content analysis, the researcher uses a set of methods to systematically examine the "symbolic content of any communication" (Singleton, Straits and Straits 1993:381). The "content" refers to the words as well as meanings contained in a text (Neuman 1997:273). The purpose is to "uncover the *meanings* (emphasis in original) of the message" (Singleton et al 1993:385). While a content analysis combines qualitative and quantitative methods, the emphasis in my thesis is on the qualitative aspects of the analysis. I begin by describing the journal.

4.1 - Description of the Journal

The description of the journal is based on my own observations as well as on an interview with an administrator at the *Canadian Medical Association Journal* office in Ottawa. It is included in order to provide a sense of the "setting" from which I have drawn my data. The *Canadian Medical Association Journal* is the official publication of the Canadian Medical Association. It was first published in 1911 and is published on a bi-monthly basis. Unlike an academic journal, the *Canadian Medical Association Journal* publishes a range of opinions or points of view. It includes peer-reviewed articles, policy statements from the organizational elite of medicine as well as letters and

commentaries from members of its association.

The Canadian Medical Association does not generally solicit articles, with the exception of requests for articles on a specific theme (aging, women's health issues) which are published in a special thematically based issue. However, *CMAJ* regularly includes specific guidelines outlining the requirements for various types of submissions. This information is also available on the *CMAJ* website. The journal will consider unsolicited manuscripts for publication and regularly assigns subjects to, and accepts articles from freelance writers under contract with *CMAJ*.

The journal has a circulation of approximately 60,000 (interview, April 14, 1998) across Canada. Physicians, including general practitioners and specialists alike, account for approximately 55,000 of this circulation total with some of the balance accounted for by pharmaceutical companies which advertise in the journal. It is intended for physicians and is a forum for the communication of clinical, public health, prevention, and political issues relating to the practice of medicine. Original research is published here as well as highlights from meetings, announcements, presidential addresses, special reports and official policies.

Each issue is approximately one hundred pages in length and each issues contains advertisements from pharmaceutical companies throughout. The format or look of the journal has changed over the years and will likely continue to change as each editor has a slightly different vision of the journal. The position of editor is renewed every four years and it is possible for an editor to retain the position for consecutive sessions.

In the 1970's the journal looked much more clinical than in the 1980's and 1990's.

For example, earlier journals appeared to be more oriented towards disease and cure. There were often photographs in the earlier journals, sometimes quite graphic, of wounds or other clinical conditions. Along similar lines, there were photos of patients with black bars across their eyes (in an attempt to preserve the anonymity of the patient) who had specific conditions or diseases which were being discussed. Through the 1980's, these types of photographs became less common. In the 1990's this type of illustrative photography has disappeared. When there are photographs in the more recent issues they are a portrait style of photography, usually of physicians.

Other features of the journal remain quite consistent, such as feature articles on pertinent medical issues of the time, a section for letters, and news briefs. Presently, there are four sections in addition to the above mentioned categories, they are: Education, Experience, Evidence, Editorials. Also included in more recent issues is a resource section (namely book reviews) and a Public Health feature section.

Over the years *CMAJ* has changed its format in an attempt to respond to demands from the CMA membership. For example, the journal was reformatted in 1994, in response to a CMA focus group study which found its members wanted better communication in a regular and accessible format. At the risk of taking his words out of context I am including the 1994 Editor in Chief's comments about his vision for *CMAJ* (152(1):11-12): "The journal's mission is to provide information and a forum for debate, not to convey solely the views of the CMA."

4.2 - Research Design

My study sample is taken from the *Canadian Medical Association Journal* from

1967 to 1997. Instead of conducting an electronic search through "Medline" I searched the indexes and tables of contents for any references to midwifery. In addition to the more obvious search word of "midwife" and its variations I also included searches for references to "home births". I made this decision based on the close association between the two terms.

Historically, the attendant at a home birth was the midwife and more recently, the increased interest and demand for midwifery have often involved the choice of a home birth. Thus, my search parameters include the tightly linked categories of midwifery and home birth. I strived for a high level of consistency in reviewing the journals in this manner in spite of the variations in formatting of the journal which took place over these thirty years. My specific approach to the task of finding midwifery representations in the journal was to begin with the most recent issue and work my way backward until a point of entry for midwifery representations was discovered in the journal.

I will refer to the representations of midwifery in *CMAJ* as "occurrences". I use "occurrence" because of the variations in the format of the representations of midwifery in the journal. "Occurrences" therefore include any text which includes reference to midwifery and could be a letter, news briefs or feature length articles. **The occurrence is therefore the unit of analysis for my study.**

I approached the occurrences of midwifery representation using two different lenses. Each "lens" permitted the analysis of the same material from a different perspective. First, I examined the formal characteristics of the representations, focusing on when and where they were published in the journal. Second I analysed the content of

the occurrences for the themes they contained and the representation of midwifery they offered. When summarizing the information gathered I hypothesized about the patterns in representation which had become apparent. In the next section I will describe in more detail these different approaches, beginning with the least abstract.

In order to group the 'occurrences' chronologically I use the events from the Ontario process of legislating midwifery as naturally occurring points of division. The first period covers the years 1967-1985, the period which marks the emergence of midwifery as an issue in *CMAJ* and ends just prior to the Ontario government's announcement of intention to legalise midwifery. The second period covers the years 1986-1992 and represents a transitional period in Ontario. The intention to legalize midwifery in Ontario has been officially announced but implementation has not yet occurred. The third period covers the years 1993 to 1997 and represents the post implementation of the new midwifery legislation in Ontario.

I am most concerned with the changes in Ontario legislation regarding the status of midwifery, and as such it is the focal point. Ontario was the first province in Canada to legislate midwifery care. Burgin (1994:2) characterizes the new midwifery in Ontario as a role model for the rest of the country. As such, there was substantial interest in the situation in Ontario across Canada. *CMAJ* became a forum for discussion about midwifery in Ontario and elsewhere.

4.3 - Levels of Analysis

I have approached the analysis of the patterns of occurrences using two levels of analysis. The first is that of formal characteristics and the second is that of the claims

making themes which are the basis of my theoretic approach. These themes which can be seen as either for or against midwifery and for or against home births, underlie a range of images, again moving from the negative to the positive. Thus my analysis consists of identifying formal characteristics of the occurrences, the themes that they contain and the images represented.

1. Formal Characteristics

This level of analysis allows for a quick overview of where the occurrences lay within the journal and allows for a tracking of various characteristics over time. It provides a structural foundation upon which the more substantial analysis of the claims-making approach can be overlaid. Table 1, shown below, identifies and defines each of the formal characteristics used to examine the occurrences.

Table 1: Formal Characteristics of Occurrences

Attribute	Description
PLACE	*refers to where, in the journal the coverage of midwifery was published (Letters, News Brief, Health Care, feature article, original research etc.)
LENGTH	*refers to the amount of space taken up by the text in columns or pages
AUTHOR	* the author and their title (MD, PHD, RN, RM, etc.), when included
NATURE OF RHETORIC	*refers to the nature of the information presented (scientific, anecdotal, historical, academic etc)
TONE	*refers to the presentation of the information (sarcastic, instructive, campaigning proseltyzing etc)
RELATION TO OTHER PIECES	*refers to how closely linked a given occurrence is with other occurrences surrounding it (eg. Letters referring to an article or news brief, or another letter)
FOCUS	*refers to whether or not the occurrence is focused on the midwifery debate or midwifery is mentioned in passing

I will now define in a more detailed manner the categories which account for the bulk of occurrences of midwifery representations in the *CMAJ*. The "Letters" section is included in all issues. It is a forum for readers to respond to specific articles or offer general comments on a subject matter covered in *CMAJ*. Nearly all letters are written by physicians, some of whom are writing in an official capacity representing a specific medical association. Occasionally a letter written by a health care professional who is not a physician is published and, less frequently by a lay person. Between five and ten letters are published in each issue.

The "News briefs" section is included in all issues. There is generally one to two pages published in this section per issue. The "News briefs" section consists of several, short, unrelated pieces approximately one column or paragraph each providing a succinct report on a medical issue. "Feature" is the title I have given to feature length articles which do not have a specific heading. There are several of this type of article in each issue. "Inserts" is the title I have given to describe boxed in sections within a longer article, this is sometimes called a "side bar". Inserts are distinct from the rest of the article, with their own titles. They expand on a specific element of the larger article they are contained in, or offer complementary information to the article. Inserts are more likely to be found within "feature" articles.

2. Claims-making

At this level of analysis I focused on the content of the representations in keeping with the claims-making framework. I examined the journal's representations of

midwifery implicitly searching for "claims" made about midwifery and home births by physicians, associations, individual readers, etc. The claims emerged in the form of themes which evoked various images of the midwife as well as tracked the shifting definitions of the "problem" with regard to midwifery and medical childbirth practices. The claims making analysis also provides insight into which groups are involved in making claims about midwifery in the journal.

Themes range from anti-midwifery positions to a conditional acceptance of midwifery. Midwifery is closely linked to the practice of home birth and so the themes which emerged regarding home births parallel the midwifery themes. The range moves from "anti" to "conditional acceptance", to "support" for midwifery or home births.. Table 2 illustrates these parallel themes.

Table 2: Themes

anti-midwifery	conditional acceptance of midwifery	support for autonomous midwifery
anti-home birth	conditional acceptance of home birth	support for home birth

Similarly, there were a range of images of the midwife which came out of the above themes. Five categories based on the findings were created to characterize each image. Below, in Table 3, I identify and briefly describe each image. Although some images are clearly negative, like the midwife from the past, others are more difficult to assign a positive or negative value. I have used a ranking schema to classify these images

from negative to positive based on how they were portrayed in the literature. For example, the nurse-midwife or the obstetric nurse were presented quite favourably in the journal and so they are place towards "positive". The lay-midwife and the midwife from the past, although potentially favourable conceptualizations of midwifery from the perspective of the midwifery advocate, received the least favourable representation in the journal, thus their placement at the most negative end of the range. The characteristics included in this table to describe these images are based upon their representation in the journal.

Table 3: Images of midwifery

Most negative ——————————————————— most positive

midwife of the past	lay midwife	direct entry midwife	nurse-midwife	obstetric nurse
*uneducated *unkept, old *dangerous *practised outside of system	*no formal education *practice outside system *reference	*university degree *licensed *autonomous from MDs	*medically trained *clean, competent *supervised by MD *midwifery is a specialty of nursing	*educated *clean, competent *supervised by MD *no recognition of midwifery as distinct from nursing

In the process of summarizing the information, I examine the patterns of the formal characteristics of the occurrences in combination with the themes and images which emerged from the claims-making analysis. In an attempt to explain these patterns I identify a possible shift in themes which has occurred in the journal's representation of midwifery. And finally, I hypothesize again about the patterns in the representation, this time I focus on the latent content as well as the midwifery literature.

Chapter V: 1967-1985 The emergence of midwifery in CMAJ

5.1 - Formal Characteristics

It was during the years 1967-1985 that midwifery first entered the pages of *CMAJ*. In Ontario the end of this time period is marked by the announcement in 1986 by the Ontario government of its intention to legalize midwifery. During these years there is an average of almost one occurrence per year, with a total of 18 occurrences. However many years do not have any occurrences at all, while others like 1977 have several. The low average over a substantial time span suggests that, prior to the announcement of intention to legislate midwifery in Ontario, there was little discussion of midwifery in *CMAJ*. This is further reflected in the high percentage of occurrences accounted for by Letters and News Briefs combined (74%). Table 4 summarizes the placement of midwifery representation during these years along with their frequency.

Table 4 Formal Characteristics of Occurrences by Place, 1967-1985

Year	LETTERS	BRIEF	"feature"	"Other"	TOTAL
1967	0	0	0	1 book review *1	1
1970	1 *1	0	0	0	1
1977	3 *2	0	2 *2	0	5
1978	0	0	0	1 CMA News	1
1979	1 *3	0	1 *3	0	2
1980	0	1 *4	0	0	1
1981	0	2 *4	0	0	2
1982	0	0	0	0	0
1983	0	1 *4	0	0	1
1984	2 *4	1	0	0	3
1985	0	1	0	0	1
TTL	7	6	3	2	n=18

The asterices denote related occurrences. For example, the *1 shows that the letter in 1970 is directly in response to the book review in 1967. We see that the letters in 1977 were written in response to the "feature" written that same year. This pattern continues and demonstrates that most of the occurrences are closely related to each other. The response letters were punctuated between the few longer pieces on midwifery which were published at this time. Although Table 4 illustrates a sparse coverage of midwifery during this time, the way the occurrences are related to each other suggests that some readers are interested and involved in the issues. Letters tend to be written by physicians,

as were the longer articles. And so I will summarize the structure of the occurrences, based on an examination of formal characteristics of "place", "length", "author" and "relation to others" as largely short pieces, written by physicians, tightly clustered and sparsely punctuated across the eighteen year period. The other descriptors of tone, nature of the rhetoric and focus will be referred to as I discuss the themes which emerged.

5.2 -Themes, 1967-1985

The earliest representations of midwifery invoke "the midwife of the past" imagery, thus setting a rather negative tone as midwifery emerges into the journal's discourse. The midwife is not portrayed as a threat, but often in contradictory terms and closely linked to both science and medicine. Direct reference to midwives equates the midwife with the nurse-midwife and/or the obstetric nurse, moving her image towards a more "positive" representation. The themes which emerge during this time involve criticisms of medical birth practices and the medicalization of birth. The problem defined here is not the midwife encroaching on a physician's practice, but the way that maternity and childbirth care are provided by mainstream medicine.

The focus therefore, is not directly related to the midwifery debate, although there are some implicit connections. The tone and nature of the rhetoric will be discussed as I illustrate the development of the claims in the description of the occurrences which follows. The first two occurrences deal directly with physicians' comments about midwifery and both are described below.

In a book review style article, Roland, MD (CMAJ 1967, Vol 96:1589-1591) mentions his views on midwifery rather casually as he discusses his dislike of a book

"The Mysteries of Montreal" about an early midwife practising in Montreal. His dislike for the book is based in his interpretation that it does not provide much insight into the history of "medicine". In his discussion he refers to the incompetencies of midwives and competencies of medical men of the time, though he does acknowledge some competency in the case of the author/midwife. The tone is authoritative and at times dismissive. The rhetoric is a combination of academic, anecdotal and historical. The following quotations from this book review illustrate these points.

A point to be made about this occurrence is how the author quotes an historical reference to midwifery of the time rather than positing his own opinion of midwifery. The specific context of this quotation is the special recognition the first two male "accoucheurs" of the time deserve (CMAJ 1967, Vol 96:1589): "...as having led the way in overcoming deep-rooted prejudices, and in the transferring to the profession, from the hands of ignorant and uneducated females, the practice of a difficult and delicate art." The image is "the midwife of the past" most definitely a negative one. The author distances himself from this uncomplimentary portrayal twice, by quoting an historical source and also by not using the word "midwifery". Although this is an historical representation which does not necessarily reflect the author's opinions it nonetheless raises questions in my mind about the attitude towards midwifery of the day.

The second occurrence (CMAJ 1970, Vol 102:762) and the first letter about midwifery is generally supportive. The author, an obstetrician refers to British nurse-midwives as quite competent in their craft while commenting on Canada's lack of this "specially trained obstetric nurse". Here we see a dramatic shift in imagery, away from

the "midwife of the past" and towards a more "positive" image. There is no distinction between a medically trained nurse and the concept of midwife in the mind of the author.

In keeping with the first uncomplimentary representation of the midwife, this author also quotes another medical source (a physician and Executive Director of the Canadian Nurses' Association) again distancing himself from this image contained in his letter (CMAJ 1970, Vol 102:762): "The term has a stigma attached to it. It conjures up a picture of an old, un-hygienic, unscientific granny, delivering babies in the backwoods, relying heavily on superstition and magic elixirs." Here we see the image fleshed out a little, and I note key words in this description "old", "un-hygienic","unscientific", "magic". His letter goes on to offer a remedy for this image problem which involves a change in name to portray a cleaner image and a more scientific sounding title of "matrician".

There is again some contradiction in the image of the midwife. Clearly the reputation or image of the midwife is problematic. There is, however, an implication that the association of midwifery with nursing or scientific training, lends some credibility to the midwife. Because the image is largely an historical one, sometimes shifting to the obstetric nurse, there is some support for the notion that the midwives who might have been practising at the time these physicians wrote, were not of much concern and, that perhaps the physicians had little personal contact with midwives of the day. Several emergent themes can be identified from this letter. First is an acknowledgement of a need for midwives (albeit a medicalized version); related to this is the implicit medical scientific training in nursing and supervision by physicians; and finally is the

notion that midwives can be competent in their work (especially if separated from their questionable past).

Several years pass and there is no mention of midwifery in *CMAJ*. But the image of the midwife as obstetric nurse remains and is developed. The midwife is portrayed as competent and professional and of potential help to medicine, particularly to the specialty of obstetrics and gynaecology in light of this area's ongoing problems in recruitment (CMAJ 1977, Vol 117:185&192). There is also a continued recognition of the lack of her services in Canada. The tone is slightly instructive but takes on a campaigning aspect.

The next four occurrences, all in 1977, focus around broader issues of public accountability in medicine. With the claims about medicine we see the definition taking shape. It begins with a page and a half article, "Is gynecology good for obstetrics" (CMAJ Vol 117:287-288) which touts the medicalization of birth as problematic, and suggests a re-naturalization of birth vis a vis the separation of the fields of obstetrics and gynaecology so that obstetrics is practised and researched outside the hospital environment. And so, the image of the midwife is no longer central. The midwife does not disappear but the problems associated with her historical image fade away for a time. There is some mention of more active participation of women in the process, showing concern for the woman's view of childbirth and her satisfaction with the process. Thus, there is an implied sensitivity to consumer demands for a more natural birth experience.

The image of the midwife takes another dramatic turn in 1977. This time the image of the midwife does not include medical training, or subordination to the physician

as in earlier representations where the midwife is equated with the obstetric nurse (CMAJ 1977;Vol 117:287): "The time seems to have come to resurrect her in improved form to replace the usual nurse-doing-obstetrics. We should avoid training her as just another nurse but instilling into her a philosophy based very definitely on physicology and accept her genuinely as a colleague." This image is closer to the lay-midwife or the direct-entry midwife. The direct-entry model of midwifery does not require previous medical training in nursing. In addition, this model does not involve medical training at all. Although this is a positive portrayal, it is not typical of the medical portrayals of this type of midwifery which have occurred in the medical literature of the past.

This same occurrence (CMAJ 1977;Vol 117:287) is notable for several reasons. There is a self-critical tone as well as a positive portrayal of the direct-entry midwife. As the historical literature has demonstrated physicians do not have a history of representing themselves in a self-critical manner. As such, I expected some rebuttal of either the self-critical tone which called for the nothing short of the demedicalization of birth, or of the promotion of the direct-entry midwife. Of the three letters written by physicians, two generally agree with the original article's self-critical tone. The first letter (CMAJ 1977, Vol 117:859) states, "Although I thoroughly agree with the general message of Dr. H.B. Atlee's commentary on this subject...." and, the third letter (CMAJ 1977, Vol 117:1128) is a near repetition, "I agree wholeheartedly with Dr. H.B. Atlee's comments on this subject...."

Despite the consensus, there seems to be a controversy emerging from the first letter's (CMAJ 1977, Vol 117:859) objection to the original article's reference to "the

callousness of professionalism". The second letter takes the form of a poem and the author's intent is not clear to me, although it seems to have a sarcastic tone (CMAJ 1977, Vol 117:1008):

"H.B. Atlee deserves a prize
For new attempts to rationalize
How OB-GYN can humanize,
For many did not realize
The problem's size.

Many of us criticize,
Verbalize and moralize -
But not hypophysectomize -
Our credibility in others' eyes
To jeopardize.

Nephrologists can dialyze;
Urologists catheterize
(Cardiologists too I realize,
But not vasectomize
Or circumcise).

Pathologists can organize,
Formalize and sometimes fossilize;
Psychiatrist can analyse,
Encourage use to vocalize -
Or hypnotize.

Androgens can masculinize;
The pediatricians immunize
But rarely oophorectomize.
Most of us can digitalize
And satirize.

The midwife Atlee would revitalize
And obstetricians feminize.
But don't you think he should revise
His nomenclature and apologize
For asking friends to "physiologize"
And (God forbid) "pathologize"?"

The third letter (CMAJ 1977, Vol 117:1128) takes pains to mention the increased safety in modern childbirth which is the result of the medical profession as well as to state that medicine has dehumanized childbirth. One theme developing here is the tentative consensus about the problems with the way in which medicine has delivered its services to birthing women. A second, contradictory theme is developing with the claims about the improvements to childbirth. This contradiction, combined with an elusive undertone in the responses, slightly defensive in nature, suggests the issues introduced are not completely resolved. There is no mention of midwifery in any of the three letters. This in itself is a curious absence.

The next occurrence (CMAJ 1978, Vol 119:178) is a report on the Society of Obstetricians and Gynaecologists of Canada's annual meeting for 1978 under the heading of CMA News. Its focus is quite technical and mentions midwifery only in passing in a report brief concerning obstetric services in the Northwest Territories. The midwife here is portrayed as competent, and is also a medically trained nurse. She is "essential" to providing obstetric care in such remote regions. The presenter was concerned with how these midwives would be replaced since Canada had no training available, at the time. As was the case earlier, physicians seem to acknowledge that Canada's lack of recognition of the midwife is a problem. As an aside, it is interesting to note that when evaluating cesarean rates, morbidity and "outcomes" the competency of the physician is not generally called into question (CMAJ 1978, Vol 119:185): "As is usual when this subject is discussed, no allusion was made to the influence of the skill, judgement and dexterity of the obstetrician on the outcome for the infant."

The self-critical tone presented as a willingness to demedicalize childbirth continues into 1979 again acknowledging the increasing desire by parents to have an emotionally satisfying and more natural birth experience. For the first time we now see the homebirth option appear in the medical discourse (CMAJ, 1979, Vol 120:1442). Homebirth is introduced here as "retrograde" implying that it along with its traditional attendants (midwives), although they are not named, are and would preferably remain a thing of the past. The image of the midwife is still fluctuating between the nurse-midwife and the midwife of the past.

This small article (about a half a page) catches the attention of a lay-person who has read the article by chance in a waiting room. Happy to see the issue receiving attention in the journal she writes to the editor to clarify what she sees as a superficial approach to creating a home-like atmosphere described in the previous article. As importantly, she emphasizes that cosmetics are not the key (CMAJ 1979, Vol 121:1348): "What they really want, I believe, is the security of being on their own territory and of being in control of their situation." Interestingly enough, this letter generates no published reactions in *CMAJ*.

As is the case with both the above article and corresponding letter, midwives are not directly mentioned. Claims focusing on the undesirability of homebirths are developed, and there is a sense of urgency to disqualify homebirth as an option. In Ontario at this time, there was a increasing momentum in the organization and support behind the midwifery and homebirth movement. It is during this period that the Quebec, Alberta, Canadian & Ontario Medical Associations ban the practice of home birth to

their members. The bans which are reported during this period are likely in response to the growing support for homebirth outside of medicine. The tone is campaigning and then authoritative as the bans are announced.

Issues surrounding the undesirability of the home birth remain a focal point. The 1980 News Brief "Childbirth at home an unacceptable regression Quebec physician says" (CMAJ 1980, Vol 123:1146) takes a particularly strong position, citing opposition even to birthing centres by the British Columbia Medical Association (BCMA) and the Province of Quebec Corporation of Physicians (PQCP). There are also claims of financial considerations, namely that money should stay within the existing medical system. Moreover, we see cited in this article, the theme, introduced earlier that medical technology has improved childbirth, (CMAJ 1980, Vol 123:1146): "...Roy quoted statistics showing that technological advances in obstetrics have improved, not hindered, childbirth in Quebec,..... 'Deaths of women giving birth dropped to one in 10 000 in 1978 from more than 1000 in 10 000 at the turn of the century.'" While British Columbia takes a stand as pro nurse-midwife, it is also against home birth and birthing centres. The tone has become more dismissive of home birth as well as proseltyzing.

The 1981 News Briefs continue along the same lines: "Alberta College bans home births" (CMAJ 1981, Vol 124:1354) and "CMA reaffirms position on home births" (CMAJ 1981 Vol 125:886). The first states that home births are "dangerous" and that doctors are better educated now and are responding to concerns of birthing women. At this point, the dangers of home birth are not provided. The second 1981 News Brief expands the position slightly saying that home births are not in the best interest of

maternal /fetal health, and claims that there is no proof that home births are safer than hospital births. The tone becomes paternalistic as the News Brief concludes (CMAJ 1981, Vol 125:886): "...while doctors have no right to tell women where they can have their babies, these women also have no right to ask doctors to take part in a woman's poor decision to give birth at home." There also seems to be an implication that the "doctor knows best", namely, not to choose a home birth. At the same time, this statement is dismissive of any evidence supporting home birth without directly arguing against it.

There is also a slight shift away from the earlier self-critical theme where medicine acknowledges problems in its maternity care (CMAJ 1981, Vol 124:1354): "The college disagrees with supporters of home births who say that doctors are not sensitive to women's concerns about using drugs in delivery." and (CMAJ 1981, Vol 125:886): "....lay groups that claim physicians make pregnancy an illness instead of an important event to be shared by the whole family do not realize how most hospitals and doctors have changed their attitudes." In these representations the medical community has resolved the "problem" by providing a solution which maintains their role in maternity care. However, there seems to be an implicit shift in the definition of the problem whereby those members of lay groups which criticize medical practices and promote home birth have become the "problem". There has been a shift towards a defensive attitude, and an authoritative tone in the presentation and development of themes of medical accomplishments and the dangers of home birth.

There is no mention of home birth or midwifery in 1982 and only one news brief

in 1983 entitled "Ontario physicians told to discourage home births" (CMAJ 1983 Vol 128:1098) . The tone is very similar to earlier news briefs which announce banning or discouragement of home birth practices. There is no direct mention of midwifery but claims about the dangers of home births are expanded upon (CMAJ 1983 Vol 128:1098): "....even when a pregnant woman has been assessed as a zero risk for complications in labour and delivery, there is in fact a 20% to 30% chance that she will require some sort of intervention available only in hospital."

Ironically, amidst the claims of dangers of home births as well as the affirmations of the safety of hospital births, standards are reported which a physician could use to evaluate the appropriateness of a woman as a candidate for home birth. As such, physicians are positioning themselves to accommodate or co-opt the persistent demand for home births.

In addition there is an acknowledgement for the first time that home birth is not likely to disappear (CMAJ 1983, Vol 128:1098) quoting an obstetrician: "Although it's probably not possible or even desirable to legislate home births out of existence, I think there is a safer alternative." These kinds of contradictions indicate to me that the hard line position against home births is becoming problematic. The tone has become slightly instructive and campaigning.

In 1984 (CMAJ 1984, Vol 130:101) a letter written by a male physician on the subject of home births but not written directly in response to the previous news briefs introduces ethics into the home birth discussion. He claims that it is unethical for a physician to refuse pre-natal care to a women planning a homebirth. Here he adds the

distinction that providing these women with service does not condone home births. This position echoes the sentiment that home birth is not going to disappear and its tone is instructive. Another letter is published not long afterwards (CMAJ 1984, Vol 130:437) which picks up on the idea of caring for women planning home births. This letter, written by a male physician also encourages other physicians to provide pre-natal care to women planning home births, not because of ethical considerations, but because it provides an opportunity to persuade her to have a hospital birth! Neither of these letters mention midwifery.

In between these letters is a News Brief (CMAJ 1984, Vol 130:437) reporting on the dismissal of a Nova Scotia court case in which midwives were charged after a baby delivered at home, died in hospital. Although it is a short report, there are many elements at play and I wish to expand upon them here. Using a campaigning tone, this report purposefully appeals to the emotions of the reader. First "shock" is reported as the reaction of the medical community that this case is not taken to the grand jury. Next, there is "fear" by doctors that not prosecuting these women is the same as condoning home birth. (The claim here is not that all home births are dangerous, but that there is no way to predict which home births will become problematic.) Also mentioned is a statistic citing low number of home births. Finally, "doubt" is introduced: was the death preventable? And to strengthen this question is an appeal to the power of technology as a lack of "equipment" at the home birth is noted.

There is no explicit argument against midwifery or homebirths, but there is a subtle argument embedded in the report which portrays homebirths as dangerous and

those (midwives) who attend them as ill-equipped. The implied image of the lay midwife is a negative one.

The last occurrence of this time period and the only one in 1985 is a News Brief entitled "Home births rated less painful"(CMAJ 1985, Vol 132:825). I mentioned earlier that as the 1986 year approached there seemed to be a softening on the home birth issue and it seems to be turned on its head with this brief. This trend was indicated earlier with the publication of the evaluation criteria for physicians to determine the pregnant woman's suitability for a home birth. There is no argument in support of home births nor is there any explanation offered regarding the reporting of less pain. It is however, the first indication of a positive portrayal of home birth. It is also remarkable that it focuses on the experience of the birthing woman rather than the medical concepts of risks and dangers or the politics of statistics and legislation. In the softening on the home birth issue and the more positive portrayal of the home birth option we can see the impact of the increasing success of the midwives and their supporters in Ontario. As we approach the 1986 announcement in Ontario of the intention to legalize midwifery physicians are again positioning themselves to provide the alternative birth services which are increasing in demand in order to maintain their role in maternity care.

In summary, early representations of midwifery invoke negative historical images of the midwife as well as more positive images of the nurse-midwife and the obstetric nurse. Surprisingly, there was some support for the direct-entry midwife in the self-critical discourse calling for the demedicalization of childbirth. From 1979 to 1985 the focus of the representation related to midwifery centres primarily around the issue of

home births, neither the midwife or the practice of midwifery are presented directly. Images of the midwife nearly disappear, hidden behind discourse about the way childbirth is practised in mainstream medicine, and in the discouragement of the practice of home births. At the end of this period the image of the direct-entry or lay-midwife reappears, strangely triumphant as a court case is thrown out in Nova Scotia. Accompanying the reappearance of the image of the direct-entry midwife is the isolated report of home birth as "less painful".

Occurrences are somewhat varied and include letters, CMA News and several News Briefs, but the majority are tightly clustered and either letters or News Briefs. The claims have shifted away from promoting the demedicalization of childbirth and the problem has been redefined to include the supporters of home birth who are critical of medical practices. Perhaps this debate which also includes ideas about the changes in maternity wards and hospital policies to allow a more home-like atmosphere at the hospital has surfaced in *CMAJ* because of the pressures on medicine from consumer advocacy groups to reform medical childbirth practices.

Chapter VI: 1986-1992: Negotiating the Shape of Midwifery

6.1 - Formal Characteristics

The bulk of the journal's coverage falls within the years 1986-1992. The average number of occurrences has increased from a little less than one to 6.6 per year. During this second period, there is a total of 46 occurrences. This suggests that as midwifery legislation in Ontario became immanent, the number of occurrences increased. There are some clusters in the representations over these years but it is balanced out by the overall diversity and more distinct representations of midwifery. This time period contains the widest variety of coverage within the journal. Although Letters and News Briefs still account for over half of the placement of midwifery representation, the remainder is more diverse than in earlier years. This also suggests more extensive coverage of midwifery issues. Table 5 illustrates the breakdown of the journal's coverage with regard to "place" within the journal.

Table #5 Formal Characteristics of Occurrences by Place, 1986-1992

Year	LETTERS	BRIEF	H. CARE	"feature"	Original Research	"Other"	TTL
1986	1 *1	2	0	1	0	1 Meetings 1 Platform *1	6
1987	1 *2	1	1 *2	0	0	2 Insert 1 editorial 1 policy summary	7
1988	3 *3	3	1	1 *3	1	1 Special Report 1 insert	11
1989	6 *3 2 *4	1	0	0	1	1 Musings *4	10
1990	0	2	1 *5	0	1	1 Insert	5
1991	1 *5	0	0	1	0	1 History 1 Ethics 1 Encore 1 Law	6
1992	0	0	0	0	0	1 Conference	1
total	14	9	3	3	3	15	n=46

Based on Table 5 we can see that there are no years in this period which do not have some representation of midwifery. We can also see that the frequency of representations peaks in 1988/89 and declines down to one in 1992. The 1988/89 peak indicates the intensity of discourse at this time. As such this intensity in occurrences likely reflects the ongoing debates involved in the shaping of the new midwifery in

Ontario. After looking only at frequencies, place, and the relations between the clusters, it becomes apparent that midwifery was of significant interest to the readers and publishers of the journal over these years.

6.2 - Themes, 1986-1992

In addition to the diversity in categories of coverage, this section is also the most complex in the development and presentation of themes emerging from the claims made in relation to midwifery. The representation of midwifery in this period commences with the 1986 News Brief announcing the Ontario government's intention to legalize midwifery. This brief names several members of the committee which will study and ultimately decide the shape of the new midwifery in Ontario. The tone is quite neutral and does not include reactions from the medical community or elsewhere.

There is an attempt to separate the issue of midwifery and home births, but clearly the issue is not resolved at this time. The first example which refers to their separation is entitled "Midwifery and home births" (CMAJ 1986, Vol 135:280/281). The physician who wrote the article presents a variety of material to substantiate his position. In this article he argues in support of an independent, non-nurse midwife but also advocates the disappearance of the self-taught midwife as well as the practice of home birth. Below I will describe in more detail the rhetoric used by the author as he attempts to persuade the reader.

To establish the danger of home birth he references a Dutch physician (CMAJ 1986, Vol 135:280): "Enthusiasts for domiciliary midwifery consider the Dutch experience to be the pinnacle of excellence, but de Hanan stated categorically that

planned home births are more dangerous for both the mother and the infant than births in hospital." He also uses statistics to further support the strength of this medical opinion.. The author refers to the European (and British) situation a second time to suggest that midwives attend "few or no home births." In brief, the rhetoric here is largely academic and scientific.

The next, longer article (CMAJ 1986, Vol 135:285-288) campaigns, using a more academic and scientific rhetoric, for the separation of the issues of home birth and midwifery. Also a physician, the author reviews the relevant literature, citing statistics as well as multiple perspectives (government, consumers, midwives, nurses and physicians). In addition to her goal of establishing a basis which can be used to separate the two issues, she identifies herself as supportive of midwifery as an independent profession "for non-domiciliary care". The midwifery images here range from the support of the direct-entry midwife to the explicit desire to see the lay-midwife disappear. By arguing for the placement of conditions on midwifery practices, physicians are positioning themselves to co-opt midwifery care and maintain some measure of control over maternity care.

The letter (CMAJ 1986, Vol 135:1064) which follows in response to these articles contains some of the most reactionary and defensive statements found over the entire span of years covered in this study. Written by an Edmonton physician, the letter indirectly denigrates the competency of the midwife (CMAJ 1986, Vol 135:1064): "In my opinion high-quality obstetric and neonatal care can be provided only by physicians with an adequate knowledge of internal medicine and surgery as modified to obstetrics."

He goes on to refute the relevancy of Canada's position among the eight countries recognized by WHO without recognition of midwifery. (This point was mentioned in CMAJ 1986, Vol 135:285). Home births are also dismissed as dangerous by citing statistics from the Netherlands which "concluded that hospital delivery under specialist care is most desirable." His tone is campaigning, the rhetoric a combination of scientific, academic and authoritative. He adds to the theme identified earlier which references medicine's accomplishments.

He also stresses that the financial cost of midwifery would be excessive (CMAJ 1986, Vol 135:1064): "The costs to the taxpayer of care for an infant born defective because of obstetric care that was of less than high quality are so enormous that the task is surely to provide adequate numbers of well-trained obstetricians backed by perinatologists in high-risk cases rather than to replace obstetricians by midwives. The financing of schools of midwifery would just add to the taxpayer's burden." The incompetency associated with midwifery care is an additional "cost" of implementing midwifery for the author of this letter. Without directly addressing midwifery care standards, practices or budgeting information he concludes dismissively, (CMAJ 1986, Vol 135:1064): "In short, the legalization of midwifery in Canada appears to me to be financially wasteful and medically obsolescent." His claims combine a negative image of the midwife with further development of the "financial criticisms" theme.

The representations of midwifery which follow, especially over the years 1986, 1987 and part of 1988 are laden with claims which range from a conditional acceptance of midwifery to an at times more marked reluctance to accept midwifery. The themes

which emerge from these claims are structured around issues not only of the safety of home births, the (implied) incompetencies of midwives and financial criticisms as seen above in the discourse about home birth. New themes are structured around positions claiming a lack of need/demand, satisfaction of women with the current system, training/education and benefits to other physicians.

I present these themes as they develop in the articles, letters, news briefs and other forums most intensely between 1986 and 1987. First I deal with the theme of financial criticisms. I have already introduced this theme above in the 1986 letter focusing on home birth. In the next example, a keynote speaker at a medical conference notes that (CMAJ 1986, Vol 135:1391-1392) "....patients would be better served if the government improved the current system of obstetric care." Later in the same article another physician representing the SOGC echoes the financial concern saying "...there will be additional health care costs...." The theme of financial burden is further reflected when it is used to substantiate the CMA's decision to take a position which does not support autonomous midwifery (CMAJ 1987, Vol 136:) "...hospital boards would likely require that a midwife have immediate medical backup, which would pose an increased financial burden on the system." The financial burden theme is developed on a slightly different level as the same article (CMAJ 1987, Vol 136:) goes on to present the CMA's preference for training obstetric nurses to take on more responsibilities as a more efficient alternative to the autonomous midwife.

Still in 1987 (CMAJ 1987, Vol 137:875-877) an editorial entitled "Midwifery and home birth: an alternative view" pursued the theme of financial criticism. With this title,

the author sets an ironic tone to the editorial. There is a sense that the author feels threatened as he describes his anti-midwifery position. Referring to the potential high costs of insuring midwives within the system the author uses finances to dismiss the viability of autonomous midwifery practice (CMAJ 1987, Vol 137:876): "If midwives are to be privately compensated for their toils it is unreasonable to think that a public institution, and thus the taxpayer, should bear the probable increase in insurance costs. Participating physicians may suffer further insurance-cost increases because of the addition of midwives." Claims arguing against midwifery based on financial criticisms is quite widespread and even appears in the insert (CMAJ 1987, Vol 136:648) which elaborates on CMA's anti-midwifery position: "Council members also warned about increasing costs...."

Another theme which is developed extensively in the claims about midwifery centres around a questioning of the " need" for midwifery. In a "Health Care" section entitled "Canadian obstetric care system among finest in world, major CMA study finds" not only commends physicians for their good work (CMAJ 1987, Vol 136:646): "It also revealed that relatively few women are interested in alternative forms of obstetric care - only 21 of the 2002 women who responded to a question on the subject had sought care from a midwife." An "insert" on the next page is even entitled "Midwives not needed: CMA" reinforces the lack of demand theme: "There is no reason for Canada to introduce a midwifery system since there is neither a calculable need nor a significant demand, the CMA has concluded." In a report on "Meetings", a physician and keynote speaker is quoted (CMAJ 1986 Vol 135:1392): "He thinks few Ontario women want midwives or

home births..." Later in 1987 and in an editorial piece a physician questions the need for midwifery (CMAJ 1987, Vol 137:867).

The position that midwifery is not needed because women are satisfied with the current system is closely related to the position which was introduced previously in the journal (1967-1985). Towards the end of that period there were several statements that medicine has effectively responded to public criticisms regarding medicalized childbirth. This position is picked up on again and most markedly portrayed in a "Health Care" feature article written by a freelance writer (CMAJ 1987, Vol 136:643-648). A study was conducted by CMA "the first of it's kind in Canada" which surveyed slightly more than 2000 Canadian women regarding their level of satisfaction with the current system. This study concludes that "most women are satisfied...". A previously cited editorial also argues that the current system is sufficiently meeting demands of birthing women (CMAJ 1987, Vol 137:867): " Instead I see overwhelming support from families for the present obstetric health care system, which has a proven record of safety and is dynamically evolving to respect consumer demands.13" The same editorial piece restates this position by reviewing American studies which he concludes suggest " a lack of demand."

This theme persists in 1988 where a News Brief reports that (CMAJ 1988, Vol 138:57) a Vancouver physician requests an inquest into "an unsuccessful, midwife-attended home birth in which a baby suffered brain damage." The unfairness of criticisms of hospital births as the Vancouver physician is quoted:"Hospital policies have changed dramatically in the last 10 years. The environment is much more flexible." which reflects not only the lack of demand theme but refers back to the accomplishments

of medicine theme.

The incompetency of midwifery is an elusive theme, often present as an undertone and or an implication rather than a more bold and direct statement on the competency of midwives. The lack of confrontation inherent in the way in which this theme is presented does not render it any less important. It is even used by the CMA to substantiate their position of non-support for midwives (CMAJ 1987, Vol 136:): The CMA feels that without close medical supervision, problems beyond the scope of midwives' training could go unrecognized or that unexpected medical emergencies, which may develop during labour and delivery, would not receive appropriate attention." A 1987 editorial expands its position against autonomous midwifery by alluding to its competency several times (CMAJ 1987, Vol 137:876): "Among 15 sets of twins, all of the second twins were discovered by the midwife after the delivery of the first twin, and medical help was subsequently called." ... "The authors doubted whether midwives would be able to select normal pregnancies out of a group of women who present for obstetric care." and, "There is no convincing evidence that the midwife is able to recognize low-risk pregnancies..." The image of the midwife invoked by such claims is inherently negative and I would characterize it as the "lay midwife". In addition to the negative images invoked, there has been a shift in the definition of the problem which is central to the discourse on midwifery. The midwife herself (or at least her incompetencies) along with the costs associated with legislating her care into the system have become the problem.

The theme of medical accomplishments is further developed as physicians

continue to report on the high quality of their own maternity care. Claims about the competencies of physicians and incompetencies of midwives are often found within close proximity to one another. In a 1988 (CMAJ 1988, Vol 139:144) news brief claims Ontario is "...a very safe place for a baby to be born and for a mother to give birth...". Interestingly enough midwives are presented here as a potential threat to the low maternal mortality rate upon which this claim is based as the article continues, "However, he is concerned that the situation could worsen when midwives are introduced into the health care system. We certainly hope that the integration of midwives will not lead to any change in perinatal or maternal mortality figures." Again indirectly midwives are represented as incompetent (and potentially dangerous).

At times, the claims about midwifery in the journal include references to physicians' concerns about losing business if midwives were to be officially recognized by the government. Below are two examples where physicians have expressed this concern openly. The first example is taken from a "Meetings" article (CMAJ 1986, Vol 135:1392): "Dr. Don Collins-Williams said normal obstetrics has always been "the domain of the family physician", and should stay that way because the GP knows the patient's health, attitudes and family." The second example is taken from the findings of the study which examined physicians attitudes towards midwifery licensure. A small number of physicians who were against midwives becoming licensed in this study used this type of reasoning (CMAJ 1988, Vol 139:395) : "... and thought that it would have a negative effect by decreasing the size of their practice or forcing them out of obstetrics.'

In addition to these themes which emerge from the more critical representations

of midwifery, are the more supportive representations whose claims are formatted to promote a conditional acceptance of legislated midwifery. The image of the midwife is closer to the nurse-midwife or obstetric nurse, trained and supervised by physicians and working in hospitals. This image is closely related to the themes of training and autonomy. There are several examples which illustrate this image as presented in concert with the training theme between 1986 and 1988.

A letter, largely opposed to midwifery (CMAJ 1986, Vol 135:1064) nonetheless advocates medical training as a requirement for midwives to practice. A 1986 report (CMAJ 1986, Vol 135:1390) of the Ontario Chapter of the College of Family Physicians of Canada meeting (CFPC) shows that these physicians imagine midwives will be medically trained: "...GPs should be "integrally involved" in the training of midwives." More support for the medically trained midwife comes on the heels of the CMA's recommendation (CMAJ 1987, Vol 136:648): "...that plans by provincial governments to license midwives 'should not be pursued'." In a letter reacting to this announcement a physician writes (CMAJ 1987, Vol 136:1019): "I was sorry to learn ....that the CMA has washed its hands of midwives, since I am convinced that midwives have a lot to contribute to obstetric care." and "I am referring, of course, to those who have undergone rigorous training and passed appropriate examinations." In this same letter the author goes on to say (CMAJ 1987, Vol 136:1019): "Doctors and hospitals could lay down training requirements and supervise the performance of midwives in a way not possible up to now." Later in 1988, the report on an evaluative study concerning physicians' opinions of midwifery licensure (CMAJ 1988, Vol 139:396) conducted in the Ottawa-

Carleton area of Ontario found most physicians surveyed believed that midwives should first be trained as nurses.

However, the medical training of midwives becomes controversial and even contradictory. For example (CMAJ 1986, Vol 135:1392): "The chapter sees "real problems" providing enough training for both midwives and GPs, and insists that midwives must not be trained at the expense of family medicine residents." In a previously cited 1987 editorial (CMAJ 1987, Vol 137:876) the physician/author hypothesizes about training problems for midwives: "Already the family physician in training is having some difficulty in this respect. There will probably be significant obstacles for the midwife in training in either the teaching or the nonteaching hospital." These claims raise questions about the extensiveness of the resistance to midwifery, reflecting a multi-levelled opposition to changes in legislation.

Closely related to the themes surrounding the training and competencies of midwives is the theme of autonomy. The image of the midwife is more positive, but again she is either an obstetric nurse or a nurse-midwife. Hypothesizing about the possible roles a midwife could play in the Canadian medical system one physician writes (CMAJ 1987, Vol 136:1019): "During labour, if allowed into the hospital, they might even conduct the delivery under the obstetrician's supervision." He goes on to describe midwives providing continuity of care "....if she was in the employ of the obstetrician and was granted hospital privileges, as long as the obstetrician was responsible for her actions." The idea of midwives taking a subordinate role to physicians was also reflected in the 1988 findings of the study I mentioned earlier which polled doctors on their

opinions about licensing midwives (CMAJ 1988, Vol 139:3960: "Most physicians, on the basis of their experience in sharing care with nurses during the prenatal and intrapartum periods, thought that care provided by a midwife should continue to be given under a physician's supervision." Again the image of the midwife is the nurse-midwife. This conditional acceptance still allows for co-optation of midwifery as well as permits medicine to maintain some measure of control over the practice of midwifery.

Often presented in conjunction with support for a medically trained midwife are the possible benefits to medicine, specifically to obstetricians and gynaecologists. One such example is aptly written in a letter showing support for the legislation of midwives. The author is not pleased with CMAs 1987 recommendation that the licensure of midwifery should not be pursued (CMAJ 1987, Vol 136:1019): "Another spin-off, as it were, of giving midwives a place on the obstetric team should be a reduction in their clamour for "free-standing birth facilities", a suggestion the CMA deplores." Physicians in the Ottawa-Carleton region (CMAJ 1988, Vol 139:396) suggested in a survey that it (the licensure of midwifery) would be beneficial to obstetricians allowing them to concentrate more on high-risk cases since many family physicians are opting out of providing maternity care. This theme clearly flies in the face of claims that question the need for midwifery .

In 1987 the CMA publishes its official position on midwifery based on findings in its 1987 study recommending the licensure of midwifery should not be pursued. The statement reads as follows:

"The CMA does not support the establishment of midwives as an autonomous

> health care profession. A detailed study of obstetrical care by the association indicates that the present system contains all the resources and personnel required to provide the highest quality of obstetrical care to Canadian women. The CMA recognizes the major contributions of obstetrical nurses and believes nurses could be trained to assume more obstetrical care responsibilities under the direction of physicians." (CMAJ 1987, Vol 136:)

Although this is a position statement it does not necessarily reflect a consensus of opinion among Canadian physicians. This position statement represents a tactical manoeuvre by physicians to support one of the claims made in opposition to the legislation of midwifery, namely the "midwifery is not needed" theme. It is significant because of the appeal to the legitimacy and supremacy of the scientific study in order to substantiate their claim. As such, their claims questioning the need for midwifery become strengthened. Their claims in this area are further formalized and entrenched by the adoption of the CMA findings into its stance as an official position of the Canadian Medical Association.

Referring back to the theme of training, I again note the letter supporting midwifery (CMAJ, 1987, Vol 136:1019) which was published following the presentation of the CMA study's findings that midwifery is "not needed". Not only are some doctors taking opposition to this position, there is continued support for midwifery outside the medical establishment which is noted in the next occurrence. Clearly, there are divisions among physicians regarding the status of midwifery.

The last mention of midwifery in 1987 is a News Brief which follows up on the above CMA position statement. It notes that (CMAJ 1987, Vol 137:1032): "Despite a recent CMA study on obstetrical care that rejected the need for a midwifery system in

Canada, an Ontario task force has called for the licensing and training of midwives." Reaffirming the claims against home births this brief refers back to the position that home births "do not reflect optimum health care - it is an outdated practice." It also questions why retraining of obstetric nurses was not pursued. A little later in 1988, another News Brief announces that the CMA has created a subcommittee whose task is to (CMAJ 1988, Vol 138:731) "keep track of the current debate about the provision of obstetrical services by midwives."

All of the themes which come out of the critical and conditional acceptance of midwifery suggest a reluctance by physicians and their associations to accept any changes to the status of midwifery. Anecdotal, scientific and academic rhetoric were used to substantiate the various claims presented. The length and placement within the journal also varied, although the authors, where identified, largely remain physicians and their associations.

The 1988 report entitled "Prenatal care: a comparative evaluation of nurse-midwives and family physicians."(CMAJ 1988, Vol 139:397-403) marks a departure from the hypothetical discourse on how midwives might practice in Ontario to an evaluative study of the practice of nurse-midwives. Briefly, the article can be described as taking the standard format of an academic paper, with an abstract, methods, findings and discussion sections. To summarize I quote from the abstract (CMAJ 1988, Vol 139:397): "These findings, even when considered in terms of several biases that may have resulted in the high proportion of NM (nurse-midwives) charts rated at least adequate, suggest that NMs provide prenatal care to low-risk women that is comparable,

if not superior, to the care provided by FPs (family physicians)."To clarify this quotation, their study based their evaluation on chart completion rates which the authors cite as an established methodology. In their conclusion the authors state (CMAJ 1988, Vol 139:403): "Although the assessment criteria should be revalidated with the use of maternal and infant outcomes, the findings of our study suggest that NMs, with appropriate support, can provide safe and adequate prenatal care to low-risk women." I have included this last quotation to illustrate that the authors do not seem interested in promoting non-medically trained or autonomous midwifery. Their tone is therefore more instructive than campaigning. Nonetheless, their report generates substantial controversy a little later in 1988.

Continuing the trend away from a debate centred discourse a "Special Report" in 1988 (CMAJ 1988, Vol 139:769-772) provides an overview of events surrounding the rising interest in midwifery in Alberta, British Columbia and Ontario. It briefly reviews recent cases of midwives involved in court cases as well as the 1987 CMA Statement on the Role of Midwives and notes that:

> "Despite such misgivings, the cause of midwifery has continued to gain support from individual doctors and other medical groups. In 1985 the Alberta chapter of the College of Family Physicians of Canada (CFPC) recommended further investigation of the possibility of using trained midwives in an economically feasible role in office and hospital settings under direct medical supervision." (CMAJ 1987, Vol 139:769)

The autonomy theme is defined here according to the Ontario chapter of the CFPC: "We aren't talking about direct supervision all the time, but we believe there should be medical screening by an obstetrician or family physician prior to referral to a midwife..."

There is more support noted from doctors in BC who petitioned the BC College of Physicians and Surgeons "...protesting its hard-line interpretation of the Medical Practitioners Act and subsequent move to forbid any form of collaboration between physicians and midwives." This illustrates the divisions amongst physicians as well as between physicians and their associations.

The themes regarding benefits to medicine and concerns over loss of business are picked up in the Special Report. References are again made to the declining number of physicians available to provide services for "low-risk" patients. This article also addresses the fear of losing patients to midwives expressed by some physicians (CMAJ 1988, Vol 139:772): "'People will not lose their patients if they refer them to a midwife. In fact, it has been shown in Washington, where there is a legal midwifery system, that midwives also refer [patients] to physicians'"

The home birth question is also tackled here and briefly characterized as "rhetoric" which has served to obscure more important issues. Although the Midwifery Task Force's (MTF) position of the midwife as a partner in health care is directly referenced there is not a clearly stated position in this article with regard to level of autonomy for midwives. The article concludes with an indicator of how little the public may know about what a midwife is. It reports that the responses to a newspaper ad run by the MTF solicited calls between ten pm and midnight by men (CMAJ 1988, Vol 139:772) "...saying they needed a midwife right away. It turns out they thought a midwife was someone who would look after their needs if they were between wives."

The half-page insert published about midpoint in the Report described above is

entitled "For some women, there's no place like home". It considers why women would choose a midwife's services when (CMAJ 1988, Vol 139:771) "Advances in medical science have lowered rates of infant mortality to levels Canadians can brag about.". The response provided include familiar themes of rigid hospital rules and a preference for alternative choice. However, when the author adds "Women's support for midwives is an act of faith, unshaken even when a baby dies." suggests a certain irrationality in the decision to have a midwife attended birth. This insert also outlines the current structures of midwifery practice outside the medical system as without legislation, without formal organization or legal protection and questionable accessibility to the poor because fees are not covered.

The next occurrence, an anecdotal essay in the Health Care section in 1988 marks the first positive portrayal of homebirth attended by midwife. This story of an "intelligent couple" who chose a midwife and home birth for the birth of their third child is authored by a physician who is also a CMA contributing editor. The following is a description of the midwife chosen by the couple (CMAJ 1988, Vol 139:773):

> "Mary Sharpe has either delivered or assisted in more than 700 home births. She is 45, with a soft and gentle voice and kind face.
>
> Sharpe trained at a birthing centre in Texas, where she gained a lot of experience in handling abnormal deliveries. Despite that training, she is very conservative in selecting candidates for home birth."

The birth is described from the physician/author's perspective (CMAJ 1988, Vol 139:773): "I had an opportunity to witness the birth, and as a doctor used to hospital deliveries I found it an extraordinary experience." The reader is left with the impression that even a physician can be in awe of such an experience. He goes on to describe the

birth as a family event which included the couple's two small children.. His chronicle is accompanied by photographs before, during and after the birth.

Many elements separate the contents of this "Health Care" article from other representations of midwifery. These elements include not only the presence of the photographs but also the image of the lay-midwife as a modern woman, an individual, with training, experience and competency. Most notably, there is no published reaction to this material either in letter format, a follow up article or editorial.

What follows this birth story are nine letters all of which refer back several issues to the Original Research report which found nurse-midwifery care equal or superior to care provided by family physicians (CMAJ 1988, Vol 139:397-403). There is a general overtone of defensiveness which colours these letters. Many of the letters were indirectly critical of the study's findings by focusing largely on problems with the methodology employed. For example, the first letter (CMAJ 1988, Vol 139:930) asks: "Is anyone surprised if the paperwork is completed when four midwives have given prenatal care to an average of 6.3 women each per annum over a 2-year period? They were hardly overworked!" and, "Personally, I have no doubt as to the efficacy of midwifery, but I am left with too many questions about this paper, which seems to conclude that four under worked and well-motivated midwives can fill out forms on 51 low-risk women in 2 years and that there was poor charting by family physicians working at their usual rates and not warn that they would be audited."

The second letter, also published in the same issue takes issue more directly with the use of the completed chart as an indicator or quality of care. He also takes issue with

the "low midwife-patient ratio" and finally concludes (CMAJ 1988, Vol 139:931): "I feel that the introduction of nurse-midwives will be a costly "add-on" to our health care system and will further dilute the experience of family physicians interested in maintaining obstetric skills." His comments pick up on the parallel themes of financial criticisms and competition for physicians.

In the third letter (CMAJ 1988, Vol 139:931), one of the study's authors is given the opportunity to respond to the above two letters. She cites the lack of evaluative literature on midwifery and suggests that their study is a contribution upon which others will build. The rhetoric here is quite scientific as she refers to significance statistics used in their study and substantiates the methodology used as established in the appropriate literature. Her tone is instructive.

Published early in 1989, a fourth letter critiques the findings from the same article. He agrees that the report demonstrates the nurse-midwives had better completed their charts, but he adds (CMAJ 1989, Vol 140:14): "What has not been established is that this quality will continue when nurse-midwives become a mainstream alternative with a full case load and without having to prove themselves." He goes on to suggest further flaws with the study in question. The fifth letter follows directly and is a response to the above criticisms by one of the study's authors. Her letter has a defensive and somewhat irritated tone to it. Shortly afterwards, four more letters regarding this same study are published in the same issue of the journal (CMAJ 1989, Vol 140:107-111).

The sixth, seventh and eighth letters all take exception to the methodology used, namely the criteria used to evaluate quality of care. One letter's author is concerned that

(CMAJ 1989, Vol 140:107) "...the message is conveyed to the public that a dangerous level of care is being provided." (by physicians). The essence of these critiques are summarized in one suggestion the findings should be (CMAJ 1989, Vol 140:110) "...nurse-midwives fill out forms better than physicians". The critical letters are not anti-midwifery per say, (CMAJ 1989, Vol 140:110)"....I am fully in favour of nurse-midwives' joining the health care team, but not at the expense of the reputation of family physicians." The last letter is a response by the senior author of the study. He gives a lengthy and academic response to the criticisms of his study's methodology. The tone is irritated and authoritative. His letter marks the end of this discussion in the journal.

This cluster of letters accounts for the peak in frequency of occurrences in 1988 and 1989 which were noted in Table 6. It is interesting to note that the authors criticisms were not directed at midwifery care, but the methodology of the study.

There is a return to the theme questioning the need for midwifery in the News Brief focused on Quebec (CMAJ 1989, Vol 140:53). In addition, this brief echoes earlier statements implying the incompetency of midwives (CMAJ 1989, Vol 140:53): "The association is also worried that the province's infant-mortality rate will increase 'if there is a return to the past' and babies are delivered at home or in birthing facilities outside the hospital.'"

The first article to follow the collection of letters is entitled "So you want to have the baby at home?" under the heading of "Musings". The information presented is anecdotal, written by a physician who has had professional experience attending home births. The tone is instructive and light-hearted.

He begins by questioning the medical stance against homebirth and relates his experiences, some good and some bad, attending home births. He acknowledges the choice is a reasonable one which can be a "wonderful experience for all concerned" but he also stresses the potential risk of the home birth. He characterizes the risks involved as "unknowns" and by not quantifying the risk seems to avoid medicalizing birth. I include his words here as they better relate the subtleties and tone of his article:

> "If you wish to have your baby at home by all means do so. (Just don't ask me to deliver it - I couldn't stand the strain.)"
>
> "Having a baby at home can be a delightful experience for all of you, but you must accept that there is a risk to the life and well-being of both yourself and your baby. I don't know the size or nature of that risk, but it exists." (CMAJ 1989, Vol 141:248)

The author does not directly encourage home birth, nor does he take a particularly medicalized approach to childbirth. However, he is clearly uncomfortable with the practice of home birth, namely on the basis of the unknown risks involved. However, I characterize this representation of home birth because of an acknowledgement of the pregnant woman's right to make an informed choice.

Unlike the previous anecdotal article showing midwifery and homebirth in a positive light, the above article does solicit two letters. The first of these letters (CMAJ 1989, Vol 141:765) is a reaction from the Society of Obstetricians and Gynaecologists of Canada. There is concern expressed that this article may "legitimize home birth as an intelligent alternative". As well: "We fear that by publishing Green's article in CMA without rebuttal the CMA has legitimized home delivery to some degree. This is unfortunate. Perhaps a follow-up article describing in detail the increased morbidity of

this practice is in order." The tone is formal and paternalistic, while the rhetoric is academic.

The second letter is written by an American physician who regularly attends home births. The American physician, is sharply critical of the high costs of specialized obstetric care (CMAJ 1989, Vol 141:1222): "...one cannot rationalize the allocation of community economic resources to modern obstetric care." (given the low numbers of women who require special interventions of obstetrics). His final remark is open to interpretation but I think it points to the resistance in accepting home births as a viable alternative: "The truth is, we have the statistics. (re: safety of home birth) We lack a society with the courage, faith and will to act on what is known."

In 1990, there is additional reporting of Original Research concerning midwifery. The article entitled, "Interest in alternative birthplaces among women in Ottawa-Carleton"(CMAJ 1990, 142(9):963-969) found that there was interest in alternative birthplaces and recommends that they be considered further in regards to the health care system.

The Medical Associations of Canada continue to oppose the licensure of midwives. In Quebec, the Medical Association is (CMAJ 1990, 143(10):1099): "...accusing the government of 'responding to the wishes of a very vocal minority that is not competent to judge the consequences of this decision". The QMA is also critical that there will only be one physician on the committee looking into midwifery practices in Quebec. Provincial reporting in News Briefs continues as the Alberta Medical Association takes opposition to midwives practising at home births (they are not safe), as

well as the fees charged by midwives. While it is reported that no meetings are scheduled between the two groups, it is noted that some physicians believe it would be of benefit (CMAJ 1990, 143(11):1212).

A "Health Care" feature changes the focus again as it expands on the positive portrayal of midwifery care from an international perspective. The author, a medical student who studied obstetrics in Kenya for two months advocates university trained and autonomous midwives for Canada. He is critical of home birth practices but most definitely feels Canada has "squandered" the talents of midwives by not acknowledging them officially through legislation and official training programs (CMAJ 1990, 143(12):1353-1355). There is also an insert included in this article entitled "Kenya's traditional birth attendants" which describes how these women are being trained and integrated into the health care system there. There is an emphasis on the discouragement of traditional practices of the local birth culture (CMAJ 1990, 143(12):1354). Again the image of the midwife is the nurse-midwife. Several issues later (CMAJ 1991, 144(5):544) a letter appears which supports the article's author for "...daring to oppose the establishment by advocating a role for professional midwives in this country."

Next I will focus more extensively on the contents of the "History" article (CMAJ 1991, 144(3):339-341). It is written by a freelance writer and stands out among the increasingly positive portrayals of midwifery during this time in the journal. Although not written by a physician, the article cites several medical historical references when she describes the past of midwifery and medicine, thereby using medical and academic rhetoric to substantiate her claims.

The author begins by noting the 1986 announcement by the Ontario minister of health to legalize midwifery as well as the mixed reactions from physicians which has followed it. She then precedes to describe the more distant past of midwifery where (CMAJ 1991, 144(3):339) "...the wise midwives not only succumbed to superstitions concerning childbirth but perpetuated many of the agonies and tortures women had to endure." Also cited are rather unpleasant sounding practices used by midwives of the past. More questionable practices are cited as the birth of a daughter to Marie Antoinette (witnessed by many) is described as "humiliating" and as "public torture". Following this the author shifts to recounting highlights in the history of obstetrics:

> "In the end, it was male physicians, not midwives, who came to the aid of women and alleviated their pain, eventually diminishing the role of the midwife."(CMAJ 1991, 144(3):340)

To this point, the image of the midwife is quite negative and strongly suggestive of inferior care and incompetence in practice. The theme of medical accomplishments is also predominant in this article.

The author returns to the present, and gives the reader a portrait of the modern midwife:

> "Today, with the midwife set to begin playing a more important role in Ontario, her job will be that of obstetric attendant; a major function will be her provision of postnatal home care. She will not assume the role of sole obstetrician, or presume to replace modern clinical and diagnostic consultation." (CMAJ 1991, 144(3):340)

There is not only the dramatic shift in imagery, towards a nurse-midwife and or obstetric nurse, there is no acknowledgement of the heated debate regarding issues of training, autonomy, need or financial criticisms. There is an implied agreement with her image of

the midwife as there is no published response to this article.

The theme of benefits to medicine returns with the next feature article. It focuses, at length, on the shortage of new recruits for the field of obstetrics and dwindling numbers of family physicians willing to provide obstetric care. In this context and although there has not been an official announcement by the CMA, the position that there is no need for midwifery appears to have taken a turn (CMAJ 1991, 144(4):482): "Initially, when the Ontario government decided to legalize midwives 3 years ago, the OMA didn't think we needed a new profession," says Krauser, "Now the association is mainly concerned that they are well trained and integrated into the medical and hospital systems." Like earlier representations in 1986 and 1987, midwives are again portrayed as a solution "...midwives can help ease his specialty's manpower problems..." Further developments in the form the new midwifery will take as there is concern expressed that the midwives will have their own regulatory bodies.

The representation of midwifery drops into the background as it is mentioned only in passing in an "Ethics" section article focusing on "fetal rights"(CMAJ 1991, 144(9):1154-1155). Midwifery again is mentioned in passing in a reprint of a 1935 CMA article (CMAJ 1991, 145(4):319-322).

The final article in this period (CMAJ 1991, 145(4):497-500) mentioning midwifery reports that an Alberta midwife charged with practising medicine without a license is found not-guilty. This decision was based on a distinction between the practice of medicine and the practice of midwifery. Relations between obstetricians, physicians and midwives are reported as more amicable and there was even a recommendation by

the Alberta medical association to support home births (with emergency back-up).

To summarize this section, it is apparent in the representation of midwifery between 1986 and 1992 that a great deal is a stake with the impending licensure of midwifery in Ontario. Issues of training, autonomy and place of practice are at the forefront of the midwifery discussions as well as ongoing questions about home births and economic feasibility. The focus of occurrences of midwifery representations shift when midwifery becomes the subject of "primary research" in the journal. At times midwifery fades into the background of more technical articles. The predominant image of the midwife in this section is the nurse-midwife or obstetric nurse. Other images are considered, but to a lesser degree. And so at the end of this period just prior to change in the Ontario legislation which will legalize midwifery there is a report on another midwife in court as the charges against her are dismissed.

Chapter VII: Post Implementation in Ontario: 1993-1997

7.1 Formal Characteristics

The third period accounts for 25% of the midwifery representation in the journal with an average of 4.4 occurrences per year. Each year has at least one item concerning midwifery with the highest concentration in the 1994 midwifery feature issue. During these four years there is greater attention paid to midwifery outside of the Letters and News Briefs categories. This is primarily accounted for by the feature issue on midwifery. While there is a lower average than in the middle section it may be premature to suggest the decrease will continue. Table 6 provides more details concerning the dispersion of occurrences over time as well as within the journal.

Table #6 Formal Characteristics of Occurrences - PLACE
1993-1997

Year	LETTERS	BRIEF	H. CARE	"feature"	Original Research	"Other"	TTL
1993	2 *1	0	1	1 *1	0	0	4
1994	2 *2	2	0	0	1	1 Editorial 1 Legislation 2 Insert 1 Insert *2 1 Policy Summary	11
1995	0	1	0	1	0	1 Book Review	3
1996	0	1	0	0	0	0	1
1997	0	1	0	0	0	1 Evidence 1 Education	3
total	4	5	1	2	1	9	n=22

The increased dispersion of representation is noticeable as mentioned above in 1994. As the Ontario legislation did not pass until December of 1993, the feature issue in 1994 was in direct response to the legislative changes. It is interesting to note the absence of letters after 1994, which affects the way the occurrences are clustered. There is less clustering over these four years than in either of the two previous periods. From the volume of occurrences in 1994 to the dramatic drop in coverage, there is a sense that perhaps the peak interest in the midwifery issue has passed.

7.2 Themes, 1993-1997

Like the middle period examined the representation of midwifery and surrounding issues remains complex in this section. However, there are some important differences. The differences are found in shifts within themes as well as some self-representation of midwifery care and challenges to medical criticisms of midwifery. As I describe the representation of midwifery in the following pages, I will illustrate these changes.

In the first article on midwifery in 1993 (CMAJ 1993, 148(6):1004-1006) the midwife's place of practice remains a contentious issue. This time the discourse revolves around Ontario's proposed birthing centres to be staffed by midwives. Francis Lankin, the health minister who spear-headed the proposals stresses a shift away from a medicalized view of childbirth and the exclusivity of physicians and hospitals as providers of medical care. In keeping with this shift in philosophy the proposed birth centres are portrayed as a remedy to high intervention rates in delivery which typify

Canadian hospital births. Surprisingly and in direct contradiction to the financial criticisms theme developed in previous years, birth centres are characterized as cost-effective alternatives.

However, as we soon see, the issues surrounding midwifery have not been entirely resolved. Both the Canadian Hospital Association and the Family Physicians of Canada are in opposition to the proposed centres. Family physicians oppose the birth centre concept because they wish to remain primary caregivers and the hospitals believe midwives are too costly and that there is no evidence they are needed. All three of these arguments recall themes developed in the midwifery discussion of the middle 1980's, most notably those which argue for the continued involvement of physicians in maternity care. Two letters are written in response to this article.

The first letter, written by a physician, questions the accuracy of a quotation regarding the safety of epidurals, a procedure commonly used in hospital births (CMAJ 1993, 148(11):1871-1872): "To suggest that the use of epidural analgesia has not been evaluated does a disservice to those who provide this method of pain relief during labour. Perhaps Wagner's comment was taken out of context. If not, other statistics or conclusions from his lecture must be viewed with scepticism." The second letter is a response to this criticism by the article's author, a freelance writer. The author states that the criticisms from the above letter (CMAJ 1993, 148(11):1874):"...is merely the opinion of one physician who clearly has a vested interest in seeing to it that midwives and alternative childbirth caregivers are given as little room as possible to practise in Ontario or elsewhere in Canada. I suspect that Halpern's real concern (author of the first letter) is

not so much the accuracy of Wagner's statements as the threat to his profession posed by midwives who function in birthing centres and don't rely on epidural analgesia." These pointed comments expose a sense self-interest running below the surface in many of the anti-midwifery sentiments espoused by some physicians and medical associations. Though this confrontational letter might have been expected to incite further discussion, it did not.

The discussion shifts to rural health issues with the next "Health Care" article (CMAJ 1993, 149(10):1541-1545) written by an Ontario physician. He explains a rural crisis in medicine as a lack of back-up and emergency services and contemplates what the implications of the changes in midwifery legislation might mean in his own rural Ontario community. The rhetoric is both anecdotal and scientific. He reports on his own survey which found little interest in midwifery with less than 5% (of the women questioned) perceiving the midwife as "the primary caregiver". The physician also surveyed local doctors on the new midwifery legislation (CMAJ 1993, 149(10):1544): "All physicians felt the presence of a midwife as a labour coach would be either unimportant or a neutral factor. Most felt the midwife would not make an acceptable birth attendant." Both of these findings support the theme questioning the need for midwifery.

Furthermore, the practice of midwifery is not perceived as a remedy to the current rural situation and the author is doubtful family physicians would be welcoming the presence of midwives. However he does add, referring to the decline in family physicians willing to provide obstetric care, that outside the issue of back-up, "midwives surely

would be a benefit to the community and, in the long run, would be accepted and busy." The contradictory portrayal of the need for midwifery again reflects the lack of consensus about midwifery.

The next article, an editorial written by a physician (CMAJ 1994, 150(5):657-660) provides the reader with a meta-analysis of midwifery issues as they have developed in a Canadian context with special attention to the resistance of Quebec physicians to midwifery. The author is very thorough, considering a variety of aspects including training, level of autonomy, place and scope of practice. Particularly noteworthy is the author's deconstructing of some of the medical positions against midwifery. Early in the article he critiques the use of perinatal mortality rates in arguments against midwifery by physicians (CMAJ 1994, 150(5):657): "In fact, low perinatal mortality rates have little to do with doctors, nurses or midwives. They are based primarily on favourable economic conditions and low birth rates." Similar to the freelance author's response letter he states (CMAJ 1994, 150(5):658): "It helps to remember that when medicine feels under attack, colleges and bargaining units may have another agenda: protection of the profession from encroachments such as "la medecine douce" - "soft" or alternative medicine (i.e., "midwives today, reflexologists tomorrow"). Attending a birth today is a medical act, and if it can be siphoned away to be performed by another professional group, what next?" and later : "As physicians we have persistently confused midwifery with home birth. To some extent this has been a deliberate confusion, undertaken as a political tactic to prevent the legalization of midwifery." These self-critical comments regarding the ulterior motives of some physicians in opposing midwifery legislation are an interesting

parallel to the earlier self-critical theme which called for the de-medicalization of childbirth. The issues surrounding midwifery, while still important, fade slightly with this shift towards a consideration of the type of claims which have characterized the discourse on midwifery in CMAJ.

Defining midwifery is the topic of the next "Original Research" article (CMAJ 1994, 150(5):691-697). Based on a 1991 mail survey of midwives, physicians and nurses providing maternity care in Quebec, it highlights areas of consensus and disagreement in the defining of midwifery care. The image of the midwife here is as an integrated member of the health care professions. The tone is rather neutral and is accompanied by scientific rhetoric. I refer to the abstract to provide the most efficient reporting on their findings (CMAJ 1994, 150(5):691): "Most of the physicians, nurses and midwives surveyed agreed that if midwifery was legalized, midwives should have a university degree, provide basic care to women with normal pregnancy and delivery, provide prenatal and postnatal care in hospitals and community health centres, perform delivery in hospitals and work in close collaboration with other maternity care professionals. Disagreement existed concerning the level of university training required, the need for training in nursing first, the scope of medical intervention performed by midwives, out-of-hospital delivery, the autonomy of midwives and control over their practice." These findings reflect to a large extent the issues depicted in the journal's coverage of midwifery issues. There seems to be a trend towards summarizing and reflecting upon the themes which were at the centre of the discourse from 1986 to 1992.

The "Legislation" article on midwifery (CMAJ 1994, 150(5):730-734) also tracks

the areas of controversy in physicians responses to the legalization of midwifery in Ontario. Written by a freelance author, this article is several pages long and includes two inserts. This article develops along the lines of economic criticisms of the implementation of midwifery in Ontario. I include several quotations here to show the breadth of the coverage on this point:

> "... 'some very distressed physicians' think it is unfair that midwives will begin earning relatively large salaries during a time of health care cutbacks. (CMAJ 1994, 150(5):730)

A promoter of midwifery and member of the Ontario Task Force for the Implementation of Midwifery says:

> "In the present financial situation, where hospitals are fighting to stay alive, does this really make sense?" Edney asked. "I'm not being antimidwifery, but [it bothers] me that we've just carried along with implementing this program as if nothing had happened to the health care system." and "Edney said the midwifery model developed in Ontario provides a Cadillac service when every other health care sector is economizing." The same person goes on to say "....normal deliveries will not cost any less if handled by a midwife.....we can't afford this the way it's been planned....Does the average person really need more?" (CMAJ 1994, 150(5):730)

And, towards the end of the article:

> "Edney says doctors who challenge the cost of Ontario's midwifery program are not medical dinosaurs. She said they are worried about the cost to the system, not about competition from midwives." (CMAJ 1994, 150(5):734)

The legislation article goes on to discount other criticisms of midwifery care, many previously developed themes in the journal's coverage of midwifery. More specifically, themes concerning the competency of midwives, home birth, and scope of practice (consultation/transfer of care protocols), and competition from midwives are responded to by systematically illustrating how these concerns are addressed by the

model of midwifery care which has been implemented in Ontario. We also see the lack of need theme squashed (CMAJ 1994, 150(5):731): "My greatest fear is that we don't have enough midwives to meet demand.".

An insert entitled "Midwife defends midwifery's cost" is printed about halfway through the above article (CMAJ 1994, 150(5):731). The main points in this "defence" are an acknowledgement of high start-up costs, an overview of a midwife's 45 hr/wk workload and the lack of proof with which to conclude midwifery care is not cost-effective. The midwife also stresses that midwives do not wish to interfere with women who chose their family physician for maternity care, again addressing concerns of competition.

A second insert (CMAJ 1994, 150(5):734) is entitled "The best and the brightest" selected for Ontario's first midwifery program". It mentions the format of the midwifery training, a three year baccalaureate degree and goes into some detail about the scope of a midwife's practice and transference of care protocols. A student midwife is quoted as wanting to foster the "collegial trust" of physicians and describes herself as "part of the medical team". The imagery is that of the direct-entry midwife. As in the previous insert, the shift in midwifery coverage is towards a self-representation which stresses non-competitive practice and the promotion of amicable professional relations with physicians.

An Ontario physician picks up on the finances involved in legislating midwifery (CMAJ 1994, 151(5):516). A section of his letter captures the tone as well as the basis for his criticisms: "In this day of hospital cutbacks and fee rollbacks, paying midwives a

salary of $52,580 or more for normal deliveries is shocking and discriminatory toward all physicians."... and, after an illustration of how midwives earn more per birth than physicians, "If ever a case for pay equity existed this one fits the bill!" In a letter which directly follows, the same midwife quoted in the "Midwife defends midwifery's cost" who is also the president of the Association of Ontario Midwives (AOM) responds. She builds her own case to illustrate the cost-effectiveness of midwifery care, including a description of duties performed by midwives, low rates of intervention and prenatal testing. As in the insert section before this letter, this midwife concludes with an appeal to noncompetitive practice with the established medical team as well as the promotion of collegial professional relations.

The CMA responds officially to the legislation of midwifery in Ontario with an updated Policy Summary on Obstetric Care (CMAJ 1994, 150(5):760A). The bulk of this summary focuses on recommendations for areas of obstetric care within the system which require improvement. They include for example, plans for education of the public about the "nature of childbirth" and risk factors associated with complications in pregnancy and delivery. There is a smaller section on "Nonphysician obstetric care" where the conditional acceptance of midwifery by the CMA is described: "The CMA approves of nonphysician obstetric practice (midwifery care) if it is performed with proper educational training, preferably in obstetric nursing, and a clearly defined scope of practice and is integrated with existing obstetric care team.....The CMA does not approve of home births." The Association is clearly reluctant in its acceptance of midwifery, preferring the obstetric nurse. At the same time, the CMA raises questions of

medicolegal issues and of cost-effectiveness.

The growing popularity of midwifery across Canada gains momentum as the title of the next News Brief declares "Manitoba becomes fourth province to introduce midwifery as insured service". Manitoba is described as following the lead set by Ontario's midwives in establishing midwifery as an autonomous profession (CMAJ 1994, 151(1):71). To date, Ontario, BC, and Alberta have all announced plans to legislate midwifery. Not long after this brief, Saskatchewan is reported to be in the process of a needs assessment of midwifery services (CMA 1994; 151(8):1166). There is the introduction of plans to move midwifery's influence beyond front line care, (CMAJ 1995, 153(10):1508): "Hird said midwives have not yet been included at all levels of health policy development, but they should be. 'If their health needs are to be recognized, women must be represented on the decision-making bodies where fundamental planning of health care occurs.'"

There are more signs that midwives are gaining acceptance in medical circles despite the CMA policy statement on nonobstetric care. For example, midwives along with family physicians and obstetric nurses, the reader is informed, are now able to join the Society of Obstetricians and Gynaecologists of Canada (SOGC) as associate members. Although it has been three years since the vote on this amendment passed, there are two midwives who have been accepted as members (CMAJ 1994, 151(1):88). In addition, midwives have gained recognition by the Canadian Public Health Association (CPHA). Not only does the CPHA support midwifery as an autonomous profession, it also supports public funding of midwifery care as well as the direct-entry

model (no training in nursing) of education/training (CMAJ 1995, 153(7):961).

Scholar, Brian Burtch's recent publication "Trials of Labour: The re-emergence of Midwifery" is reviewed in the journal (CMAJ 1995, 152(6):895). The review is overall, quite positive, although the reviewer notes the academic and "dense" writing style might be a problem. What I find interesting here is not that the book was commended but to whom this book is recommended. Rather than suggesting the book for anyone in the health care field who may be affected by the legislation and might want to know more about midwifery the physician who reviewed the book recommends it to "midwives and those advocating the legalization of midwifery".

Above I grouped a number of "News Brief" announcements together which illustrate midwifery's growing acceptance in several Canadian provinces. We have also seen in this section that physicians are still reluctant to accept midwifery as they continue to state their disapproval of home births, their preference for training in nursing and their ongoing questions about the cost of midwifery care. In 1996 (CMAJ 1996, 155(1):1592) there is an implication that these concerns may be taken more seriously in Nova Scotia as they consider the implementation of midwifery. Although a "critical" shortage of obstetricians and family physicians providing maternity care is noted, physicians assert the familiar themes of reluctance. For example, the Nova Scotia Medical Society (NSMS) supports (CMAJ 1996, 155(1):1592) "a properly established midwifery service, which operates collaboratively with all other providers of obstetrical services and in appropriate facilities....the society cautioned that the cost-effectiveness of midwifery should be evaluated prior to implementation and re-evaluated regularly."

Earlier announcements regarding the plans of other provinces for midwifery do not include these themes and, for the first time, the conditional acceptance of midwifery includes a prior evaluation of its cost-effectiveness. The theme of financial criticism now framed as "cost-effectiveness" seems to be gaining credibility. It is the only theme which was not portrayed as resolved in the 1994 Legislation article.

The next article (CMAJ 1996, 156(6):775-784) is another first in the representation of midwifery in the journal. It is the first time that a midwife, now with the title "RM" is included as an author of a peer-reviewed article of an original study. The study included all Ontario midwives as participants which was designed to evaluate practices, knowledge and opinions of health care providers on the Ontario Maternal Serum Screening Program. Midwives here are represented without commentary on their professional status, training or other attributes as full-fledged members of the health care team. This type of representation of midwifery continues as the next article (CMAJ 1996, 156(6):831-835) mentions midwives rather casually and only once as part of the health care team.

Despite the recognition of integration into the health care team implied in the two previous, technical articles Canadian physicians are still struggling to have their say in shaping the practice of midwifery. The last representation of midwifery I found is a News Brief which outlines the conditional support for midwifery by the Manitoba Medical Association (CMAJ 1997, 156(8):1108): "The MMA supports implementation of regulated, hospital-based midwifery and hopes that it will eliminate lay midwifery but believes that all providers who practise obstetrics should be overseen by a single

regulatory agency." This is in sharp contrast to the earlier News Brief which announced Manitoba's intention to legislate midwifery practice (CMAJ 1994, 151(1):71): "Midwifery will be an autonomous profession covered by its own legislation and regulatory body, and will provide women with new childbirth alternatives and services, Health Minister Jim McCrae stated in a press release."

In spite of continued criticisms regarding midwifery, there is an implied success outside Ontario as several other provinces are shown to have an increased interest in midwifery. In addition, midwives are included for the first time as co-authors of technical articles suggesting that they have indeed become members of the medical team. Representations of midwifery by midwifery advocates and midwives marks an important distinction in how midwifery is represented after the legislation in Ontario was passed. There is an ongoing questioning by physicians of the cost-effectiveness of midwifery as well as her training. Economically based criticisms are strengthened in this section when they are espoused by midwifery advocates. Longer articles (outside Letters and News briefs) appear to be more multidimensional in that they include multiple perspectives on the issues.

7.3 Overview of Formal Characteristics, 1967-1997

After presenting the formal characteristics and themes of each period separately, it is helpful to review the data overall. As such, this next section summarizes the formal characteristics from 1967-1997. The themes which have emerged from the data will be summarized at the beginning of the discussion chapter.

I counted eighty-seven occurrences dealing, either directly or indirectly, with

midwifery. The occurrences were distributed throughout the different sections of the journal suggesting a diversity in levels of reporting and discussion about midwifery. However, the majority fell into the "letters" or "news brief" sections. Table 7 (shown below) summarizes the Place, Length, Author and Nature of Rhetoric categories of the formal characteristics as well as their frequencies and percentage of total occurrences. It includes only those sections which had two or more occurrences. A more general description of the sections accounting for the remainder of the midwifery representation will follow Table 7. The categories identified in Table 7 are the actual headings found in CMAJ. There are two exceptions which I have labelled as "feature" and "insert" categories because they did not have their own headings.

Slightly more than half (52%) of the occurrences were Letters or News Briefs, with letters representing 28% and News Briefs representing 23% respectively. The volume of letters suggests to me a fair bit of interest among the readers of CMAJ in the issues surrounding the practice and status of midwifery. The coverage in the News Briefs category suggests an interest in tracking the progression of events regarding the status of midwifery across Canada rather than extensive or in-depth reporting on midwifery.

Table 7 Frequencies and Descriptions of Formal Characteristics, 1967-1997

#/%	Place	Length, Author, Nature of Rhetoric, Tone
20 (23)	News brief	*one paragraph or column *no author indicated *rhetoric varies *tone is usually neutral, reporting style
8 (9)	"feature"	*several pages in length *authors vary, MDs, academics, freelance journalists *rhetoric varies *tone varies
7 (8)	"insert"	*length varies from a couple of paragraphs to close to a full page *no author indicated *rhetoric varies *tone varies * boxed-off but contained within a longer article
4 (5)	Health Care	*several pages in length *author is usually an MD *rhetoric varies - can be academic or anecdotal *tone varies - can be campaigning
3 (4)	Original Research	*multiple pages *multiple authors, academic and medical *rhetoric is scientific and/or academic *tone is generally instructive
2 (2)	Editorial	*one to two pages in length *author is an MD *rhetoric varies - can be anecdotal *tone varies - can be sarcastic
2 (2)	Book Review	*length varies - one column to two pages *author is an MD *rhetoric varies - historical, academic *tone varies - sarcastic, instructional
2 (2)	Policy	*length varies - one half to a full page *no author indicated - represents an Association *rhetoric is academic *tone is authoritative

When the overall occurrences are broken down into the three time frames introduced earlier in the methodology chapter (1967-1985; 1986-1992; 1993-1997) patterns emerge in the location of the reporting on midwifery within individual issues of the journal. The percentage of coverage in form of News Briefs and Letters has declined over time. Letters and news briefs account for nearly 75% of the occurrences of midwifery representation prior to 1986, 50% of the occurrences between 1986-1992 and finally, post 1993 they accounted for 40%. This suggests an increase in other types of occurrences about midwifery and a move to perhaps a more substantial reporting on midwifery possibly because of its gains in popularity and in the political arena towards its legislation in various provinces.

In addition to the location of the occurrences across time there are two main clusters of occurrences which deserve mention. I again refer back to the events surrounding midwifery legislation in Ontario to offer a possible explanation for these clusters. The first is found shortly after the 1986 announcement by the Ontario government of the intention to legalise midwifery. This cluster peaks in 1988 & 1989 with 11 and then 10 occurrences respectively. The second cluster of 11 occurrences is found in 1994 shortly after the 1993 implementation of Ontario's new midwifery legislation. More generally, if we look at where the bulk of the coverage occurred regarding the time periods I've identified we can see that more than half the coverage (53%) occurred between 1986 and 1992, with the pre-1986 and post 1992 coverage representing 22% and 25% respectively. This reflects the increased amount of activity

surrounding the studies and proposals generated during this time regarding the shape the new legislation governing midwifery practice would take.

Chapter VIII: Discussion, Implications and Conclusions

We can best understand the shifts, changes and repetitions of the themes and images of midwifery which emerged from the journal's coverage of midwifery issues by revisiting the claims-making framework. The theoretical concepts of medical dominance and medicalization form the basis for understanding the claims-making activities of physicians and their associations. In this chapter I illustrate how the medical responses to ongoing changes in the status of midwifery reflect an effort to maintain dominance on the part of a profession whose position is threatened.

Over the thirty years, I examined there is an impressive volume of coverage within the journal. There is some support for midwifery indicated in these representations and, some of the hardline positions against midwifery appeared to soften once the midwifery legislation was implemented in Ontario. However, the midwifery debate is clearly not over. Financial criticisms appear to be gaining momentum and, as the CMAJ policy on non-physician obstetric care illustrates, closure on issues like training and place of practice have not been reached, from the CMA perspective. In the next three paragraphs I briefly review the findings.

It is important to note that the claims made about midwifery in the journal have little to do with the actual practice of midwifery between 1967 and 1997. To be certain, there were some changes in the practice of midwifery during these years. But, the changes involved an increase in the number of self-trained women practising as midwives, rather than more substantive changes in their model of midwifery care. As

such, the representations of midwifery in the journal do not reflect a response to the changes in midwifery over these thirty years but, reflect a re-definition of the medical ideology surrounding midwifery.

Early representations are not particularly concerned with the role of the midwife other than the occasional suggestion that the midwife may alleviate shortages of obstetric physicians. The early period is also marked by a recognition of the problems connected to traditional obstetric care. Home births are portrayed as dangerous and there are several announcements of medical associations banning the practice. Little distinction is made between the obstetric nurse and the midwife, although there is some reference made to the midwife of the past who was characterized as untrained and incompetent. However, there is isolated support for the non-medically trained midwives.

The middle time period is characterized by more intense coverage of the midwifery issue. There is a marked resistance to the legislation of autonomous midwifery care. This resistance is manifest in claims made about inadequate training, lack of need, quality of current medical care, reaffirmations of pregnancy and childbirth as medical events, and the dangers of home birth. This resistance ranged from outright opposition to any midwifery care being legislated to conditional acceptance of midwifery. The conditional acceptance was framed by issues of preference for medical training in nursing, supervision by physicians and restrictions on place of practice. Supporters of home births and later, midwives and their advocates are considered most problematic as arguments are centred around changing the system from within rather than adding

midwives into the system. Towards the end of this period, there is some support of home birth as well as some initial positive reporting on midwifery care.

The third period continues with diverse coverage of midwifery issues. There is a feature issue on midwifery which follows shortly after the midwifery legislation is passed in Ontario. This feature accounts for much of the coverage during this time period. There is a more positive tone to most of the coverage but there are still unresolved issues. The CMA position statement opposes home births, non-medical training as well as the political and professional autonomy of midwives. Below I quote the CMA policy statement as it is published in the journal:

> *The CMA approves of nonphysician obstetric practice (midwifery care) if it is performed with proper educational training, preferably in obstetric nursing, and a clearly defined scope of practice and is integrated with existing obstetric care teams. ...Nonphysician obstetric care should focus on providing antenatal, intrapartum and postpartum care of low-risk pregnancies and the interim care of newborns.
> *Births should take place in hospitals, clinics and low-risk birthing units associated with hospitals. The CMA does not approve of home births.
> *Nonphysician obstetric caregivers should be medico legally responsible for their actions. A defined licensing and self-regulating authority, legal responsibility and malpractice insurance system should be detailed for such caregivers before they practice.
> *The cost-effectiveness of any new nonphysician obstetric care system should be thoroughly evaluated."(CMAJ 1994:150(5): 760A)

The CMA reservations about "non-physician obstetric care" should not be underestimated. These unresolved issues seen in these reservations reflect larger themes of professional autonomy and medical dominance.

8.1 - Discussion

The official position to re-train obstetric nurses into the role of the midwife as well as the more general arguments which state a preference for altering the mainstream system rather than adding on new workers is an attempt to co-opt the ideology of the midwifery model and their supporters. Burt Rusek (1980) points to co-optation as one of several measures used by mainstream medicine to maintain its control in the field of obstetrics. The co-optation process is described in relation to medical responses to feminist health demands (Burt Rusek 1980:339): "By incorporating feminist demands but taking credit for originating the change, physicians re-legitimate control over their social world and simultaneously reduce discontent."

Abbott's characterization of the "history of professions as claims makers" as a history of jurisdictional disputes is also useful in understanding the nature of the journal's representation of midwifery (Pawluch 1997:137). Referring back to the history chapter we can see that the history of claims making activities between medicine and midwifery did not begin in 1967. The jurisdictional disputes go much further back in North American history, and even further back in European history. Once more, this "history" continues as the jurisdictional disputes remain, at least as they appear in the journal, unresolved.

My discussion relating to the literature on medical dominance revolves around two central points. The first concerns the various strategies represented in CMAJ which attempt to maintain control over maternity care. The second point is the differentiation between the more hard-line, official positions on midwifery versus the struggle of the

individual physicians re-negotiating their understanding of maternity care and midwifery in response to the changes in legislation.

Freidson's (1970) model of professional dominance provides a backdrop against which the images of midwifery can be placed. The reluctance I have identified in medicine's acceptance of a new and autonomous form of midwifery care is based upon the assumption that Freidson was for the most part correct, that medicine had, in the past secured the monopoly on health care practice through the state and that they have exercised the various dimensions of the resulting control. Medicine has been able to control other health care practitioners, the content of their care, greatly influence health policy, the training of its recruits, etc.

As Coburn (1983) has suggested, medical dominance as embodied by Canadian mainstream medicine is declining. Coburn identifies increasing state intervention (indirectly related to political pressure from the working class) as the main contributor to the decline in medical dominance in Canada. The legalization of midwifery in Ontario is an indication of this decline. Unlike the case of chiropractics in Canada (Coburn 1983) the working class has not been responsible for pressure to the state to change the status of midwifery. Midwifery supporters who pushed for its legislation in Ontario, are largely white, educated, urban and middle-class. Therefore, my findings do not support Coburn's work in that the pressure on the state to intervene in medical affairs comes from the working class.

Coburn also identifies the area which relates to the power of defining the "content" of the practice as most affected by this decline in dominance. More recently,

(Coburn et al:1997) and with specific reference to Ontario, the authors identify a further decrease in medical dominance in Ontario's mainstream medical community. They argue that this decrease is no longer solely rooted in the power dimension of the ability to define its own boundaries or content. What follows is the illustration of these theoretical concepts in the representations of midwifery and home birth found in the journal.

The earliest images in the journal are of the midwife of the past and are closely related to the historical medical representations of midwifery. The theme of cooptation emerges with suggestions of the inclusion of midwifery into the health care system as an obstetric nurse. The midwife is portrayed as coming to the aid of the field of obstetrics due to their "manpower" shortages. In this way, medicine is attempting to maintain its dominance in maternity care through the control over other health care workers and the content of their work. These areas have been defined by Freidson (1970) as part of professional dominance.

The self-critical theme is first represented in the late 1970s as a recognition of the problems in maternity care as delivered by mainstream medicine. This theme can also be characterized as a form of cooptation by which medicine may remain in control of maternity care (Burt Rusek 1980). It also attempts to preserve the dominance of physicians over the content of their work (Freidson, 1970).

One of the stronger representations in favour of non-medically trained midwives elicits some indirect criticism which re-asserts the accomplishments of medicine in regard to improved safety of childbirth. Even in the representations' characteristic of co-optation which maintains professional dominance for medicine, there is no consensus

among physicians. And, as such, the debate illustrates the reluctance by some physicians to relinquish any amount of control in maternity care through the recognition of midwifery as a potential member of the health care system.

This reluctance to relinquish control is further demonstrated in the discourse on home births beginning in 1979. The discourse is characterized by phrases like "retrograde", "thing of the past" and, "dangerous". Strategies at this time go beyond an appeal to the safety of childbirth in hospital (due to accomplishments of medicine) and the dangers of the past. Statistics are used to strengthen the position against home births. This appeal to scientific authority and the use of statistics to establish a condition as problematic are reflected in the professional dominance literature (Freidson 1970) as well as the claims-making literature (Best 1989; Pawluch 1997).

With the official bans on homebirth by provincial and federal medical associations the strategy moves to an appeal of the power of medical authority. This power is recognized by Freidson (1970) as a result of securing monopoly on health care via the state. These steps to ban the practice of homebirth represent an intensification of efforts to maintain control over maternity care as they call upon the power of medical authority as the "ultimate arbitrator of reality".

These bans are further strengthened by appealing to the emotions of the reader with repeated, though undefined, claims about the "dangers" of home birth. An appeal to the emotions, namely fear, are also recognized as part of the process used by claims makers in establishing an issue as problematic (Best 1989).

Claims against home birth which refer to the accomplishments of medicine in the area of childbirth shift as they accommodate the criticisms of medicalized childbirth. This strategy to maintain control is furthered with references to guidelines for the evaluation of pregnant women as candidates for homebirth. This strategy directly illustrates Burt Rusek's (1980) model of the co-optation process which follow the failure of more drastic measures (ie. the bans). These illustrations of medicine's attempts to co-opt home birth also reinforce the notion that these claims represent an effort to preserve professional dominance.

References to scientific evidence and financial criticisms are important themes which recur extensively and, often are used in conjunction to strengthen a position. The financial theme, in particular, becomes more prevalent as time passes. It is most often supported by references to incompetent care by midwives and references stating a preference for integrating the obstetric nurse into the role of the midwife. The intensification of the positions against midwifery by combining strategies and appealing to the authority of scientific evidence as well as the incompetency of midwifery care underscore the foundation of these claims in turn of the century medical opinions of midwifery (Oakley 1993). They also point to medical dominance, particularly the control over the content of work and other health care workers, (Freidson 1970).

A crucial theme in strengthening the position against midwifery posits that there is "no need" for midwifery care and that women are satisfied with the current system. These claims are, in turn, substantiated via appeals to medical authority and scientific evidence. This is best illustrated by the CMA conducted study which found few women

were interested in midwifery and, a very high satisfaction rate with the current system. In turn, these findings are used to bolster the position against midwifery.

A pivotal strategy in the development of the official position to midwifery comes in 1987 with the publication of the CMAs position statement. In it, the CMAs opposition to midwifery is hinged on its own study which found high satisfaction rates with the current system and suggests a retraining of obstetric nurses to fill the role of the midwife. The creation of the study, its publication and then, the adoption of its findings as the basis for the official opposition to the licensure of midwifery illustrates most directly the vested interest medicine has in maintaining control or professional dominance over maternity care. As with other hard line stances (ie the bans on home birth) the controversy which followed demonstrates the distinction between the associations's position and the individual physician's struggles with a changing health care system. Suggestions of the incompetency of midwifery care, seen especially in the middle eighties, is demonstrated in the fears about mortality rates increasing and the inability of midwives to diagnose problems as they arise. These are best understood as attempts by physicians to reaffirm their own position as experts.

Training also becomes a more important theme developed in the middle period. Preference for the medical training of midwives is often accompanied by the reappearance of claims promoting the benefits integrated midwifery care would yield for the field of obstetrics.

Support for the decline of medical dominance (Coburn et al 1983, 1986, 1997) is reflected in reports which document the continued governmental support for midwifery

despite medical opposition. This is also demonstrated by reports which describe medical outcry with the government's continued plan to legislate midwifery in Ontario and the lack of physicians on implementation or review committees.

The themes of safety and financial criticisms find a new focal point in the official opposition to birth centres. Following midwifery's implementation in Ontario medical associations continue their attempts to maintain control over midwifery and maternity care. Even the return of the self-critical theme, this time in the form of exposing previous tactics to block midwifery legislation can be characterized as attempts by medicine to remain in control of the situation.

The representation of midwifery shifts to an educational format after 1993, midwives and their advocates represent themselves. Midwives are included as co-authors of technical articles. Together these two trends are indicative of a certain level of acceptance of midwifery by medicine and, a certain decline in medical dominance. The passage of the midwifery legislation in Ontario in itself, represents a demedicalization of childbirth and pregnancy as well as loss of control over the content of its work, and more generally, over health care policy for medicine. This loss in professional dominance for medicine has been accomplished through the state's increasing intervention into medical spheres in response to pressure from midwives and their supporters. The success of midwives in Ontario to gain legal recognition through legislation is illustrative of Coburn's position regarding the decline of medical dominance in Canada.

However, the theme of financial criticism is picked up again and is reported as a concern for midwifery advocates. The significance of the return of the financial criticism

theme is discussed later in this chapter. Financial concerns along with the preference for medical training is cited in the 1994 CMA update on its nonphysician obstetric care policy.. This policy statement comes in reaction to the passage of midwifery legislation in Ontario and it too denotes a reluctant loss of control over maternity care. Furthermore, the decline in control over health care policy vis a vis the midwifery issue is reflected in the reporting of several provinces at various stages of revising their health care legislation regarding midwifery.

8.2 - Implications

Oakley's (1993) work which examines the underlying assumptions of medical representations of midwifery is helpful as well, in understanding some of the underpinnings of the journal's representation of midwifery. In reviewing these representations of midwifery in the journal it became clear that claims which argue against autonomous midwifery were structured, at least in part, on some of the assumptions Oakley identified. In the history chapter I recounted how Oakley had identified several assumptions which underlie early medical claims about midwifery.

In order to illustrate their presence in the journal I am focusing on the first of Oakley's six assumptions about turn of the century medical representations of midwifery. The first assumption states that "...midwives are ignorant and dirty, therefore their practice is dangerous". In an earlier version of this discussion (Winkup 1997) I examine the articles for the presence of the other assumptions identified by Oakley. However, my intention at this point is to illustrate the presence of this one assumption, rather than to focus extensively on an analysis of the occurrences based on all six assumptions.

I re-visited all of the journal's representations of midwifery and found three illustrations of the first assumption which are found in 1967, 1970 and 1991.The first assumption is illustrated in a 1967 book review written by a male physician, a 1970 letter by a male physician and a 1991 "History" article by a female freelance writer. I note that they all are found prior to the passage of the Ontario legislation which legalized midwifery. All of these illustrations refer to an historical image of the midwife rather than current views on midwifery. In addition, the illustrations of this particular assumption in CMAJ is fairly literal and therefore does not need to be further defined beyond Oakley's original wording.

It is interesting to note the indirect nature of these illustrations. All of the authors are referring to historical images of midwifery. In this way, this assumption is included in representations of midwifery in CMAJ but is not presented by the author as a personal opinion or a truth. These illustrations are also reflective of a reporting style which permits a statement to be accurate but not necessarily true. Best (1989) refers to this strategy by claims makers in the reporting of inflated statistics which are used to establish a situation as a "social problem".

The first illustration, in the book review is actually a quotation of an 1850's author of a book on American medicine of that period. It refers to the special recognition deserved by two physicians of the time (CMAJ 1967; Vol 96, June 17:1589): "...and in transferring to the profession (of medicine), from the hands of ignorant and uneducated females, the practice of a difficult and delicate art." It should be noted that the author is not categorically against the practice of midwifery. His review of a book about a

Montreal midwife living in the 1850's is critical, more generally, of this book's lack of information about medical practice of the time, than it is of midwifery itself.

In the second illustration, a letter the physician is citing a quotation by the Executive Director of the Canadian Nurses' Association (a physician) of the time from a popular media source. Referring to the term midwife he says (CMAJ 1970; Vol 102, April 11:762): "The term has a stigma attached to it. It conjures up a picture of an old, unhygienic, unscientific granny, delivering babies in the backwoods, relying heavily on superstition and magic elixirs." Again, the physician writing the letter is not anti-midwifery. In his article, he presents an argument for a change in name from midwife to the more scientific sounding (and formally trained in nursing) matrician. This illustration is particularly close to Oakley's wording.

In the third illustration, a medical historian and physician says (CMAJ 1991; 144(3):339): "....the wise midwives not only succumbed to superstitions concerning childbirth but perpetuated many of the agonies and torture women had to endure." This illustration is slightly less obvious that the previous two. However, there is a strong connection. Any practitioner who perpetuates agonies an torture surely is considered a "danger" and likely "ignorant" as well.

The strategy of discredit midwives based on the turn of the century assumptions about midwifery stop around the same time as the legislation in Ontario was passed. This suggests that the legislation of midwifery in Ontario has essentially removed the opportunity for criticisms based in turn of the century assumptions about midwifery. Incompetency cannot be argued when university degrees are earned, protocols and

hospital privileges are in place. Images of the ignorant, dirty and dangerous midwife are less likely to appear when her current status is a colleague and a recognized member of the health care team.

8.3 - Implications of Clusters

I would like to return for a moment to the cluster of occurrences of midwifery representation in 1988 and 1989 which were mentioned earlier in my thesis. Initially, I had thought this cluster represented an increase in debate about midwifery. I subsequently discovered that this cluster was a result of a large volume of letters written in response to an article reporting the findings of a study comparing nurse-midwifery and family physician care, (CMAJ 1988; Vol 139, September 1:397-403). When I looked at the content of both the article and the letters written in response, with the assumptions Oakley identified in mind, I realised the possibility of another explanation.

The article in question, "Prenatal care: a comparative evaluation of nurse-midwives and family physicians" reports that nurse- midwifery care is of comparable if not superior quality to the care provided by family practitioners (CMAJ 1988; Vol 139 September 1:397-403). The reporting of midwifery in this light is a marked departure from the second and fifth assumptions identified by Oakley which are at play in other representations of midwifery during this time period. These assumptions state that "even trained midwives are incompetent" and "doctors know more about obstetrics than anyone else" (Oakley 1993:67). How can midwives be incompetent or physicians know more about obstetrics if midwifery care is comparable or superior to physician care? It is the departure from these assumptions which underlies the volume and intensity of the

responses to it. As such, it also accounts for the clustering of occurrences in the 1986-1992 period.

8.4 - Financial Criticisms and Future Trends

Financial criticisms represent a strategy which attempts to discredit the value of midwifery care. In total I have counted 16 occurrences of midwifery representation in CMAJ from 1967 to 1997 which refer to economic criticism of legislated midwifery. They are present from 1980 to 1996, and close to half (seven) are in occurrences in the 1993-1997 period. The economically based argument used to discredit midwifery is of particular interest because it appears to be the only strategy which gains momentum after the 1993 legislation changes in Ontario.

The increased momentum of this criticism is based in a shift in strategy. This strategy involves the representation of economic criticisms by midwifery supporters. Prior to the Ontario legislation change all economic criticisms of midwifery have been made by physicians where there was an author indicated. In a 1994 legislation article (CMAJ 1994, 150(5):730-734) a female physician, member of the Midwifery Taskforce of Ontario and "longtime promoter of midwifery" is quoted extensively, outlining dimensions of economic problems with the implementation of midwifery legislation in Ontario. She refers to the context of implementing midwifery in the midst of an economic crisis in health care. She continues by questioning the economic savings of a midwife attended birth as well as the salary of midwives, saying that Ontario's model of midwifery (CMAJ 1994 150(5):730)"...provides a Cadillac service when every other

health care sector is economizing." This economic criticism by a supporter of midwifery services combined with the extensiveness of her criticisms increases the intensity.

To further underscore my point here, I note the inclusion of the importance of cost-effectiveness in the 1994 CMA Policy Summary on non-physician obstetric care (CMAJ 1994; 150(5):760A). Another indication of the importance and possibly the perceived legitimacy of this type of criticism among physicians is illustrated in a 1996 news brief style announcement of midwifery support by Nova Scotia physicians (CMAJ 1996 155(11):1592): "However, the society (Medical Society of Nova Scotia) cautioned that the cost-effectiveness of midwifery should be evaluated prior to implementation and re-evaluated regularly."

The importance of the shift in financial criticism of midwifery which occurs after the implementation in Ontario is not found solely in an increased number of this type of criticism. Of greater significance is the representation of financial concerns voiced extensively by a midwifery supporter. This shift is further substantiated with the reporting of demonstrated economic feasibility *as a requirement* of the implementation of midwifery legislation in Nova Scotia. As a result, the continued struggle of medicine to maintain some element of control over maternity care provided by midwives has moved away from criticisms based in turn of the century assumptions about midwives.

Perhaps this strengthening of economic criticisms of midwifery also suggests that economics rather than medicine will become the "final arbitrator" of the "realities" of midwifery care in Canada. In addition, the use of economics to question the value of

midwifery care may lead to a revitalisation of the jurisdictional dispute over maternity care by a medical community struggling to regain its dominance.

8.5 - Conclusions

The journal's coverage of midwifery and related issues has shown some important trends. On the surface, we see a decline in the claims-making activities which campaigned against an autonomous midwifery. These claims often included questions about training, competency and autonomy and, were most prevalent between 1986 and 1992. Despite this decrease, these concerns clearly remain relevant as they are included in the CMA policy summary of "nonphysician obstetric care" (CMAJ 1994, 150(5):760A). Hence, the claims-making activities against midwifery care will likely continue, on the part of established medicine. These claims, I argue, will more and more, be couched in terms of financial concerns rather than the historically prevalent concerns about competency, training and autonomy. As such I have identified financial criticisms as becoming more important in medicine's claims-making activities in relation to midwifery.

The debates which reveal a more varied and supportive position on midwifery by individual physicians highlight the disparity between the more resistant institutionalized views on midwifery illustrated in the CMA position on midwifery care and the individual physician's experiences with midwives. As such, there are some very supportive claims in the journal made by individuals as well as several, recent "scientific" surveys published in the journal which reflect that this support is not isolated. However, the

CMA position on midwifery care, as identified in the journal, is indicative of a reluctant redefinition of occupational boundaries.

The representations of midwifery in CMAJ are consistent with the professional dominance literature which describes medicine as historically dominant in the health care field. This dominance included the power to define the contents and conditions of their work and health care policies that ensured the subordination of other health care workers (Freidson 1970). In more recent times, the professional dominance has declined (Coburn et al 1983, 1986, 1997). The success of Ontario midwives and supporters in the passage of the 1993 legislation is illustrative of this decline. The attempts of physicians and their associations to discredit midwifery, as represented in CMAJ, are a reflection of the profession's struggle against the processes by which their professional dominance has been eroded.

The lasting impact of the medico-historical claims about midwifery is illustrated as they are found to inform, at least in part, the strategies used to discredit midwifery. While the political process of renegotiating midwifery legislation has brought these images to light, this process also illustrates the vested interest which remains part of the medical dominance of our times.

For midwives, especially those practising in Ontario, the resistance of medicine to an autonomous midwifery perhaps has translated into strained professional relations. There will certainly be a great deal of pressure on midwives as their practices will be carefully scrutinized for financial excesses in order to substantiate the claims in the journal focusing on economic concerns of the "cost of midwifery".

The sociological and anthropological literature on midwifery will likely continue to expand but, to my knowledge, there has not been a study focused the analysis of medical representations of midwifery. Consequently, the major contribution of my thesis lies in its focus on the analysis of medical representations of midwifery. Other recent graduate work on midwifery has largely focused on tracing the historical development of midwifery. These important dissertations include references to representations of midwifery by medicine, but they have not centred on a consideration of representations as such. I am aware of one PHD dissertation in progress which deals with midwifery representations as they relate to issues of race and ethnicity with the larger focus on interlocking systems of oppression.

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Appendix: Occurrences from CMAJ (in chronological order)

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Bruser, M "Mysterious Montrealer: Charlotte Fuhrer" CMAJ, April 11, Vol 102, pp 762. (Ltr)

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Abbott, EC, (1977) "Is gynecology good for obstetrics?", CMAJ, Nov 5, Vol 117, pp 1008 (Ltr)

Shea, P (1977) "Is gynecology good for obstetrics?", CMAJ, Nov 19, Vol 117, pp1128 (Ltr)

Andison,(1978)"SOGC president urgers members be concerned with broad issues", CMAJ, July 22, Vol 119, pp178, 79 &85.

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1980 "Childbirth at home an unacceptable regression Quebec physician says", CMAJ, Dec 6, Vol123, pp 1146

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IMAGE EVALUATION
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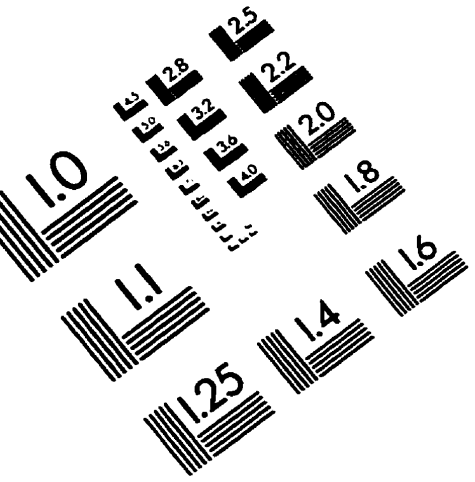

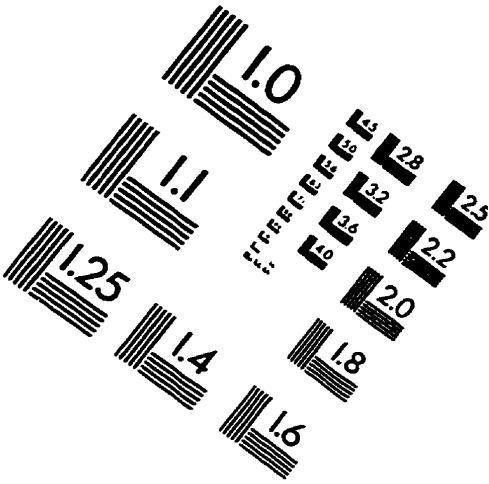

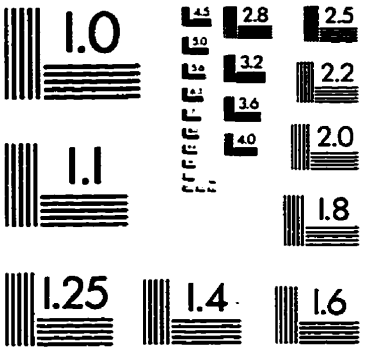

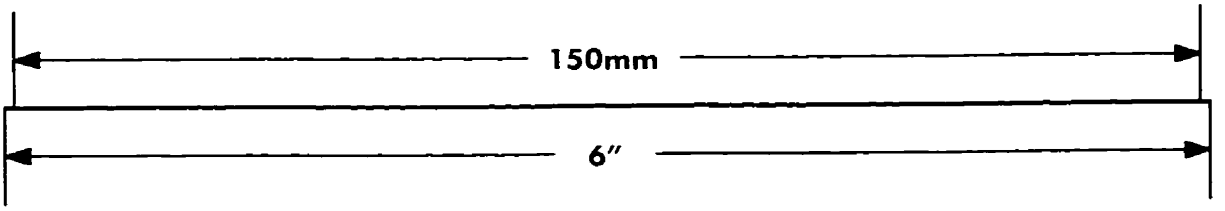

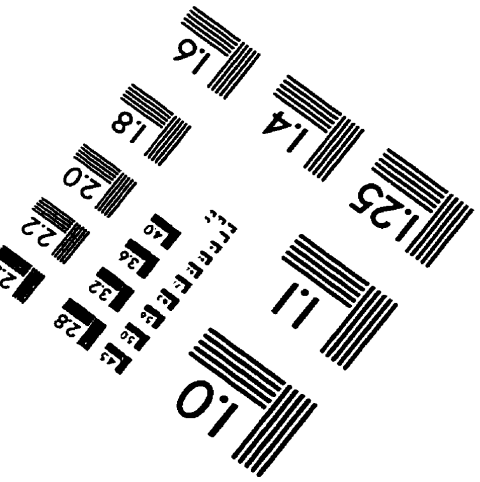

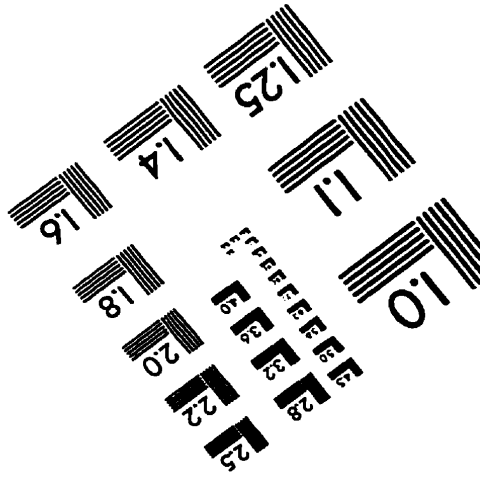

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