

**Birthing at the Margins:
(Re)conceptualizing Maternal Health Care in BC**

By:

Melissa Murdock Vandekerkhove
University of Victoria, BA (Hons), April 2005

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

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Abstract

Generations of women's health workers, writers, activists, and academics have tended to present midwifery as the opposite of obstetrics; to summon the appealing association of midwifery by advocating 'tradition and nature' over 'modernity and medicalization;' and to invoke the melodrama of the subordination of female patients by and to male doctors. This thesis suggests that it is much more productive (and historically accurate) to think of the shifting roles and identities of childbirth practitioners and their clients in terms of "boundary work" rather than the oft-touted dichotomy of domination/resistance. The thesis navigates Enlightenment theories of body and nature and moves to explore the example of the Foucaultian "clinic" to illustrate a relatively unstable foundation on which the biomedical clinic appears not as an entity trapped in time and space, but always already subject to change and negotiation. A discussion of maternal health policy and the roles of birthing women in actively shaping the care they receive brings home the central argument that what is crucial to the ever-developing birthing models is not resisting that which appears to dominate, but *affirming* a practice that more adequately meets the needs of birthing women in BC today.

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Dedication

Darren “Troy” Purden (1972 – 2004)

Preamble

My life-journey came to curious cross-roads this past year when I found myself simultaneously immersed in maternal health care graduate research and pregnant with my first child. Like many women born and bred on the west coast, I had decided to postpone parenthood until obtaining a post-secondary degree (first my Bachelors, then my Masters). But this decision did not stave childbirth completely. In fact, I soon learned just how much childbirth and the female body had become an important area of academic study in Canada since the 1970s.

Much of my undergraduate education was spent reading various scholarly accounts and personal narratives of western birth practice, not to mention an array of critical works that readily targeted the biomedical maternal health system and medicalized childbirth, more generally. It would not be long before a perceived circularity that perpetuated past wounds in order to fuel the resistance to medicalized birth came to light in many of these works. Scholarly nuances pervaded the literature even as each era told a more expansive, yet similar story: ‘the oppressed must resist that which dominates.’ As a young student eager to identify with and support a broader, organic health movement, it was easy to pick sides; but, in so doing, I soon realized that I was reenacting a polarized dichotomy that was craving political and social transformation.

The title of my thesis is *Birthing at the Margins: (Re)conceptualizing Maternal Health Care in BC*. The thesis is a manifestation of a long, sometimes arduous struggle with academia and the more organic (im)possibilities inherent to the study of childbirth. Where my studies and my pregnancy most obviously come together, however, is a commitment to multidisciplinary and an engagement with increased collaboration rather than interest-based professional competition. In writing this thesis, I have attempted to gesture towards a movement that is taking place within a larger epistemological shift and a new ontology of the body that is increasingly coming to light. The actualization of this shift within the birthing realm does not lie in an explanation of past experience, but in works of advocacy and moments of clearly articulated strategy and negotiation that contribute to the ever-developing models of maternal health care in BC. For myself, the public offering of multidisciplinary, collaborative birthing centres in BC is the next step and a natural conclusion to this phase of research.

Introduction

The politics of childbirth has led generations of women's health workers, writers, activists, and academics to perpetuate the division between midwifery and obstetrical practice. Often lending their positions well to an orthodox play of stereotype and limit, to purport midwifery as the opposite of obstetrics, to summon the appealing association of midwifery by advocating 'tradition and nature' over 'modernity and medicalization,' and to invoke the melodrama of the "subordination of women by and to men,"¹ does little in the way of creativity and mutual accommodation. In fact, the (re)creation of the same historical identity formations – associating men with modernity, medicine, science and technology, and women with tradition, nature, and nurture – is regrettably overplayed. Even as leading anthropologist Robbie Davis-Floyd identifies and elaborates the technocratic/holistic dichotomy for analytic purposes, she recognizes that scholars often risk overemphasizing "the polarities, which although real can obscure some important commonalities."²

For many feminist writers of the 1970s, maternity care was a clear illustration of an oppressive patriarchal social structure. Their scholarly works examined the power relations among physicians, pregnant women, and midwives. Medical science and the medical professions remained central in most studies even as this work developed. Biomedicine was seen as the source of power for maternity care professionals, allowing hospitals and medical specialists to assume control over birthing practice and guidelines. While the early academic study of birth practice perpetuated the single-minded focus on

¹ Isaac Bulbus, "Disciplining Women" in *After Foucault: Humanistic Knowledge, Postmodern Challenges*, Ed. Jonathan Arac, New Brunswick, New Jersey, Rutgers University Press, 1991, p. 140

² Robbie Davis-Floyd, quoted in MacDonald, Margaret, "Tradition as a Political Symbol in the New Midwifery in Canada" in *Reconceiving Midwifery* Eds. C. Benoit, et al. McGill-Queen's University Press: Montreal, 2004. p. 53

power relations, the fields of study have come a long way. Not only have these studies expanded, merged, blended and crossed, but exciting perspectives and new areas of inquiry are always emerging.³

The epistemological and ontological assumptions of traditional biomedical childbirth are being challenged, and previously defined professional boundaries are beginning to blur. Questions regarding bodily perceptions and scientific applications lingered at the margins for centuries; but it was not until the 1960s and 1970s that women in North America started to report being heavily-medicated, tied to their beds by their hands and feet, and left in pain for hours in their hospital rooms.⁴ The drug scopolamine, for example, was often prescribed to birthing women to put them into a kind of “twilight sleep” that did not stop pain, but merely eliminated the memory of pain, often resulting in a kind of psychosis in thousands of new mothers. The cultural milieu came to be marked by a general lessening of trust in professional authority; an unprecedented decline in respect for medicine; and a growing recognition of the emotional, social, and spiritual components of life and healing in particular. Many women and their families began to navigate alternative birthing options as they questioned whether institutional and technologically mediated births were the best options available.⁵

Canadian midwives have long been working to reconcile client-centred traditions of birthing with the advantages of biomedicine. In the 1980s, sociologist Brian Burtch observed that community midwives in British Columbia (BC) were quickly resembling what he saw as defenders of tradition as well as creative inventors of mutual

³ Sirpa Wrede, “Introduction to Part I” in *Birth by Design* eds. R. Devries, et al. (New York: Routledge) 2001. p. 3

⁴ Betty-Anne Daviss, “Reforming Birth and (Re)making Midwifery in North America” in *Birth by Design* eds. R. Devries, et al. (New York: Routledge) p. 71.

⁵ *ibid.*

accommodation.⁶ Many contemporary midwives currently act as primary birthing attendants in many BC hospitals; and anecdotal evidence suggests a few doctors are recommending some alternative approaches to prenatal care and childbirth, such as acupuncture and perineum massage, to respond to the shifting expectations of women and the latest scientific research. That said, many physicians are also opting out of the provision of maternal care altogether; while some midwives across Canada are concerned that their practice risks becoming too standardized and bureaucratic. To be sure, policy makers and governments are becoming increasingly concerned with the shortage of physicians and midwives needed to maintain the highest standards of maternal care under the Canada Health Act. As pregnancy and childbirth remain the single largest causes of hospitalization for women in Canada, decision-makers and policy planners are increasingly looking for innovative solutions to the impending maternal care crisis.

What happened when women no longer identified with the *either/or*? What happened when childbirth practitioners advocated two static conceptualizations of birthing and bodies, each complete with its own competing and often violent discourses, each fueled by previous commitments, each preoccupied with the maintenance of a bounded entity, and thus each compelled to recreate the polemic of ‘us against them’? What happened when women moved to negotiate with the apparent limits that held them historically (and biomedically) captive? This thesis sets out to explore these and other questions about the shifting tides of maternal health care in BC and indeed elsewhere.

The central argument in this thesis suggests that the “politics of birthing” is better understood in terms of “boundary work” rather than the oscillating dichotomy of domination/resistance. Put differently, I hope to show that it is much more productive

⁶ Margaret MacDonald, “Tradition as Political Symbol in the New Midwifery in Canada,” p. 60.

(and historically accurate) to think of the shifting roles and identities of childbirth practitioners and their clients in terms of negotiation and strategy, rather than a struggle between two diametrically opposed way of doing things. Boundary work theories are particularly important here as they highlight how different political and societal actors strive to shape the parameters of a debate and have their knowledge claims translated into the legitimate and authoritative voice on a policy issue.⁷ Boundary work studies commonly show that while the distinction of what is and is not science (or, is and is not politics) is often presented as quite sharp, it turns out, in practice, to be quite blurry.⁸ Boundary work theories are often used to consider how different disciplines, professions, and social organizations negotiate and maintain the boundaries that demarcate their spheres of influence and authority. Importantly, these boundaries are not fixed or impermeable; they are “ambiguous, flexible, historically changing, contextually variable, internally inconsistent, and sometimes disputed.”⁹

Boundary work theories are often seen as a form of manipulation between ‘insiders’ and ‘outsiders’ that enable connections but, at the same time, set people and activities apart. While boundary work is indeed both, I want to suggest that the intricacies within such a theory and practice do not have to be viewed negatively, but can be interpreted as a creative and strategic activity that can invoke change and various forms of action. Importantly, the term boundary work is not euphemism for ‘resistance.’ Resistance as political action is often futile, whereas boundary work as a form of negotiation and strategy can be intrinsically engaging and, when applied effectively,

⁷ Francesca Scala, “*Scientists, Governments...*” p. 212

⁸ Clark Millar, “Hybrid Management: Boundary Organizations, Science Policy, and Environmental Governance in the Climate Regime,” in *Science, Technology, and Human Values*, Vol. 26, No. 4 (Autumn, 2001), pp. 478-500.

⁹ Scala, “*Scientists, Government...*” p. 4.

creative, active and useful. Although dichotomies such as domination/ resistance may initially provoke emotion and political fervor, I hope to show there are more useful ways to interpret and negotiate past, present, and future (birthing) experiences in BC and elsewhere in Canada.

As a prelude to my central aim, I begin by depicting the dominant historical narrative that illustrates the early epistemological mappings of scientific truth onto the female body and childbirth. This first section suggests that contemporary obstetrical practice in Canada can be traced to western European Enlightenment scientific conceptualizations of body and nature. This section also aims to situate the female body on the continuum of various epistemological and ontological debates that often fuel political and scientific negotiations within the biomedical enterprise. By setting the backdrop in this way, it is hoped that one can begin to appreciate the situated knowledge involved and the potential for future negotiations with (and within) the ongoing development of maternal health care in Canada.

The second section aims to build upon the above discussion by using the example of “the clinic” as discussed by Michel Foucault in *The Birth of the Clinic*. As Foucault works to map the shifting tides of the doctor-patient relationship in and through the establishment of the modern clinic, he simultaneously alludes to the fact that it is not so much continuity of a dominant biomedical discourse that is important, but those *counterpoints* that hold within them the locus of change, singularity, and difference. By engaging with Foucault in this way, I attempt to suggest that the clinic was never simply a site of a dominant discourse, but a site always already subject to change, not through resistance, but timing, negotiation and strategy.

In the third section I provide a brief background of the past and present maternal health policy arena in Canada and move to show how midwives and physicians have used, and continue to use, “boundary work” to negotiate their roles within the biomedical enterprise. Many midwives have been generating criticisms of the biomedical model of birth since its beginnings in Europe four centuries ago.¹⁰ Meanwhile, midwives have not only long appreciated the need for up-to-date reproductive care research and holistic practice, but as a community have become increasingly political over the years: midwives and their colleagues have long recognized their need for an organized political voice if they are to persevere in the biomedical domain. Midwives in BC today work to build organizations in their communities, join national and international midwifery organizations, and work within them for policies and legislation that support midwives and the mothers they attend.¹¹ Importantly, midwives’ roles are increasing in the hospital and clinics not because of their resistance to the biomedical organizations in general, as much as because of their willingness to negotiate their boundaries, their practice, and their organization as a whole.

Finally, discussions about the role of Canadian midwifery today may seem largely academic, with no clear connection to the pregnant and birthing women that ultimately form the study population in a given work. One might even question the relevance of academic work to midwives and the women for whom they care. Even the most contemporary accounts of Canadian midwifery tend to (re)emphasize issues of legalization, regulation, public funding, and education. The fourth section of this thesis thus comes together with the work of medical anthropologist Margaret MacDonald to

¹⁰ Robbie Davis-Floyd, “Daughters of Time: The Postmodern Midwife” p. 12.

¹¹ *ibid.*

suggest that pregnant and birthing women are active producers of midwifery as a social and cultural phenomenon in Canada, and not mere recipients of pre-established model of care. Together the above sections bring home the central argument that what is crucial to the ever-developing birthing models in BC today is not resisting that which appears to dominate, but *affirming* a practice that more adequately meets the needs of birthing women.

Mapping Epistemological Promise

The female body, and childbirth in particular, generates and combines fascination and perplexity, knowledge and ignorance, contradiction and conformity. The imperative to 'know' childbirth over the last hundred years, to understand it through medicalized ordering and disciplined science, has in many ways contributed to the reduction of childbirth to a series of distinguishable, measurable, recognizable processes. In essence, childbirth as cultural event seems to have required more and more careful containment, not within moral strictures but through epistemic systems, discourses, and medical practices.

Systems of medical practice often operate on one specific form of rationality that readily formulates specific codifications and prescriptions; these same practices tend to call forth a domain of 'objects' which make possible the articulation of 'true and false' propositions about the body and its capabilities. It is suggested that the rise of one such rationality has entailed the devaluation of alternative approaches to birthing and care. In the early decades of the twentieth century it appeared as though Canadian women were surrounded by two warring ontologies of the body: one interventionist, technical, more inclined to objectification, the other generally more attentive to the rhythms of the body and the subjective experiences associated with childbirth.

History through this lens points to a knowledge formation that sought to reduce all things for the purpose of calculation, categorization, and a desire to define and control all things in relation to 'nature.' The human body would not escape the tabling of 'controllable' parts and processes. Illness, disability, obesity, and even death, might be considered 'losses of control' over nature in this view. While women have a long history

of being deemed 'natural,' as indicated by menstruation, hormones, pregnancy, and childbirth, early feminist scholars argued that these are the things that science set out to improve upon, fix, delay, stop, manage, and control. Hence, as the mystery of childbirth came to represent a 'fearful counterpart' to scientific rationality, these scholars took to criticizing the gaze of the suspicious scientific eye that would ultimately extend itself over the entire female body - ambivalently fascinated yet repelled by its reproductive activities. For Vaheed Ramazani, such activities "seem inherently unsettling in a culture whose dominant values include stability and regularity, self-control and autonomy."¹² As a matter of cultural refinement, therefore, the female with her mysterious depths was to be called under the domain of scientific exploration and thus governed by rules, procedures, and means to an end: the female body emerging as a medical space – childbirth as a medical event.

Since the early 1900s the vast majority of childbirths occurring in western industrialized countries, Canada included, have been conducted under one general set of beliefs with roots deep in the *scientific episteme* – a set of rules that govern discursive practices in a given culture through scientific rationality.¹³ A discursive formation consists of practices and institutions that produce knowledge claims that the knowledge-system finds useful. Davis-Floyd, writing in the 1980s, uses the term 'paradigm' to describe a similar conceptual template for reality: "since the early 1900s, birth in the United States has been increasingly conducted under a set of beliefs, a paradigm, which I

¹² Vaheed Ramazani, "The Mother of All Things: War, Reason, and the Gendering of Pain." in *Cultural Critique*. 54 -Spring 2003- Copyright 2003 Regents of the University of Minnesota. p. 28-29.

¹³ Michel Foucault, "Interview with Michel Foucault" in *Michel Foucault: Power*. Ed. James Faubion. New York: The New York Press: 2000. p. 267.

believe is most appropriately called ‘the technological model of birth.’”¹⁴ Davis-Floyd argues that this particular paradigm is both delineated and enacted through the rituals of modernized hospital birth.

According to Marsden Wagner, childbirth consultant for the World Health Organization, with the devout application of positivism to western childbirth over a hundred years ago came a particular knowledge-set that sought to explain the female physiological and biological body complete with a desired degree of management and precision.¹⁵ Rene Descartes (1596-1650), suggests Wagner, spearheaded the cultural phenomenon that would later come to hyperbolize science as the only path to pure knowledge. Wagner maintains that in this dichotomized world view, science and art are antithetical in the same way as are objectivity, logic, masculinity, and emphasis on quantity on the one hand, and subjectivity, intuition, femininity and emphasis on quality on the other.¹⁶ This same path simultaneously demanded control over artistic impulse and way of life. Ultimately the profession of medicine aligned itself with science and mechanical physics, applying them to the body, its functions, and its disease processes. Pregnancy and childbirth – two intimate domains thought previously to belong wholly to the domain of health and well-being – were thus brought under scientific purview and would remain there relatively uncontested for almost a century.

Art	Science
Subjective	Objective
Feminine	Masculine
Intuition	Logic
Quality	Quantity

¹⁴ Robbie Davis-Floyd, “The Technological Model of Birth” in *The Journal of American Folklore*, Vol. 100, No.398, Folklore and Feminism (Oct. – Dec, 1987), pp. 479-495.

¹⁵ Marsden Wagner, *Pursuing the Birth Machine: The Search for Appropriate Birth Technology*. Australia: Ace Graphics: (1994) 2001. p. 27.

¹⁶ *ibid.*

“Modernism” is viewed by anthropologists not as a particular point in time, but as a univariate orientation defined in terms of “Westernized forms of education, technologization, infrastructural development, factory production, economic growth, and the development of the global marketplace.”¹⁷ Modernism identifies a single point in a given area in which ‘development’ should be progressing; Davis-Floyd suggests “in economics, that single point is capitalism; in health care, it is Western biomedicine.”¹⁸

Modernity’s progression toward univariate points

- In economics, capitalism;
- In national development, the building of infrastructure: water, sewage, electricity, telephones, and transportation systems (water-, air-, rail, and highways);
- In production, the elimination of the small in favour of the large: industrial agriculture and the factory production of goods;
- In health care, biomedicine.¹⁹

Biomedicine is the rational-legal genre of health care in Canada, as well as abroad in the United States and much of Western Europe. Many contemporary scholars, Wagner and Davis-Floyd included, have traced contemporary obstetrical practice – and biomedicine, more generally – in North America to western European Enlightenment scientific conceptualizations of body and nature. Biomedicine is defined as the application of the principles of the natural sciences – especially biology and physiology – to clinical medicine. The biomedical model is often criticized for being the panacea for an always already predefined prescription for ‘health and security’ and ‘pathology and nuisance.’ Curiously, the human sciences are said to be linked originally not with the comprehensive, transferable character of biological concepts, but rather, with the fact that

¹⁷ Robbie Daviss-Floyd, “Daughter of Time: The Postmodern Midwife,” p. 1

¹⁸ *ibid.*

¹⁹ *ibid.*

these concepts – transference, importation, and metaphor – were epistemologically mapped onto a profound structure that responded well to the ‘healthy/ pathological’ opposition.²⁰

Certain literary devices such as the metaphor were curiously crucial to the development of biomedicine. Derived from the Greek term *metaphora*, *meta* means “over,” and *pherein*, “to carry.” The term metaphor refers to a particular set of linguistic processes whereby aspects of one object are carried over or transferred to another object, so the second object is spoken of as if it were the first.²¹ Speaking of the metaphor in his *De Poetica*, Aristotle writes: “the greatest thing by far is to be a master of metaphor. It is the one thing that cannot be learned from others; it is also the sign of genius, since a good metaphor implies an intuitive perception of the similarity in dissimilars.”²² Colin Turbayne suggests the application of metaphor “is to create by saying ‘no’ to the old associations, the things that have constantly gone together, the things already sorted, and ‘yes’ to new associations by crossing old sorts make new ones.”²³ For Max Black, a metaphorical statement has two distinct subjects: a “principal” subject and a “subsidiary” one. In the statement “the human body is a machine” for example, “human body” is the principal subject and “machine” the subsidiary. The danger hidden therein, however, is that “a given metaphor...may be transformed into myth” when the differences between the metaphor’s principle and subsidiary subjects become lost and the metaphor is taken literally.²⁴

²⁰ Foucault, *The Birth of the Clinic*, p. 41.

²¹ Terence Hawkes, quoted by Eugene Garfield in *Essays of an Information Scientist*, Vol: 9, 1986.

²² Aristotle, *ibid.* p. 316.

²³ Colin Murray Turbayne, *ibid.* p. 317.

²⁴ Douglas Berggren, *ibid.* p. 320.

While the apparent consequences of the ‘human body/machine’ metaphor are discussed in more detail below, *analogy* is another literary term used to illustrate a resemblance in some particulars between things that are otherwise unlike. Davis-Floyd suggests analyses of the rituals of modern biomedicine reveals an analogy of American society in which our society’s deepest beliefs stand out in high relief against their cultural background:

American biomedical cures based on science, effected by technology, and carried out in institutions founded on principles of patriarchy and the supremacy of the institution over the individual. These core values of science, technology patriarchy and institutions derive from the technological model of reality on which our society is increasingly based.²⁵

Biomedicine has long been accepted as best because it is technological and scientific. Meanwhile, women who have access to biomedical birthing options choose it because they believe in its promise – or want to. As the historical guardian of reproductive technology – birth control, abortion, and the means for safe childbirth – biomedicine for some time held the promise of escape from hundreds of fears and complaints that have encumbered women throughout history.²⁶ But as far as the technology itself is concerned, to neglect the beneficial contributions of many technological innovations, including those that pertain to reproductive health and well being, would be to deny the fact that science and technology contain a doubled possibility for society – negative and positive. However, an important question remains: with the more technological options that exist, does it become less possible to choose options that do not involve technology?²⁷

²⁵ Davis-Floyd, “The Technological Model of Birth” P. 481.

²⁶ Barbara Ehrenreich, et al. *Complaints and Disorders*: New York: The Feminist Press: 1973. p. 5

²⁷ Barbara Katz Rothman, quoted in Robbie Davis-Floyd et al. *Cyborg Babies*, Routledge, New York and London, 1998. p. 2

Donna Haraway suggests that women “fetishized” biomedical science.²⁸ By this she refers to an ‘object’ that human beings create only to forget their role as its architects. In other words, women have created a space where they are no longer responsive to the dialectical interplay of their bodies with the surrounding world in the fulfillment of social and organic needs. Women, for Haraway, have perversely worshipped science as a fetish in two complementary ways:

1) By completely rejecting scientific and technical discipline and developing feminist social theory totally apart from natural sciences, and

2) By agreeing that ‘nature’ is our enemy and that we must control our ‘natural’ bodies by techniques given to us by biomedical science.²⁹

Thus while this cultural construction of reality defines the ‘real world’ as inherently deceptive, the double logic of the Freudian fetish – knowledge and belief – the real and unreal – comes into play and describes the ways in which each citizen experiences science: “We all know, at some level, that science is but one truth, yet we continue to behave as if it were not, indeed as if the paradox did not matter.”³⁰

For Haraway, science may have contributed more to the domination of women’s bodies, and not their liberation.³¹ As this central legitimating body of skill and knowledge undermines their efforts, she argues that women may have rendered science as utopian in the worst sense: “[Women] cannot accept lightly the damaging distinction between pure and applied science, between the use and abuse of science, and even between nature and culture.”³² The latter distinctions, after all, are versions of the

²⁸ Haraway, *Simians, Cyborgs, and Women...* p. 8.

²⁹ *ibid.*, p. 8-9.

³⁰ Ramazani, “The Mother of All Things...” p. 47.

³¹ Haraway, *Simians, Cyborgs, and Women...* p.8

³² *ibid.* p. 8.

philosophy of science that exploits the rupture between *subject* and *object* to justify the double ideology of firm scientific *objectivity* and mere personal *subjectivity*.³³

But in looking back it appears that epistemological mappings and divine ontologies of the body were indeed cast in a new light in the seventeenth century. The conceptual divorce of body from soul, and the subsequent removal of the body from the purview of religion permitted the opening of the body for scientific investigation.³⁴ Davis-Floyd suggests at that time the Catholic belief system of Western Europe held that women were inferior to men – closer to nature, with less-developed minds.³⁵ Consequently, this religious system perpetuated the view of the “body-as-machine” which firmly established the male body as the prototype of this machine.³⁶ Elizabeth Grosz shows how the male body, marked as the scientific template to which all deviations would measure against, still haunts much of the female existence and modern discourses.³⁷

For Grosz, whereas the female body has traditionally been constructed “as a leaking, uncontrollable, seeping liquid; as formless flow; as viscosity, entrapping, secreting,” the male body has been constructed as “self-contained, impermeable, and

³³ *ibid.* p. 8.

³⁴ Robbie Davis-Floyd, “The Technological Model of Birth” p. 481.

³⁵ Nancy Stepan examines analogies that were prevalent in the nineteenth and early twentieth centuries such as racist and gender theories on human variation. She discusses how scientists used analogical and metaphorical reasoning in an attempt to compare the supposedly inferior intellectual capacities of women with those so-called “lower races.” See Stepan N.L. “Race and Gender: The Role of Analogy in Science.” *ISIS* 77(272): 261- 77, 1986. See also Zine Magubane’s “Simians, Savages, Skulls, and Sex – Science and Colonial Militarism in Nineteenth-Century South Africa” in *Race, Nature, and the Politics of Difference* (Duke University Press, 2003) for another interesting discussion of metaphor and analogy in scientific discourse.

³⁶ *ibid.*

³⁷ Elizabeth Grosz, quoted in Jarvis, Christina *The Male Body at War: American Masculinity during World War II*: Northern Illinois University Press: 2004. p. 89.

sealed up.”³⁸ Grosz suggests that through these efforts men can “demarcate their own bodies as clean and proper.”³⁹ More recently, scholars in gender studies are writing about the “dirty side of women’s health.”⁴⁰ Picking up from Mary Douglas’ definition of dirt as ‘matter out of place’ (1966),⁴¹ these contemporaries recognize the clean/dirty hierarchal structures yet maintain that the pregnant woman is a “paradigm case of boundary transgression as well as the forbidden mixing of kinds.”⁴² As for the role of hospital-midwife, these scholars suggest the following paradox captures the hospital-midwife as the ‘dirty worker:’ “The midwife is...dirty and clean, powerless and powerful. She is the manager of the dirt and is responsible for controlling, containing and cleansing the dirt of birth.”⁴³

The female body is an inherently complex cultural phenomenon. Today the body is said to be “punctured, pierced, probed, and pummeled” via “breached boundaries,” the “informatics of domination,” or even infiltrated by the cultural codes of “posthumanism.”⁴⁴ In the 1970s Foucault argued that it was the early view of ‘bodies as machines’ that permitted the disciplining of the body, the maximization of its capabilities, and its integration into systems of efficient and economic controls. This view of the human body soon advanced to focus on the species body. Here, the body is mapped onto the mechanics of life and serves as the foundation of biological processes: reproduction, births and deaths, the level of health, life expectancy and longevity, not to mention all the

³⁸ *ibid.*

³⁹ *ibid.*

⁴⁰ Mavis Kirkham et al. *Exploring the Dirty Side of Women’s Health* Ed. Mavis Kirkham, New York, NY: Routledge, 2007.

⁴¹ Mary Douglas, *Purity and Danger: An Analysis of the Concepts of Pollution and Taboo*, Routledge: London and New York: 1966.

⁴² Kirkham, *Exploring the Dirty Side*...p. 16

⁴³ *ibid.*

⁴⁴ Arthur and Marilouise Kroger, *Life in the Wires: The CTheory Reader*, Canada: New World Perspectives, 2004. p. 12.

conditions that can cause these to vary.⁴⁵ Management of the body is, for Foucault, thus achieved through an entire series of interventions and regulatory controls. Foucault calls this arrangement the “bio-politics of the population.”⁴⁶

Biopolitics was an indispensable element in the development of capitalism. The great instruments of the state and institutions of power ensured the maintenance of production by creating techniques of power that would be present at every level of the social body and implemented by a multiplicity of institutions: the family, schools, police, the administration of collective bodies, and *individual medicine*.⁴⁷ These mechanisms act as factors of segregation and social hierarchy, exerting their influence on the forces that guarantee relations of domination and the effects of hegemonic structure. The emphasis on the human body as a machine and the female body as worthy of routine maintenance would serve this goal, while the level of a speculative discourse, in the form of concrete arrangements, was to make up the great technology of power with the deployment of sexuality of utmost importance.⁴⁸ Meanwhile, the cyborg – “a cybernetic organism, a hybrid of machine and organism” is also said to represent how in various ways human life, from conception to old age, have become “symbiotic fusions of organic life and technological systems.”⁴⁹

Haraway invokes cyborg imagery to help express two crucial arguments concerning the body today. First, she suggests that the production of a universal, totalizing theory (of the body) is a major error that misses most of reality, probably

⁴⁵ Michel Foucault, “The History of Sexuality,” Vol. 1, New York: Vintage, 1979 (1975) p. 139

⁴⁶ *ibid.*

⁴⁷ *ibid.*, p. 141.

⁴⁸ *ibid.* p. 140.

⁴⁹ Donna Haraway, “A Manifesto for Cyborgs: Science, Technology, and Socialist-Feminism in the Late Twentieth Century” in *Simians, Cyborgs, and Women: The Reinvention of Nature*. New York: Routledge: 1991.

always, but certainly in modern times; and second, that we must take responsibility for the social relations of science and technology by refusing a demonology of technology.⁵⁰ Haraway suggests we embrace the skilful task of reconstructing the boundaries of daily life, in partial connections with others, in communication with all of our parts. It is not just that science and technology are possible means of great human satisfaction, as well as a matrix of complex dominations: cyborg imagery can suggest a way out of the maze of dualisms in which we have explained our bodies and our tools to ourselves. For Haraway, “[t]his is a dream not of a common language, but of a powerful infidel heteroglossia. It means both building and destroying machines, identities, categories, relationships, and space stories.”⁵¹

We are all cyborgs now, according to Haraway.⁵² In suggesting so, one might be tempted to speculate that she is responding to certain depictions of the biomedical hospital childbirth. Consider, for example, the image of the body provided by Davis-Floyd in *The Technological Model of Birth*:

If we stop a moment now to see in our mind’s eye the images that a labouring woman will be experiencing – herself in a bed...staring up at an IV pole, bag, cord on one side, and a big whirling machine on the other...wires coming out of her vagina, and a steel bed – we can see that her entire visual field is conveying one overwhelming perceptual message about our culture’s deepest values and beliefs: technology is supreme, and you are utterly dependent on it and on the institutions and individuals who control and dispense it.⁵³

Davis-Floyd and many of her feminist counterparts writing in the 1980s were adamant in pointing out how the more complicated and specialized the modern hospital becomes, the more its supporting apparatus demands the detached, strictly objective expert. For these scholars the bureaucratic arrangement created the attitudes that are both expected and

⁵⁰ *ibid* p. 181

⁵¹ *ibid*

⁵² *ibid*

⁵³ Davis-Floyd, “The Technological Model of Birth” p. 485.

demanded by the operation of a modern hospital. Davis-Floyd suggests there were definite tradeoffs for women within this construct. For her, women were degraded as objects as the technology that surrounded them took on human attributes – hence, the fusion of bodies to machines – and the cultural prescription of ‘cyborgified’ birthing identities. Meanwhile, the ways in which the body and its parts were reduced to operative parts, each organ complete with its own boundary, its own function, came to resemble the typical modern bureaucracy, complete with a parallel division of tasks and work roles.⁵⁴

Not so long ago, the hospital was considered a highly sophisticated technological factory – an institution whereby the birth process conforms more to institutional than personal needs.⁵⁵ Louise Levesque, author of *Being Pregnant: There’s More to Childbirth than Having a Baby*, suggests that modern maternity wards are equivalent to a typical, modern-day bureaucratic arrangement – characterized by hierarchal authority, a division of labour bounded by specialized competence, and depersonalization.⁵⁶ However, during the last two decades many large hospital maternity wards have been revamped to promote more family-centred care and rooming services.⁵⁷ Meanwhile, although hospital birth with a doctor traditionally emphasized institutional determinations including control over time, space, patient, and outcome, “hospital birth” has very different meanings for different people in different countries, even for people in different locations within one country. For some, hospital birth describes an assembly line

⁵⁴ Note another interesting example of analogy – that between the maternity ward and the modern bureaucracy.

⁵⁵ Davis-Floyd, “The Technological Model of Birth” p. 482

⁵⁶ Louise Levesque, *Being Pregnant: There’s more to Childbirth than being pregnant*, Dilion Publications, Inc. St. Catherines, Canada: 1980.

⁵⁷ Cecilia Benoit, et al. *Moving in the Right Direction? Regionalizing Maternity Care Services in British Columbia, Canada*. National Network on Environments and Women’s Health (NNEWH) Working Paper Series #13. p. 1

procedure, complete with a manufactured birthing experience and the use of all associated technologies; while for others, it refers to a birth in a quiet room with family members and caregivers standing by.

Pregnancy and childbirth are the single biggest causes of hospitalization for women in Canada today. Three in four of births now involve some form of surgical intervention. Caesarean births, epidurals, forceps, vacuum extraction and episiotomies are all commonplace according to a 2003 report from the Canadian Institute of Health Information (CIHI).⁵⁸ The Report suggests one in two women receive epidural anaesthesia during labour; one in four women undergoes episiotomy during delivery; one in five births is medically induced using either drugs or surgical techniques; one in four births is by caesarean section; and one in six babies is delivered using forceps or vacuum extraction.⁵⁹ In 2006, Victoria General Hospital was recognized as having the highest caesarean birth rates in Canada;⁶⁰ this, despite the hospital's reputation for an ever-increasing collaborative atmosphere between doctors and hospital-midwives.

The meanings and practices associated with hospital birth, science, and technology are said to reflect many dominant societal values. Dr. Stanley James suggests that because “people are surrounded in their homes by various electric and electronic appliances...when they come to the hospital they expect to have new forms of instrumentation.”⁶¹ Is this faulty logic, or, is it possible that the majority of birthing women today have entered a culturally marked context whereby they can neither refuse

⁵⁸ Andre Picard, (2004, September 10) “Natural Childbirth No Longer the Norm in Canada” Health. *Globe and Mail*, pp. A11.

⁵⁹ *ibid.* A11.

⁶⁰ “BC Experts search for solutions” *Times Colonist*, Sunday, July 29, 2007.

⁶¹ Dr. James Stanley, quoted in Levesque, Louise, *Being Pregnant: There is More to Childbirth than Having a Baby*. Diliton Publications, Inc. St. Catherines, Canada: 1980. p .62.

technology since it is has become the essence of a cultural birthing identity, nor can they stand comfortably in the technocratic vortex without feeling a deep separation between themselves and what has become the meaning of an ‘progressive’ birthing experience?⁶² Although women might interpret the meanings of both technological intervention and biomedical discourse differently, the ever-increasing rates of surgical and pharmacological involvement is leading scholars in Canada to question whether there exists either in our knowledge or in our reflection that still recalls the memory of what was once thought of as a ‘natural’ process...⁶³

Finally, even as maternal care clients along with their practitioners actively work to re-shape their negotiations with medical technology and biomedical practice, the scholarly framing of these issues carries the potential to recreate a tautology that often risks overlooking the people that matter and the creative opportunities for future negotiation. Then again, as an increasing number of women in BC and elsewhere in Canada currently slip back and forth across the conceptual and practical divide between biomedical and midwifery care, birthing women *are* negotiating their access to biomedical technology and a particular form of care that hospital-midwives have fought so hard to provide. One might wonder if this is what Haraway had in mind? Do the choices of midwifery clients constitute a case in which women are becoming responsible for, rather than ‘dominated’ by, biomedical technology? If so, their engagement with

⁶² Arthur Kroker, *The Will to Technology & The Culture of Nihilism: Heidegger, Nietzsche, and Marx*. Toronto: University of Toronto Press: 2004. p. 38

⁶³ Andre Picard, (2004, September 10) “Natural Childbirth No Longer the Norm in Canada” *Health. Globe and Mail*, pp. A11.

midwifery and biomedical practice might best be described as a critical repositioning and not resistance or acquiescence.⁶⁴

⁶⁴ MacDonald, "Postmodern Negotiations with Medical Technology..." p. 255.

Biomedical Tensions: A Reading ‘With and Against’ Michel Foucault

Various classificatory schemes have organized the framing of disciplined scholarship to greater and lesser degrees. Many academic disciplines have for decades emphasized the importance of category and classification of everything from different cultures, their rituals, and their rites of passage, to the body, its organs, and its functions. For reasons not entirely clear, something could not be truly understood, truly known, until reduced to a tidy-bounded box of classification. With important questions concerning epistemology and ontology cast to the margins, classificatory schemes, often fueled by disciplinary thought and practice, were designed in such a way that simply said what something “is” - and therefore what something “is not”; put differently, in this base systematic something could be one or the other, but never both. But then, by looking indirectly at the edges – where things come together with other things – one can often discern as much about them, as can looking at them straight on.⁶⁵

For Gilles Deleuze, the most important events happen “at the boundary between things and propositions” – “everything noisy happens at the edge.”⁶⁶ Hence, it is not the identification of tidy categorical boxes that necessarily rings true, but edges of knowledge and identity - the margins - that are of crucial importance. Deleuze suggests there is always more than what presents itself, a surplus beyond what is directly experienced. That surplus is not another fixed identity, a “something else,” but the virtuality of difference with no identity and every measure of potential.⁶⁷ To explore such excess is not simply an exercise in transcendence with certain communities searching for another

⁶⁵ Clifford Geertz, quoted in Wendy Brown, “At the Edge” in *Political Theory*, Vol. 30 No. 4, August 2002. pp. 556 – 576.

⁶⁶ Gilles Deleuze. *The Logic of Sense* (Trans) M. Lester (Ed) C. Boundas (Columbia University Press; New York) [1969] 1990. p. 155

⁶⁷ Todd May, *Gilles Deleuze: An Introduction*, Cambridge University Press, 2005. p. 55.

form of superiority or the “beyond-ness” of present circumstance. Transcendence merely allows things to be explained in such a way as to privilege one form at the expense of another, to preserve the superiority of what might be described as “edge work.” On the contrary, the intention is to make borders porous and identities fluid.

Early medical textbooks assigned in Canadian medical schools were predominantly American and British during the first half of the twentieth century.⁶⁸ These influential texts promised not only the latest research and the representation of a new “reality,” but also the orthodoxy of the medical profession.⁶⁹ Wendy Mitchinson, author of *Giving Birth in Canada: 1900-1950*, suggests that these texts demonstrated how physicians at the time worked within two worlds. The first was the construct of science: *positivist* in character, and focused on the reduction of things in order to study them through experimentation and formalizing knowledge into generalized cause and effect relationships.⁷⁰ The method of examination was ultimately directed towards the form and magnitude of the patient: their different parts, their number, their position, and the very substance of every “thing.” In effect, description becomes to the object one looks at as position became to the representation it expresses: its arrangement in a series, elements succeeding elements.⁷¹ The second world consisted of the physician’s medical practice, where on a day-to-day basis the doctor was exposed to the “vagaries” and “contradictions” of human bodies.⁷²

⁶⁸ Wendy Mitchinson, *Giving Birth in Canada, 1900-1950*, Toronto: University of Toronto Press, 2002. p. 15.

⁶⁹ Foucault, *The Order of Things* [1966] Routledge Classics. NY, New York: 2004. p. 148

⁷⁰ *ibid.*

⁷¹ *ibid.*

⁷² Mitchinson, *Giving Birth in Canada...* p. 21

When Foucault produced *The Birth of the Clinic: An Archeology of Medical Perception* in 1966, he did so by situating himself at what he believed was the beginning of a contemporary shift in the way western subjects interacted with the medical world. Although he denies writing either “in favor of one kind medicine and against another kind of medicine, or against medicine in favor of the absence of medicine,” he makes clear that he is writing with the present in mind: “The research that I am undertaking...involves a project that is deliberately both historical and critical, in that it is concerned...with determining the conditions of possibility of medical experience in modern times.”⁷³ In essence, Foucault’s thought was dedicated to revealing the foundation that systematizes medical patients from the outset.

My decision to engage with this methodological text, and with Foucault more generally, is by way of *flexion* – a simultaneous coming with and against in order to fulfill my aim in showing 1) how “the clinic” was never simply a site of biomedicine to be resisted, but rather a complex and political site where various ways of thinking/doing/learning interact; and 2) that it is not so much the continuity of dominant biomedical discourse that is important, but those very fissures that identify the locus of change, complexity and difference; and further, that it is within those very fissures that boundary work might be viewed as the most effective.

To begin, during the 1960s and 1970s birthing women in Canada and the United States (US) started to report being heavily medicated, tied to their beds by their hands and feet, and left in pain for hours in their hospital rooms.⁷⁴ An Alternative Birthing

⁷³ Michel Foucault, *The Birth of Clinic: An Archaeology of Medical Perception* New York: Tavistock Publications [1963] 1973. p. xxi - xxii.

⁷⁴ Betty-Anne Daviss, “Reforming Birth and (Re)making Midwifery in North America” in *Birth by Design* eds. R. Devries, et al. (New York: Routledge) p. 71.

Movement (ABM) grew quickly in North America as more and more women spoke out about their dissatisfaction with biomedical hospital birth and began to explore alternative birthing options such as birthing at home. As the cultural milieu came to be marked by a general lessening of trust in professional authority, an unprecedented decline in respect for medicine, and a growing recognition of the emotional, social, and spiritual components of life and healing in particular, many birthing communities insisted upon alternative childbirth practices.⁷⁵ Emerging from the ABM were several small yet vocal childbirth groups formed by consumers and their midwives in the US and later Canada. These groups challenged the necessity of “routine” obstetrical practice and questioned the effectiveness and possible iatrogenic effects of intervention.⁷⁶ Many instead pushed for “family-centered” maternity care that included childbirth education and professional support for homebirth parents.

For many feminist writers of the 1970s, maternity care was an apt illustration of an oppressive patriarchal social structure. Their early work examined the power relations between physicians, pregnant women, and midwives. Medical science and the medical professions remained central in most studies even as this work developed. Biomedicine was seen as the source of power for maternity care professionals, allowing hospitals and medical specialists to assume control over birthing practice and guidelines. But in the late 1960s a number of like-minded women came together and called themselves the Boston Women’s Health Book Collective. Originally called “the doctor’s group,” these women came together to share their frustration and anger toward specific doctors, and the biomedical enterprise in general. Community discussion groups formed to evaluate

⁷⁵ *ibid.*

⁷⁶ *ibid.*

critically the medical institutions that claimed to meet their health needs – the hospitals, the clinics, doctors, medical schools, nursing schools, public health departments, and so forth.⁷⁷ Many discussion participants learned for the first time how little control they had over their lives and bodies. Potential forces soon emerged that targeted political and social change.

Our Bodies, Ourselves arose out of a thirty-cent booklet called *Women and Their Bodies*, published in 1970 by the New England Free Press and written by twelve feminist activists who spearheaded the Health Book Collective. The original booklet was intended as the basis for a women’s health course, the first to be written for women by women: “We weren’t encouraged to ask questions, but to depend on the so-called experts,” says Nancy Hawley: “Not having a say in our own health care frustrated and angered us. We didn’t have the information we needed, so we decided to find our own.”⁷⁸ Many would argue this single publication spearheaded the alternative birthing movement led by healthy birthing advocates, women and their families, and midwives.

The publication of *Our Bodies, Ourselves* has an interesting convergence with *The Birth of the Clinic*. Things were indeed beginning to change. Yet despite much acclaim from various feminists and alternative birthing advocates for Foucault’s historical and critical works, there are significant tensions between his work and feminist politics. Where Foucault and feminist thinking most obviously come together is the emphasis on the “culturally constructed,” rather than the naturally dictated, quality of codes of behavior. Foucault laid the groundwork for feminist denunciations of the

⁷⁷ Boston Women’s Health Collective, *Our Bodies, Ourselves: A Book By and for Women*, Simon and Schuster: New York: 1971.

⁷⁸ Molly McGinty “Our Bodies, Ourselves Turns 35 Today” May 04, 2004.

<<<http://www.womensenews.org/article.cfm/dyn/aid/1820/context/archive>>> January 23, 2008.

‘naturalness’ of bodies themselves. *The Birth of the Clinic*, more specifically, established the parameters of discursive analysis involving the clinic, the physician, and the patient – an analysis that essentially mapped out the “medicalized body” as an effect of a decentered activity, a politics decentralized.⁷⁹

It may be useful here to recall Foucault’s comments concerning the ‘biopolitics of the population’ discussed above to help frame what is meant by ‘decentered activity, politics decentralized.’ Again, for Foucault, the mapping of the body onto the mechanics of life serves as the foundation of the biological processes: reproduction, births and deaths, the level of health, life expectancy and longevity, not to mention all the conditions that can cause these to vary.⁸⁰ As an instrument of and for the state apparatus, institutions of power – such as the medical profession – ensured the maintenance of production by creating techniques of power – such as medical assistance and the discourse of contagion – that would be present at every level of the social body and implemented by a multiplicity of institutions: the family, schools, police, the administration of collective bodies, and *individual medicine*.⁸¹

For Foucault, linking medicine with the destinies of state governments granted to medicine the ‘positive’ role of health, virtue, and happiness – a far cry from its earlier responsibility of the ‘dry, sorry analysis of millions of infirmities’ – “the dubious negation of the negative.”⁸² Medicine was thus no longer confined to curing ill and the knowledge required to do so; it was to embrace the knowledge of the *healthy man*, that is, to become a study of *non-sick man* and a definition of *model man*: “At last medicine will

⁷⁹ Sheldon S. Wolin, “On the Theory and Practice of Power” in *After Foucault*, p. 194

⁸⁰ Michel Foucault, “The History of Sexuality,” Vol. 1, New York: Vintage, 1979 (1975) p. 139

⁸¹ *ibid.*, p. 141.

⁸² Foucault, *The Birth of the Clinic*, p. 39.

be what it must be, the knowledge of natural and social man.”⁸³ In this way, the unique character of the “science of man” becomes linked with the positive role that medicine implicitly occupies as the norm.⁸⁴

In short, prior to this development, nineteenth-century medicine, according to Foucault, was regulated more in relation to ‘normality’ than to ‘health;’ it formed its concepts and prescribed its interventions in relation to standard functioning, organic structure, and physiological knowledge. The new emphasis on ‘health’ was to become established at the very centre of all medical reflexion. Hence, the prestige of the sciences of life in the nineteenth-century, their role as model, especially in the human sciences, was, as discussed above, linked not with the comprehensible, transferable character of biological concepts, but, rather, with the fact that these concepts were arranged in a space of profound structure that responded to the healthy/pathological opposition.⁸⁵

Foucault suggests the doctor, now supported and justified by the state artifice, was endowed completely and fully with the power of decision and intervention in the late eighteenth century. New objects of science were to present themselves to the medical gaze in the sense that, and at the same time as, the knowing subject reorganizes him/herself, changes him/herself, and begins to function in a new way. But, at the same time: the phenomenon itself came to represent the *whole*. The deviation from the norm (the disease), the phenomenon, the symptoms, etc., came to constitute their totality, the form of their coexistence, *and* the absolute difference that separated health from disease. The deviation thus signified the totality of what it is, and by its emergence, the exclusion of what it is not; the medicalized subject was thus doubly signified: by itself as an object

⁸³ *ibid.* p. 41.

⁸⁴ *ibid.*

⁸⁵ *ibid.*

of science and by the phenomenon as the whole of the negative.⁸⁶ All of this came under the mandate of the medical profession with the clinic as that spatial zone to where the doctor's reflexion worked actively to keep the Enlightenment paradigm cleverly constant.

The Birth of the Clinic is a prominent text with multiple layers of nuanced theoretical and practical arguments. Foucault set out to provide a historical account of the dramatic shift that occurred in the relationship between "doctor" and "patient" in the first decades of the nineteenth century. In describing the political, social, and scientific milieu in which this transformation occurs, Foucault's historical work is concerned with revealing the structures through which modern medical subjects still experience the world:

In the last years of the eighteenth century, European culture outlined the structure that has not yet been unraveled; we are only just beginning to disentangle a few of the threads, which are still so unknown to us that we immediately assume them to be either marvelously new or absolutely archaic, whereas for two hundred years (not less, and not much more) they have constituted the dark, but firm web of our experience.⁸⁷

In the preface, Foucault speculates that it is only now possible to uncover the structures of medical experience because we are on the brink of yet another transformation:

Medicine made its appearance as a clinical science in conditions which define, together with its historical possibility, the domain of its experience and the structure of its rationality. They form its concrete a priori, which is now possible to uncover, perhaps because a new experience of disease is coming into being that will make possible a historical and critical understanding of the old experience.⁸⁸

But Foucault does not only set out to conduct a structural study that aims to disentangle the conditions of medical history and practice on a material level. He is also critiquing the historians of medicine that came before him. This might be read as a provocative

⁸⁶ *ibid.* p. 112.

⁸⁷ Foucault, *The Birth of the Clinic*, p. 246.

⁸⁸ *ibid.*, p. xvii

move, since he will frame a similar critique of scientists in *The Order of Things*, published three years later. In *The Birth of the Clinic* he asks how we can be sure that the doctors of the eighteenth century did not really see what they claimed to have seen. He argues that nineteenth-century historians found continuity in the development of the scientific spirit because their own practice demanded it. For Foucault it was not so much about whether earlier historians found what they claimed that was important, but why their historical-theoretical circumstances compelled them to report these facts and patterns.⁸⁹

In *The Order of Things* Foucault lays claim with perceived certainty to three discontinuities that facilitated the scientific structure of western thought and practice. In tracing the rise of scientific truth through the Renaissance, the Classical, and the Modern epistemes, he claims not to make his ideas coherent and true in general, but to question whether the scientists responsible for scientific discourse were not determined in their situation, their perceived capacity, by conditions that might have dominated them. He asks: were there rules - values – “scientists used in order to be recognized at the time when it was written and accepted, as contributing to scientific discourse of a particular type?”⁹⁰ For Foucault these early scholars rarely set out to challenge dominant practice, but rather “repressed” the methodology of the clinic to show the existence of a natural scientific curiosity that they believed themselves to possess. At the same time, Foucault maintains that the liberal historians of that era simply tied the development of medicine to

⁸⁹ Michael Roth, ‘Foucault’s “History of the Present” in *History and Theory*, Vol. 20, No. 1 (Feb., 1981), pp. 32-46.

⁹⁰ Michel Foucault, *The Order of Things* [1966] Routledge Classics: NY: New York: 2004. p. xv

their political beliefs and basically “forgot” early debates of the Revolution in order to justify their views about the relationship between knowledge, power, and freedom.⁹¹

In much of Foucault’s works, including *The Birth of the Clinic*, he maps and analyzes *discourses*. He suggests discourses are historically variable ways of specifying knowledge and truth. Scientific discourses function as sets of rules, and the operation of these rules and concepts in programmes in turn specifies what is, or is not, the case – the constitution of ‘disability,’ for example. Discourses in and of themselves therefore wield a certain amount of power, for Foucault. Officials through institutions may exercise this power, or through many other practices, but power, for Foucault, is constituted in discourses and it is in discourse, such as clinical medicine, that there lies the overt ability to wield power. Foucault is not interested in what discourses *mean*, but what *in them* makes them possible. Foucault insists that the notion of power could not be usefully investigated independently of discourse because “relations of power cannot themselves be established, consolidated nor implemented without the production, accumulation, circulation and functioning of discourse.”⁹² Evidently, this view makes it problematic as to whether it is possible to think in terms of pre-discursive reality such as the existence of the human body before it is socially constructed.⁹³

But recall that Foucault does not wish to suggest that a scientific discourse was handed down to the human sciences in response to some unresolved scientific problem; rather, the natural sciences simply decided to include humans among the objects of

⁹¹ Roth, ‘Foucault’s “History of the Present” on History and Theory, Vol. 20, No. 1 (Feb., 1981), pp. 32-46

⁹² Foucault, quoted in Wolin, “Theory and Practice of Power,” p. 195

⁹³ Caroline Ramazanoğlu, “Introduction” in *Up against Foucault*, p. 19-20

science despite the still unproven ability to classify them.⁹⁴ Hence, the human sciences appeared only when man constituted *himself* in western culture as both that which must be conceived of and that which is to be known⁹⁵ - the dawn of the “individual,” so to speak.

This arrangement is much more than a phenomenon of opinion for Foucault: it is an event in the order of knowledge by which the modern patient remains trapped within a recognizable epistemology with roots deep in the Enlightenment – the shift in European thought stemming largely from the eighteenth century. Although these ideas have been intensely contested, they remain influential in affecting commonsense assumptions about what is ‘true,’ how we discover truth, the superiority of reason over emotion, objectivity over subjectivity, mind over body. Meanwhile, much of feminism has criticized Enlightenment thought as concealing masculine bias beneath the appearance of neutrality and objectivity.⁹⁶

One of the axioms of European Enlightenment is the “disenchantment of the world in which knowledge, which is power, knows no obstacles.”⁹⁷ With modernity comes a new form of institutional power which is based on visibility and transparency and which refuses to tolerate areas of darkness. For Jamie Smith-Windsor, author of “The Cyborg Mother,” exposing the womb, monitoring the female body, locating motherhood outside of the mother/child symbiosis, creates a space where the human

⁹⁴ Recall, for example, that our working definition of *biomedicine* is application of the principles of the natural sciences – especially biology and physiology – to clinical medicine.

⁹⁵ Foucault, *The Order of Things*, p. 376

⁹⁶ Ramazanoglu, “Introduction” p. 23

⁹⁷ Michel Foucault, quoted in Yegeboglu, Meyda, “Veiled Fantasies: Cultural and Sexual Difference in the Discourse of Orientalism” in *Feminist Postcolonial Theory*. Eds. Reina Lewis and Sara Mills. New York: 2003 p. 553.

condition is filtered through a technological gaze.⁹⁸ But even more so, internalizing the technologies of the state, both material and political, allows the cultivation of human life in and for the state. For Smith-Windsor, the epistemic branding of the state on bodies and minds of the subordinate citizenry is about *exposure*, about making visible everything private of the human body for the purpose of controlling individual life.⁹⁹ As the space for constituting life, therefore, viewed in this way, the womb comes to represent a crossroads for institutional discourses that are directed toward managing that life, the relationships between various institutions, to each other and to individuals – all to be understood in and through a connection with ‘prenatal space.’¹⁰⁰

Let us digress a moment to consider the ultrasonic fetus as a semiotic object cast upon the screen to give meaning to this aforementioned ‘prenatal space’ - hence, the premise set forth by Rosalind Petchesky that the fetal image is a symbol, “a kind of empty signifier that condenses within it many different meanings at once.”¹⁰¹ Petchesky argues that the semiotic fetus is always already culturally marked; moreover, while the physical world may exist independently of us, “still ‘it’ has no meaning outside a conceptual system of *a priori* figurative, rhetorical, metaphorical meanings in the sense of understanding one thing in terms of another.”¹⁰² For Petchesky the ultrasound machines used to ‘see’ into the interior of the pregnant woman, are “...instruments through which multiple, overlapping, and changing discourses about the body, gender, disability, health economics, and sexuality operate on and construct women, fetuses,

⁹⁸ Smith-Windsor, “The Cyborg Mother” p. 187

⁹⁹ *ibid* p. 189.

¹⁰⁰ Nathan Stormer, “Prenatal Space” in *Signs*, Vol. 26, No.1 (Autumn 2000), 109-144.

¹⁰¹ Rosalind Petchesky, quoted in Mitchell, Lisa, *Baby’s First Picture: Ultrasound and the Politics of Fetal Subjects*. Toronto: University of Toronto Press: 2001. p.13. p. 17.

¹⁰² *ibid*. p. 30.

sonographers, and others.”¹⁰³ Importantly, discourses about the body are not static – they have always been subject to negotiation, cultural specification, and ontological depictions of what it means to be an individual in modern times.

Sarah Franklin suggests the “very term ‘individual,’ *meaning one who cannot be divided*, can only represent male. Pregnant women, in contrast, are divisible: simultaneously one and two, self and other.”¹⁰⁴ Sara Ruddick also comments on this paradox. For her, childbirth undermines the individuation of bodies. The growing fetus, increasingly visible in the woman’s swelling body, an infant emerging from the vagina, a suckling infant feeding off a breast, express in dramatic form a fusion of self and other.¹⁰⁵ Pregnant women, in this view, are the precise antithesis of in-dividuality. This conceptualization does more than simply call into question our assumptions about the uniform and unitary being. The notion of individuality leads directly to links between person, gender, and power.¹⁰⁶ Haraway argues that this might be why “women have had so much trouble counting as individuals in modern western discourses. Their personal, bounded individuality is compromised by the body’s troubling talent for making other bodies, whose individuality can take precedence over their own.”¹⁰⁷

The depiction of the ‘individual’ that Foucault problematizes in *The Birth of Clinic* (and indeed elsewhere) is slightly different. Although his depiction may also be based upon a masculine template,¹⁰⁸ he casts an important critique upon the

¹⁰³ Mitchell, *Baby’s First Picture* p. 14.

¹⁰⁴ *ibid.* p.13.

¹⁰⁵ Sara Ruddick, quoted in Ramazani, Vaheed, “The Mother of All Things: War, Reason, and the Gendering of Pain.” in *Cultural Critique*. 54—Spring 2003—Copyright 2003 Regents of the University of Minnesota. p. 12.

¹⁰⁶ Mitchell, *Baby’s First Picture* p .13.

¹⁰⁷ *ibid.*

¹⁰⁸ Foucault is criticized on this point extensively; see, for example, Soper, Kate, Caroline Ramazanoglu, et al. *Up Against Foucault*, Routledge, London and New York, 1993.

'homogenous' body. He suggests the modern patient is enveloped in a collective, homogenous mass of truth and method. Furthermore, biomedical discourse does not merely observe and report on bodies; it constructs bodies through particular strategies of investigation and surveillance based upon a preconceived notion of what the body "is" and of what the body is capable. Meanwhile, the institution of medicine is responsible for defining a specific set of meanings that are constantly involved in the social processes that are appropriate for that institution, and engages with those meanings and practices as they are mediated through the patient, surgeon, researcher and so on.¹⁰⁹

Foucault's works are written to encourage his readership to look critically at specific historical events in order to uncover new layers of significance, especially the arbitrary nature to which modern subjects seemingly succumb to various codes of knowledge. Often recognized for providing ammunition to feminist scholars seeking to 'reclaim' the birthing body from 'clinicization' and its subjection to an intrusive 'male' science, Foucault alerted various communities to the collusive role of the subject in the operation of a 'biopolitic' and its routinizing techniques. His works focused on the body as the site of an objectivizing disciplinary power exercised through various medical, educational, and familial institutions and their associated forms of scientific know-how. Feminist scholars were quick to see the relevance of his arguments to the understanding of the more 'unofficial' processes of medicalized childbirth.

In *The Birth of Clinic* Foucault focuses on some of the constraints that bound the individual to the medical system – constraints that seem natural and inevitable – in order to show that they are, in fact, historical and contingent. For example, he argues that medicine has tended to recount its own history as if the bedside of the patient had

¹⁰⁹ Mitchell, *Baby's First Picture*. p. 6.

remained a constant, stable experience, in contrast to theories and systems. The theories and systems were masked beneath their speculation of the purity of clinical evidence. The theoretical, it was thought, was the element of perpetual change, the starting point of all the historical variations in medical knowledge, the locus of conflicts and disappearances. In short, it was the theoretical element that medical knowledge marked as fragile relativity.¹¹⁰ The clinic, by contrast, was thought to be the element of positive accumulation with its constant gaze upon the patient. Ever renewed attention to the patient facilitated not the disappearance of medicine with each new speculation, but its self-preservation assuming little by little the figure of a truth that is definitive, if not complete. Hence, medical practice developed below the level of the noisy episodes of history, in a continuous historicity: in the “non-variable of the clinic, medicine, it was thought, had bound truth and time together.”¹¹¹

For Foucault there are aspects of the medical system that appear immune from change unless we recognize the historically contingent power dynamics inherent to the medical system itself. Foucault suggests his historical study reveals the arbitrariness of institutions that are far from being determined by “anthropological constraints,” but are instead molded by historical and political forces. Only when medicalized subjects recognize the historical character of these constraints, will they be able to invoke change.¹¹² What Foucault seems to be suggesting is that human subjects conform to the limits the medical institution places before them, and order their medical experience with those limits in mind.¹¹³ That said, it might also be the case that human subjects learn to

¹¹⁰ Foucault, *The Birth of the Clinic*, p. 65

¹¹¹ *ibid.*

¹¹² May, *Gilles Deleuze*, p 10-11

¹¹³ *ibid.*, p. 9

appreciate the medical profession and the clinic as always already in a state of development, even when moments of relative stasis and/or hyperbole are politically (and historically) justified as expedient.

There arises a productive dimension of power in relation to the medical institution proffered by Foucault. This, more specifically, is as a source of power called *resistance*. He writes, “We must make allowance for the complex and unstable processes whereby discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling block, a point of resistance and a starting point for an opposing strategy.”¹¹⁴ For Foucault, oppressed subjects – birthing women and their families, alternative birthing advocates, such as midwives – must form a resistance against that which they believe dominates them, namely the biomedical clinic. According to this Foucaultian logic, such resistance can be used as a catalyst to cast light on power relations, locate their position, and find out their point of application and the methods used.¹¹⁵ Foucault identifies three different forms of resistance as productive:

- 1) Against forms of domination (ethnic, social, religious);
- 2) Against forms of exploitation that separate individuals from what they produce;
- 3) Against that which ties the individual to himself and submits him to others in this way (struggles against subjection).¹¹⁶

Importantly, however, resistance by and in itself does not contain a critique, a vision, or even the grounds for organized collective efforts. As political theorist, Wendy Brown, suggests, insofar as resistance avoids rather than revises problematic practices, resistance

¹¹⁴ Foucault, quoted by Karen Bridget Murray, “Governmentality and the Shifting Winds of Policy Studies” in *Critical Policy Studies*, Eds. Michael Orsini and Miriam Smith, University of Vancouver Press, Vancouver, BC, 2007.

¹¹⁵ Foucault “The Subject and Power” in *Michel Foucault: Power* p. 329

¹¹⁶ *ibid.* 331

goes nowhere in particular, has no inherent attachments, and hails no particular vision.¹¹⁷ Furthermore, the biomedical enterprise might be resisted, but it will never be overcome given its valuable contributions to health and health care.

A certain reading of Foucault suggests that his presentation of a dominating, historically contingent discourse contains little to no room for transformation. According to Sheldon Wolin, Foucault not only provides a vision of the world in which humans are caught within confining structures of knowledge and practice, but there is also no hope of escape. Moreover, while every framing of discourse embodies a power drive and every arrangement is repressive, there is no exit because Foucault has closed off any possibility of a privileged theoretical vantage point that would not be infected by the power/knowledge syndrome.¹¹⁸ Fredric Jameson also criticizes Foucault for presenting a powerful vision of a total, all encompassing system that in turn leaves readers essentially powerless.¹¹⁹ For Jean Baudrillard, two streams of thought are often overlooked in Foucault's early works: the first is the way he creates a powerful generating spiral that is no longer a despotic architecture but a coil without origin and catastrophe, unfolding ever more widely and rigorously; the second, is an interstitial flowing of power that seeps through the whole porous network of the social, the mental, the body, infinitesimally modulating the technologies of power.¹²⁰ Put simply, what Baudrillard finds especially impressive in Foucault's work is how he propounds so readily a discourse that mirrors the very power he describes.¹²¹

¹¹⁷ Wendy Brown, "Postmodern Exposures, Feminist Hesitations" in *States of Injury: Power and Freedom in Late Modernity*, p. 49

¹¹⁸ Wolin, "Theory and Practice of Power," p. 186.

¹¹⁹ Fredric Jameson, quoted in *Introducing Foucault*, p. 168

¹²⁰ Jean Baudrillard, *Forget Foucault*, p. 9-10.

¹²¹ *ibid*

But Foucault's contributions to the analysis of complex bodies and decentered practice should not be overlooked. Perhaps most notably, it is his emphasis on the "culturally constructed" quality of codes of behavior and the genealogical mappings of the "medicalized body" that compels social political theorists and activists to revisit his works for reference and inspiration alike. It should be noted that Foucault does appear to retreat from the emphasis on total institutions in his later works. In the *History of Sexuality*, for example, he declares that "power is not an institution, and not a structure...it is the name that one attributes to a complex strategical relationship in a particular society."¹²² More importantly, his works may not be so much about totalizing power or totalizing critiques after all. For example, when looked at obliquely something much more tentative comes to light; namely, those specific counterpoints that are essential to complex lines of alliance and difference between science and non-science, medical norms and alternative forms of practice.

Foucault self-assuredly situated *The Birth of the Clinic* as a pivotal text targeted at illustrating the brink of a dramatic shift in the structures of modern medical experience. The positioning of writing a history of the present is essential to his task because it enables him to conceive of the present as that which itself is almost history. Hence, the moment of 'discontinuities' alludes to a turning point wherein it is not so much the longevity of this or that discourse that is important, but those very *fissures* that identify the locus of change, complexity and difference. Consider, for example, the way in which the medical profession conveniently aligned with state governments and the resulting shift in ontology of the body. To be sure, Foucault was not about reinstating or privileging a particular form of medical practice. Rather, his focus privileges surfacing

¹²² Foucault, quoted in Wolin, "Theory and Practice of Power," p. 194.

the inconsistencies inherent to the development of modern medicine in order to invoke action by those communities sitting on the edge of yet another transformation.

Finally, I believe Foucault knew that his archaeologies were much more than a basic attempt at reconciliation with the apparent limits within a particular period or historically contingent structure; rather, they were more suitably dedicated to revealing the arbitrary limits in totalizing thought and practice more generally. Writing in the late sixties and early seventies, Foucault cast light upon the subtle excesses that are subject to both dramatic discontinuities and momentary ruptures that hold within them an immanent space for negotiation and struggle.¹²³ To be sure, negotiations with the biomedical clinic have been occurring for some time in Canada. Perhaps the biggest transformative example of these negotiations is the increasing acceptance of midwives as primary birthing attendants in hospital and clinical settings. Hence, “the clinic,” as defined by Foucault in *The Birth of the Clinic*, was never meant as a simple site of a pre-determined dominant biomedical discourse, but rather a complex site where various ways of thinking, doing, and learning interact despite being inundated at various times and to varying degrees by a politics that was, and is, indisputably our own.

¹²³ The idea of ‘subtle excess’ is similar to the Deleuzian concept of *surplus* discussed above; hence, the idea that if we can imagine a “something else” beyond what is directly experienced, then it is possible to imagine alternatives with no identity and every measure of potential.

“Boundary Work” and the Shifting Tides of Biomedical Policy and Practice

In the past twenty years there has been no more important maternity care policy initiative in Canada than the integration of midwifery into various provincial health care systems. Prior to the 1970s, there were few midwives in Canada, and their practice was neither legal nor officially recognized by the federal or provincial governments. In fact, Canada was the only western industrialized nation without any formal provisions for midwifery care. By the end of 1993, however, Ontario became the first Canadian province to fully license, integrate into, and fund midwifery services by the provincial health care system. Legislation followed in the provinces of Alberta, British Columbia, Quebec, Manitoba, and Saskatchewan. Within a mere decade, midwifery in Canada moved from obscurity to an officially recognized maternity care option.¹²⁴ In this next section I provide a brief background of the past and present maternal health policy arena in Canada and move to show how midwives and physicians have used, and continue to use, “boundary work” to negotiate their roles within the biomedical enterprise.

Canadian midwives had been excluded from licensure in most provinces in the early decades of the twentieth century. Midwifery remained a traditional craft across most jurisdictions of the country, and in many provinces physicians led successful campaigns to eradicate the occupation. This move essentially deprived women of the option to seek out a midwife to care for them during pregnancy, childbirth, and the postpartum period. Traditional “granny midwives” continued to practice in many areas of Canada. However, in the long run midwifery was undermined in most areas of the country. By World War II childbirth attendance was the mandate of the medical

¹²⁴ Ivy Lynn Bourgeault, et al. . “Changing Birth: Interest groups and Maternity Care Policy” in *Birth by Design*, P. 52-53

profession. Women had no option but to pay for physician services out of their own pockets.¹²⁵

In part to help remedy this situation, the federal government of Canada introduced the Hospital Insurance and Diagnostic Act in 1957.¹²⁶ This Act provided payment for a number of medical services associated with hospitalization and medical testing. A cost-matching scheme between the federal and provincial governments determined the payment structure, with provincial governments reimbursed fifty percent for a fixed portion of the expenditures. The Act did not cover the cost of physicians' services, however. Pregnant women across Canada paid for services using their own money or private insurance for most of their maternity care – by now almost exclusively provided by the medical profession.¹²⁷

Universal health insurance arrived with the passage of the federal Medical Care of 1968 (implemented in 1972). The act couples national values with provincial administration through an innovative program, eventually known as Medicare. Under this second Act, physicians' fees were insured. Pregnant women in Canada now had access to physician and hospital services at no cost. The five fundamental principles of the new Canadian health insurance Medicare plan included Universality of Coverage, Portability, Comprehensiveness, Accessibility, and Public Administration.¹²⁸

- **Universality of Coverage** The act stipulated that ninety-five percent of all residents of Canada had to be covered within two years;
- **Portability** Provincial governments had to ensure that the benefits would be portable from one province to another;

¹²⁵ Sirpa Wrede, et al. "The State and Birth/ The State of Birth" in *Birth by Design* p. 28 – 50.

¹²⁶ *ibid*

¹²⁷ *ibid*

¹²⁸ *ibid.*, p. 42

- **Comprehensiveness** Provincial governments had to cover all “medically necessary” services inside or outside hospitals, as well as dental surgery performed inside hospitals;
- **Accessibility** Provincial governments had to ensure medical services were “reasonably” accessible, were provided on “universal terms and conditions” and were free of any barriers to access (such as extra billing by physicians);
- **Public Administration** Provincial governments were to administer their health plans directly or through a non-profit public agency fully accountable to the provincial government.¹²⁹

Physicians were initially resistant to the implementation of a “socialized” health care system for Canada, but in the end, and only after the massive doctors’ strike of 1962 in Saskatchewan, did the medical profession – and obstetricians in particular – gain much by the new state policy. First, services were reimbursed by the public purse, virtually guaranteeing practitioners’ economic security. Second, Medicare granted to physicians the monopoly over maternal health care. ‘Alternative’ health services, such as midwifery, remained uninsured, leaving women to seek midwifery services in the private market only. Third, physicians retained their right to remain private entrepreneurs, establishing their practices wherever they deemed appropriate and making available a wide range of medical services to women that physicians themselves, not their clients, deemed necessary. Finally, hospitalization of childbirth had long been a goal of the Canadian medical profession. Medicare solidified the hospital as the lynchpin to the maternity care system. One important reason for doctors to promote hospital birth over domiciliary care was the need for the physicians to be able to use substitute health providers to assist them in the care of birthing women and their newborns. Canadian physicians thus gave their support to the training of obstetrical nurses, a strategy that was

¹²⁹ Premier Gordon Campbell recently announced in his Speech From the Throne 2008 that “Sustainability” will be added as a sixth principal in BC context “to ensure our health care system will be there for our children, our grandchildren, and their families:
<http://www.gov.bc.ca/premier/2008_throne_speech/index.html>

enthusiastically supported by the nursing lobby.¹³⁰ In short, until recently maternity care services were divided among specialized medical fields of obstetrics and gynecology, while prenatal care was provided by family doctors/general practitioners, public health nurses, and, in some jurisdictions, by private prenatal and postnatal educators, labour coaches/dulas, and midwives working in the private market.¹³¹

On January 1, 1998, licensed midwives commenced public practice in BC. Midwives in BC could now legally attend birth either at home or in hospital. Regulation was the culmination of an arduous struggle for legitimization by some midwives through their professional association, The Midwifery Association of B.C. (MABC), and for consumers, through the Midwifery Task Force (MTF) - that began in the 1970s.¹³² Currently, the College of Midwives of British Columbia (CMBC) regulates the profession of midwifery in BC. The College's Mandate is to "serve and protect the public interest of midwifery in accordance with the Midwives Regulation under the Health Professions Act and the CMBC bylaws."¹³³

According to the CMBC official website, the philosophy of care that concerns the midwives of BC is dynamic, based upon knowledge derived from the arts and sciences, and tempered by experience and research. In seeking to combine knowledge of the social, emotional, cultural, spiritual, psychological and physical implications of each and every birthing experience, midwifery prides itself on its holistic approach.¹³⁴ Many midwives have long recognized the importance of 'forward-looking' midwifery, some

¹³⁰ Sirpa Wrede, "The State and Birth/ The State of Birth," p 43.

¹³¹ Benoit, Cecilia, et al. *Moving in the Right Direction? Regionalizing Maternity Care Services in British Columbia, Canada*. National Network on Environments and Women's Health (NNEWH) Working Paper Series #13.

¹³² Kornelsen, et al. "Challenges to Midwifery Integration..." p.111.

¹³³ *College of Midwives in British Columbia* official website <http://www.cmbc.bc.ca>

¹³⁴ *ibid.*

even spearheading the implementation of midwifery services in many provincial hospitals.¹³⁵ The original Manual (1998) entitled *Implementing Midwifery Services in British Columbia: A Manual for Hospitals and Health Regions* was created in collaboration with CMBC, the BC Health Association, the BC Children's and Women's Health Centre, the BC Ministry of Health, individual midwives, physicians, nurses and administrators working in hospitals around BC. The *Manual* was updated in 2005 – an indication that the role of midwives in hospitals is continuously being re-visited, even enhanced and strengthened.

Today, in almost every province with legislated midwifery, there are provincial colleges that act as a regulating body. The colleges provide midwives with their registration. There are also provincial associations that represent midwives as a professional body, providing professional development, public relations and lobbying on their behalf. In a growing number of provinces there are midwifery education programs that set and deliver curricula at the university level. Midwifery is legislated in some provinces, while some provinces also have funding, some offer choice of birth site, and some provide all three. In other areas, there may be active midwifery practices not yet recognized by provincial legislation. The chart below provides a convenient cross-Canada look at which provinces offer public funding, formal training, and birth site options:¹³⁶

¹³⁵ *Implementing Midwifery Services in British Columbia: A Manual for Hospitals and Health Regions* -- Luba Lyons Richardson, past president of the College of Midwives of BC.

¹³⁶ Hawkins, *The Midwifery Option*, p. 41.

PROVINCE	LEGISLATED	FUNDED	FEE FOR SERVICE	HOME/ HOSPITAL/ BIRTH CENTRE	EDUCATION PROGRAM
Alberta	Yes	No	Yes	Home/ Hospital/ Birth Centre	No
British Columbia	Yes	Yes	No	Home/ Hospital	Yes
Manitoba	Yes	Yes	No	Home/ Hospital	No
Newfoundland and Labrador	No	No	No	Hospital (remote areas only)	No
New Brunswick	No	No	Yes	Home	No
Northwest Territories	No	No	Yes	Home	No
Nova Scotia	No	No	Yes	Home	No
Nunavut	Partially	Partially	No	Home/ Hospital	No
Ontario	Yes	Yes	No	Home/ Hospital	Yes
Prince Edward Island	No	No	Yes	Home	No
Quebec	Yes	Yes	No	Birth Centre	Yes
Saskatchewan	Yes	No	Yes	Home	No
Yukon	No	No	Yes	Home	No

Midwifery legislation in each of the participating provinces has neither come about nor been implemented in exactly the same ways, though each has had its legislative outcomes translated into public policy. In 1992 Leslie A. Pal defined public policy as an identifiable “course of action or inaction chosen by public authorities to address a given problem or interrelated set of problems.”¹³⁷ Public policies, for Pal, are largely “instrumental” – that is, they are not ends in themselves, or even good in themselves, but are instruments or tools used to tackle issues of concern involving the political

¹³⁷ Leslie A. Pal, *Beyond Policy Analysis: Public Issue Management in Turbulent Times*. 2nd Ed. Nelson Thompson Learning: Canada 2001 p. 2

community.¹³⁸ Pal more recently came forward to suggest the “real world” of policy making is increasingly marked by *crisis*. He argues that policy makers and students of public policy re-examine their tool kits and reflect on just what policy analysis is supposed to achieve.¹³⁹

Given the relative dearth of hospital beds and mounting shortage of childbirth practitioners across Canada, it may not be surprising that reform strategists are increasingly being called upon to respond to what is being deemed an impending ‘crisis’ in maternal health care. The Society of Obstetricians and Gynecologists of Canada (SOGC) also declared the shortage of maternity care providers across Canada as a primary factor that threatens the sustainability of maternity care.¹⁴⁰ The shortage in human health resources was in fact a priority identified in the First Ministers’ 2003 Accord and is a key element of its 10-year plan. The Health Council of Canada also stated that Canada needs more obstetricians, family doctors, midwives, and nurses who are willing to participate in collaborative maternity care teams.¹⁴¹

To be sure, the shortage in maternal care providers and insufficient access is not limited to physicians. Midwives, too, are limited in number and, similar to the geographic tendencies of physicians, are concentrated in large urban pockets. In 2000, seventy percent (67 registrants) of certified midwives in BC practiced in or adjacent to the two major cities of Vancouver or Victoria. Only two midwives were practicing in the north of the province, both in the city of Prince George with a population of 75, 000.¹⁴²

¹³⁸ *ibid.*, p. 3.

¹³⁹ Pal, *Beyond Policy Analysis* (2005), quoted in Orsini, Michael et al. *Critical Policy Studies*, Eds. Michael Orsini and Miriam Smith. UBC Press: Vancouver, 2007 p, 1

¹⁴⁰ National Birthing Strategy for Canada 1.5

¹⁴¹ National Birthing Strategy for Canada

¹⁴² Benoit, *Moving in the Right Direction?* p. 10

In 2007, there were a total of 128 registered midwives in BC, with 102 in active practice.¹⁴³ Despite the high concentration of midwives in Victoria (13) and Greater Vancouver (56), midwives now practice in fifteen BC communities, from Salt Spring Island (2) to Lister (3).¹⁴⁴ That said, midwifery also suffers from the same recruitment and retention problems as other professions: student midwives do not complete their midwifery education programs; some choose not to register after graduation; registered midwives retire early; and reimbursement and liability issues contribute to the shortage.¹⁴⁵

The *Rural Maternity Care Research Program of BC* recently suggested there are three primary implications for policy and practice affecting maternal care in rural BC today: 1) midwifery services in rural communities are vulnerable to shifting labour and delivery services to regional centres including hospital closures and lower GP attrition rates; 2) although one rationalization for the regulation and public funding of midwifery in BC was increased access, to date rural women, for the most part, have not benefited from regulated midwifery; and 3), legislative deterrents including current fee-for-service models of remuneration that make practice in low-volume environments challenging.¹⁴⁶ As such, *maternal health policy* – the “enforceable government legislation, institutional policies, or everyday practices that occur within the system of care for childbearing women”¹⁴⁷ – should also be open to a critical re-thinking of the fundamental assumption

¹⁴³ http://www.bcmidwives.com/MABC___Fact_Sheet.pdf

¹⁴⁴ *ibid*_Fact sheet

¹⁴⁵ *National Birthing Strategy for Canada*

¹⁴⁶ Stefan Grzybowski and Jude Kornelsen, “Rural Women’s Experiences in Maternity Care: Implications for Policy and Practice” http://www.ruralmatresearch.net/p_ruralwomenimplications.htm

¹⁴⁷ Lynn Bourgeault, et al. “Changing Birth: Interest Groups and Maternity Care Policy” in *Birth by Design* eds. R. Devries, et al. (New York: Routledge) 2001. p.52.

about political power and about the social and political structures that underpin the maternal health policy process in BC.¹⁴⁸

Classic texts of public policy focus on what the state does and why. Discussions centred on traditional domains of policy such as economic policy, social policy, foreign policy, and agricultural policy. Michael Orsini and Miriam Smith suggest the main theories of policy making were around the society/state binary. That said, contemporary theories of public policy challenge this traditional picture in a number of ways. As a sub-discipline of political science, policy studies embraces radically different theoretical and methodological approaches borrowed from other sub-disciplines of political science; examples include historical institutionalism, feminist analysis, social movement analysis, and Foucaultian analysis – all of which have injected new vigour into the public policy field. Similarly, extensive interdisciplinary cross-fertilization has also resulted in the adoption of theoretical approaches from other disciplines such as geography, sociology, communications, and cultural studies.¹⁴⁹ Leading policy analysts are also increasingly sharing and spreading their concern with moving beyond objectivist conceptions of reality, especially the fact/value dichotomy.¹⁵⁰

Maarten Hajer, professor in critical policy studies, suggested recently that policy-making and politics in Canada are increasingly taking place in an “institutional void” where “there are no clear rules and norms according to which politics is to be conducted and policy measures to be agreed upon.”¹⁵¹ He maintains that this does not mean that traditional institutions cease to matter; rather, there are policy problems that have

¹⁴⁸ Orsini, *Critical Policy Studies*, p. 15

¹⁴⁹ *ibid.*

¹⁵⁰ Maarten Hajer, quoted in Orsini, *Critical Policy Studies*, p. 3.

¹⁵¹ *ibid.*, p. 1 – 2.

necessitated political action of a different order. Hajer lays out some implications for the new domain of policy making: the dispersal of decision making, the new spatiality of policy making and politics, a rethinking of standard views of participation and governance, the undermining of scientific expertise, and an expansion of the context of policy making.¹⁵²

For Hajer, although states remain important units of analysis, politics and policy occur at a number of scales, and across different spatial horizons. Moreover, recognition of the importance of the spatial question and the dispersal of decision making requires a re-examination of widely held views of democratic participation and governance. Citizen consultations may be insufficient in an age in which citizens want greater say in the decisions that affect them. The role of citizens in policy making invariably raises the question of how evidence, whether scientific or experiential, can and should be incorporated into decision-making. This dilemma has been made worse by the profound mistrust and distrust of “science” to provide authoritative answers to complex policy problems,¹⁵³ as the example of New Reproductive Technologies demonstrates.¹⁵⁴ But then, just as new tools may be required to conduct policy analysis in situations of crisis, ways might also be found for institutions, networks, and even communities to put together order and knowledge in different ways so that each can successfully sustain its own internal processes while forming productive relationships with one another – as the case may be with midwives and doctors, for example.

¹⁵² *ibid.*

¹⁵³ Orsini, Michael et al. *Critical Policy Studies*, Eds. Michael Orsini and Miriam Smith. UBC Press: Vancouver, 2007 p. 1 – 2.

¹⁵⁴ Scala, 211-232

Boundary work is a conceptual tool typically used in Science and Technology Studies (STS) but also in policy studies. Boundary work is particularly important here as it highlights how different political and societal actors strive to shape the parameters of a debate and have their knowledge claims translated into the legitimate and authoritative voice on a policy issue.¹⁵⁵ Boundary work studies commonly show that while the distinction of what is and is not science (or politics) is often asserted to be quite sharp, it turns out, in practice, to be quite fuzzy.¹⁵⁶ More specifically, “boundary work” theories have provided a useful tool for understanding the relations between the biomedical industry and health policy to more adequately assess *the processes* involved in the interaction among social and political actors in negotiating their roles in governing the biomedical enterprise.

Francesca Scala maintains that boundary work theories take very seriously the role of insiders and outsiders that may (or may not) affect the policy process; while actual boundary work is thought to secure, close, and control the influences that may (or may not) effect its definitions of value and practice. Boundary definitions that involve diverse groups in society must constantly (re)negotiate their borders especially as they seek to define themselves by epistemologically distinct sets of beliefs within a specific cultural formation. As such, boundary work theories are used to consider how different disciplines, professions, and social organizations negotiate and maintain the boundaries that demarcate their spheres of influence and authority. Importantly, these boundaries are not fixed or impermeable; rather, they are “ambiguous, flexible, historically changing,

¹⁵⁵ *ibid.*, “*Scientists, Governments...*” p. 212

¹⁵⁶ Clark Millar, “Hybrid Management: Boundary Organizations, Science Policy, and Environmental Governance in the Climate Regime,” in *Science, Technology, and Human Values*, Vol. 26, No. 4 (Autumn, 2001), pp. 478-500.

contextually variable, internally inconsistent, and sometimes disputed.”¹⁵⁷ Scala uses the application of the concept of boundary work to contest the notion that scientific ‘experts’ enjoy a privileged status in society because of some inherent and essential quality to knowledge. Instead, she argues the empirical authority of the biomedical community is a product of its boundary work.¹⁵⁸

By definition *insider groups* are traditionally viewed as respected by government policymakers and permitted to play a consultative role in policy creation. By contrast, *outsider groups* are not accepted as legitimate and find it difficult to penetrate the policymaking process.¹⁵⁹ Users of the public health system have all been affected – physically and psychologically – by ‘insider’ groups, government, and biomedical policy. Many studies show how scientific authority continues to supply and maintain the narrative for maternal health policy deliberations.¹⁶⁰ According to Scala’s logic, the early polemic between obstetricians and midwives was at times exacerbated when biomedical industry leaders and scientific researchers celebrated the benefits of ‘objective’ and standardized models and methodologies while representing the ‘insiders’ of the debate with access to health policy and the decision-making process. By contrast, midwives and other persons concerned with biomedical consequence – the ‘routinization’ of medical technologies, for example – by default constituted the ‘outsiders’ with little to no access to the health policy decision-making process in this view of boundary work.

¹⁵⁷ Scala, “Scientists, Government...” p. 4.

¹⁵⁸ *ibid.*

¹⁵⁹ Bourgeault, et al. “Changing Birth: Interest Groups and Maternity Care Policy” p. 52.

¹⁶⁰ See “Bringing Up Baby – Spanking, C-sections, Midwives: We Check up on the Latest Research” in *The Vancouver Sun*, Saturday, February 23, 2008 A6-A7

Scala's work on biomedical policy negotiation points to four types of boundary work: monopolization, expansion, expulsion, and protection.¹⁶¹ *Monopolization* refers to the acceptance of "certain knowledge claims as authoritative and authentic."¹⁶² When activities are labeled science, individuals who are not scientists are automatically precluded from participating in the circle. Bridgett Jordan's suggestion that the devaluation of alternative knowledge systems is one mechanism by which hierarchical social structures are generated, maintained, and displayed is an example of monopolization in this sense.¹⁶³ *Expansion* occurs when "insiders broaden their sphere of influence and authority that are already claimed by others."¹⁶⁴ As a case in point, the medicalization of childbirth beginning in the 1900s saw midwives quickly 'displaced' by the newly emerging obstetric profession and exclusionary medical schools. *Expulsion* occurs when affiliates are "rejected because they do not conform to the accepted principles and practices of the group."¹⁶⁵ What comes to mind here is the case that left an obstetrician fighting for her professional life, contesting a suspension that resulted from a charge made by colleagues that she made insufficient use of birth technology in the hospital where she worked.¹⁶⁶ And finally, *protection* occurs when scientists "strive to safeguard their autonomy in a particular sphere of activity against external controls."¹⁶⁷ For Scala, the struggle for control is most evident in the boundary negotiations between science and politics. For example, the scientific community generally resists any effort

¹⁶¹ *ibid.*, p. 4-5.

¹⁶² Scala

¹⁶³ Jordan, *Birth in Four Cultures*, p. 153.

¹⁶⁴ Scala

¹⁶⁵ Scala

¹⁶⁶ Wagner, *Pursuing the Birth Machine*, p 5.

¹⁶⁷ Scala

on the part of legislators to determine its standard for practices of care and even biomedical research.

Scala's application of boundary work points to a form of manipulation by 'insiders' whereby the exclusionary relationship between science, government and biomedical practitioners is made transparent and highly criticized. Boundary work does indeed enable connections between some people and groups, and at the same time, sets people and activities apart. However, I want to provide a twist on Scala's appropriation of boundary work theory and practice to suggest that the intricacies within boundary work might not be viewed so narrowly, but rather, be more adequately understood as a creative and strategic activity that may even turn out to be a more accurate interpretation of negotiation and strategy within the biomedical enterprise.

I want to further suggest that Scala's appropriation of the insider/outsider dichotomy is complicated by the fact that the government and the medical system in BC actually *support* midwifery today and are working hard to increase the roles of midwives in the current medical system; this, despite their backing of a more rigid, biomedical birth model in the past.¹⁶⁸ Boundary work, to be sure, is neither the 'property' of governments and biomedical practitioners, nor is it a tool confined to the four forms defined by Scala above. Rather, boundary work, when viewed in a different light, would seem to hold within it the ability to invoke change and various forms of action through timing, organization, and strategy, regardless of who the specific actors are, debates over who is the more 'scientific,' and who successfully resisted or 'out-played' the other.

¹⁶⁸ Daviss-Floyd, et al. "Daughters of Time: The Shifting Identities of Contemporary Midwives" in *Medical Anthropology*, Vols. 20 (2-3 and 4): 105-139.

For William Arney, author of *Power and the Profession of Obstetrics*, the decline of midwifery resulted in part from the creation of a boundary, a social boundary, around the “profession” of obstetrics.¹⁶⁹ The decline of midwifery is thus understood by Arney as the defense and manipulation of that boundary in order to protect the interests – social status and economics, to name a few – that it encircled. Echoing this insight, medical anthropologist John Janzen suggests that the ‘corporate character’ of healing and medicine demonstrates the effect of organization (or the lack thereof) and the transformation of corporate organizations or their relationships to each other.¹⁷⁰ Janzen suggests that the fate of midwives was caused in part by the fact that physicians were recognized as an early corporate category that readily permitted them to align with the state and national organizations to ensure early protections of power and interest.¹⁷¹ Over time, and not much time, the boundary created around the profession of obstetrics became increasingly reified.

But changing such a significant part of a birth culture is never an easy task, nor does it proceed straightforwardly. Generally, changes must occur at two levels: the *symbolic order* and in the *material aspects of society*; hence, the level of *meaning* and the level of *social practices*.¹⁷² Ultimately, the biomedical community had to have a theory of childbirth that declared it unsafe, contrary to popular opinion of the day, and the general view held by midwives. Barbara Ehrenreich suggests the medical profession recognized early that this was a *political* task, *not a scientific* one. Early ‘scientific’

¹⁶⁹ William Arney, *Power and the Profession of Obstetrics*, Chicago: The University of Chicago Press, 1982. p. 21.

¹⁷⁰ John Janzen, *The Social Fabric of Health: An Introduction to Medical Anthropology*. New York: McGraw-Hill: 2002. p. 225.

¹⁷¹ Foucault suggests the first task of the doctor is political. By linking medicine with the destinies of the state, medicine was provided the splendid task of establishing in lives the positive role of health, virtue and happiness to the ultimate benefit of the state.

¹⁷² Arney, *Power and the Profession of Obstetrics* p. 21.

manipulations that constructed the feminine qualities of ‘head and heart’ during the initial shift of maternal health care from midwives to obstetricians are extensive. Nineteenth and early twentieth century claims of ‘femininity as a disease,’ ‘the female rest cure,’ ‘the dictatorship of the ovaries’ and the widely held theory that the ‘uterus dominated the brain’ are well documented.¹⁷³ Rhetoric was also an essential tool: Dr. Hugh Hodge argued that “[i]f females can be induced to believe that their suffering will be diminished, or shortened, and their lives and those of their offspring be safer in the hands of [doctors]; there will be no difficulty in establishing the universal practice of obstetrics.”¹⁷⁴

A series of events culminated in the Flexner Report of 1910. Essentially a study of the American medical organization, the Carnegie-sponsored research revealed a wide array of unregulated and competing schools of medicine. By successfully de-legitimizing all other kinds of knowledge and practice, the Report corresponded with substantial funding for biomedical schools and physicians while putting the newly defined medical profession in a position of “cultural authority, economic power and political influence.”¹⁷⁵

Paul Starr suggests the Flexner Report was instrumental in cementing the cultural ascendancy of “regular” biomedicine and in ensuring that the vast majority of American physicians would be white, upper-class, and male.¹⁷⁶ Many Americans campaigned not only in favour of scientific medicine, but also for scientific management, scientific public administration, scientific housekeeping, scientific child raising, and scientific social

¹⁷³ Ehrenreich, et al. *For Her Own Good* p. 111-155.

¹⁷⁴ Dr. Hugh Hodge, quoted in Ehrenreich, p. 60.

¹⁷⁵ Brigitte Jordan, *Birth in Four Cultures* 4th ed. Illinois, USA: Waveland Press, Inc. 1993. p. 153.

¹⁷⁶ Paul Starr, quoted in Jordan, p. 153.

work. The United States was, according to the *Atlantic Monthly*, “a nation of science.”¹⁷⁷ Meanwhile, the American midwife came to be classified as not only unscientific but also ‘un-American.’ Overturning almost three hundred years of American history, obstetricians A.B. Emmons and J.L. Huntington argued in 1912 that midwives...

...are not a product of America. They have always been here, but only incidentally and only because America has always been receiving generous importations of immigrants from the continent of Europe.... It has almost been a rule that the more immigrants arriving in a locality, the more midwives flourish there, but as soon as the immigrant...becomes part of our culture, then the midwife is no longer a factor in his home.¹⁷⁸

At the same time, however, midwives had long since recognized their own need for anatomical knowledge. Early research also shows that midwives were not effective because they were more “natural,” instead they were more effective based upon their scientific, yet holistic, approach to maternal care and birth practice in general. Even so, prior to regulation in BC, family physicians and nurse practitioners submitted various concerns regarding midwifery practice; the most prominent of these concerns being homebirth and midwifery competence.¹⁷⁹

An interesting point to note here is that homebirth was included under midwives’ scope of practice in BC in 1998 – as defined in Health Professions Act – in spite of widespread opposition by the medical community. This came about due to a confluence of factors, most notably consumer demand for the choice of birth place combined with the government’s general agenda to move health care out of institutions, and where possible, “closer to home.”¹⁸⁰ Furthermore, coinciding with legalization in BC, the minister of health also announced the *Home Birth Demonstration Project* – an initiative

¹⁷⁷ Ehrenreich, *For Her Own Good* p.77.

¹⁷⁸ Emmons et al. quoted in Ehrenreich, *For Her Own Good* p.106.

¹⁷⁹ Jude Kornelson (et al) “Interprofessional Relationships in British Columbia”, p. 115

¹⁸⁰ *ibid.* p. 118.

designed to see how home birth might “fit” into the health care system. More specifically, the minister was curious to see how midwives would interface with ambulatory services when they need to transfer clients to hospitals.¹⁸¹

Midwifery and home birth was for decades deemed “unscientific,” even “ignorant” in various biomedical circles; but on April 9, 2006 CTV News reported a Canadian study that showed at-home births to be as safe as and more convenient than hospital births. The study, deemed “the most definitive to date,” has since become the most-read since being first published in the influential *British Medical Journal*.¹⁸² To be sure, researchers from all over the world are looking to Canada curious as to how our “New Midwifery” will unfold. The above study follows a 2002 report concerning the outcomes of planned home births versus planned hospital births after regulation of midwifery in BC, essentially the results of the *Home Birth Demonstration Project*.¹⁸³ The conclusions of the two studies are the same: there is no increased maternal or neonatal risk associated with planned home birth under the care of a regulated midwife.¹⁸⁴ As for in-hospital deliveries attended by midwives, a 2007 BC study showed those births to be just as safe as those attended by a doctor but that midwives tend to rely less on medical interventions.¹⁸⁵

There is an assumption by many in the midwifery community that regulation addressed some of the physicians’ concerns regarding midwifery; yet, on a professional

¹⁸¹ *ibid.*

¹⁸² Kenneth Johnson and Betty-Anne Daviss, “Outcomes of Planned Home Births with Certified Professional Midwives: Large Prospective Study in North America” in *British Medical Journal* 2005; 330:1416 (18 June).

¹⁸³ Patricia Janssen, et al. “Outcomes of planned home births versus planned hospital births after regulation of midwifery in British Columbia”, in *Canadian Medical Association Journal* Feb. 5, 2002; 166 (3).

¹⁸⁴ *ibid.*

¹⁸⁵ “Is there any difference between having your baby delivered in hospital by a midwife versus a doctor? In *The Vancouver Sun*, Saturday, February 23, 2008 A6.

level, the interpersonal relationships between physicians and midwives since regulation have been turbulent at times, according to Jude Kornelson, author of “Challenges to Midwifery Integration: Interprofessional Relationships in British Columbia.”¹⁸⁶ The lack of support of the physicians' regulatory college is but one impediment to the full-fledged support of midwifery. According to Kornelsen, there is a perceived conflict between the official policy of their professional organizations and the legislation permitting home birth in BC, for example. Dr. Michael Helewa of the Society for Obstetricians and Gynecologists states: “[w]e are being asked to collaborate [with midwives] where those that guide us say it is not safe.”¹⁸⁷

But even as studies continue to support the longstanding, scientific claims of the midwifery model, including home birth, it must be recalled that the majority of Canadian women *want* to give birth in the hospital. Moreover, it is becoming increasingly common for women to seek out one-to-one care with a midwife while choosing the hospital as their preferred birthing site.¹⁸⁸ Yet despite the many collaborative interprofessional relationships between various physicians and midwives, there are several areas where physicians' negative attitudes may hinder patient care, including discharging patients from care if they choose midwifery or home birth, reluctance or refusal to accept transfers from midwives, lobbying hospital boards to refuse to grant admitting privileges to midwives, and refusing to accept midwifery clients altogether. Not as drastic but equally detrimental is the gate-keeping role that many physicians play with patients who inquire about midwifery care. Unsupportive physicians often express doubts over midwives' competency blatantly through verbal condemnations or in other more subtle

¹⁸⁶ Jude Kornelson (et al) “Interprofessional Relationships in British Columbia”, p. 115

¹⁸⁷ *ibid.*

ways such as raised eyebrows or a shift in intonation. Meanwhile, many physicians across BC (across the country, even) have opted out of obstetrical care entirely.¹⁸⁹

The above impediments lead Kornelson to suggest that “currently in BC competition overrides cooperation.”¹⁹⁰ She suggests that perhaps the answer lies not in reducing the number of physicians providing maternity care but in recasting the debate to focus on woman-centered care as opposed to interprofessional competition over turf between midwives and physicians. While she then goes on to illustrate the turf war between midwives and nurse practitioners, I am somewhat surprised by her emphasis on the failure of cooperation in the face of competition between midwives and physicians in BC. Although the history between midwives and doctors has indeed been contentious at times, a more useful assessment might be to note that the so-called dispute over science is deeply political in character. Put differently, the “turf-war” may be more about politics than it is about science.

Many physicians and midwives are increasingly working to develop collaborative relationships that promote quality care for birthing women. Multidisciplinary collaborative maternal care is in fact a current focus of the Society of Obstetricians and Gynecologists of Canada (SOGC). The *Multidisciplinary Collaborative Primary Maternity Care Project* (MCP²) is a national initiative designed to address the availability and quality of maternity services in Canada. The strength of MCP² is said to lay in the partnerships that were established in its assembly. Associations representing the full range of maternity care providers are collaborating in this initiative in order to

¹⁸⁹ Kornelson, “Interprofessional Relationships in BC...” p. 122

¹⁹⁰ *ibid.*

collectively champion changes to the provision of maternity services and the move to collaborative models of primary care. The partnerships in MCP² include:

1. Association of Women's Health;
2. Obstetric and Neonatal Nurses Canada (AWHONN Canada);
3. Canadian Association of Midwives (CAM);
4. Canadian Nurses Association (CNA);
5. College of Family Physicians and of Canada (CFPC);
6. Society of Obstetricians and Gynecologists of Canada (SOGC); and the
7. Society of Rural Physicians of Canada (SRPC).

Before continuing with the discussion on MCP², it serves the purpose of multidisciplinary care to appreciate that maternity care provider groups *do* have different attitudes towards birth. A BC study published December 2004 in *BJOG: an International Journal of Obstetrics and Gynecology*, compared family physicians', obstetricians', and midwives' self-reported practices, attitudes and beliefs about central issues in childbirth.¹⁹¹ All registered midwives in the province, and a sample of family physicians and obstetricians in a maternity care teaching hospital were approached via mail-out questionnaire. Researchers received a ninety-one percent response rate to inquiries addressing attitudes toward routine electronic fetal monitoring, induction of labour, epidural analgesia, episiotomy, doulas, vaginal birth after caesarean (VBAC), birth centres, provisional educational material, birth plans, and caesarean section. The study findings show that obstetricians were the most attached to technology and interventions including caesarean section and induction; midwives the least, while family physicians fell in the middle.¹⁹² While generalizations are problematic at best, the researchers conclude that obstetricians and midwives generally follow a defined and

¹⁹¹ Birgit Reime, et al. "Do maternity care provider groups have different attitudes towards childbirth?" in *BJOG: an International Journal of Obstetrics and Gynaecology*, December 2004, Vol 111, pp. 1388 - 1393

¹⁹² *ibid*

different approach to maternity care. Family physicians, however, are “heterogeneous”, sometimes practicing more like midwives and sometimes more like obstetricians.¹⁹³

MCP² is a pan-Canadian initiative that focuses on increasing the availability and quality of maternity care for women. With an emphasis on multidisciplinary collaborative solutions, the goal is to improve the availability of care across the continuum and build capacity in primary maternity health care that is women-centred. The project seeks to encourage maternal care practitioners to consider alternative models of primary maternity care and to disseminate information about these models as well as their guidelines and implementation tools. Such approaches, it is believed, could improve confidence amongst health care providers and the public about the benefits of collaborative maternity care services.

The working definition of “collaboration” for the MCP² project is defined by Health Canada:

Collaborative women-centered practice designed to promote the active participation of each discipline in providing quality care. It respects goals and values for women and their families, provides mechanisms for continuous communication among caregivers, optimizes caregiver participation in clinical decision-making (within and across disciplines), and fosters respect for the contributions of all disciplines.¹⁹⁴

The MCP² working groups are asking a number of important questions:

- How can we ensure Canadian women will have access to quality maternity care services as close to home as possible?
- How will declining birth rates, the increase in multiple births and other demographic trends affect the demand for health care services for mothers?
- What is the best mix of obstetricians, family physicians, midwives, and other care providers to meet the maternity care needs?

¹⁹³ *ibid*

¹⁹⁴ MCP2 p. 1

- What are the implications for training, costs, and scopes of practice and the delivery of health services?
- With several jurisdictions developing maternity care programs, how can we achieve economies of scale and reduce duplication by establishing communities of practice and by sharing best practices in the provision of efficient maternity care services?¹⁹⁵

The MCP² working groups made available their draft discussion paper in August 2006 entitled *A National Birthing Strategy for Canada* (NBSC). The NBSC calls for the implementation of an “inclusive, integrated and comprehensive pan-Canadian framework for sustainable family-centred maternity and newborn care.”¹⁹⁶ The working groups recognize a number of demographic and societal trends that are significantly impacting the delivery of maternity care. These trends include the increase in the age of women giving birth in Canada, the decrease in fertility rates, the increase in multiple births, the increase in the number of babies requiring medical attention in intensive care units, the health human resource shortage among maternity care providers, and regional disparities in the provision of maternity care services.¹⁹⁷

The NBSC recognizes some of the more obvious tensions inherent to the proposed Strategy. For example, accountabilities for maternity care are not consistent across jurisdictions with changes to maternity care systems often occurring at the local level without regional or province-wide input. Some hospitals restrict access to their maternity care services or have eliminated the service entirely without consultation at a regional or provincial level. Challenges such as these have compelled the working groups to support the implementation of multi-dimensional and multi-jurisdictional solutions to these fairly complex problems.

¹⁹⁵ A National Birthing Strategy for Canada

¹⁹⁶ A National Birthing Strategy for Canada

¹⁹⁷ *ibid*

A number of ‘Strategies for Action’ are listed in the NBSC, including stakeholder engagement and networking, a better process for data collection, standardized clinical guidelines for all maternity care providers, inter-professional post-graduate education programs, and the establishment of multidisciplinary maternal and new born care models.¹⁹⁸ For a number of reasons, the establishment of multidisciplinary care models and inter-professional post-graduate education programs are two strategies that I find particularly exciting. This, not only because of the suggestion that NBSC will “fund the organization of models and the coordination of efforts, and will facilitate the hospital by hospital implementation by provinces and territories,”¹⁹⁹ but because multidisciplinary maternity care models and inter- professional education programs may be innovative mechanisms to invigorate the current maternal care structure.

The concept of multidisciplinary collaborative maternal care in Canada has yet to be fully defined. However, the NBSC suggests that an innovative approach to addressing the maternal care crisis in Canada might be community maternal care teams, at least in the short term. By introducing new collaborative models of maternity care, the NBSC is designed to appeal to new practitioners, encourage practitioners to return to the provision of maternal care, reduce the number of practitioners leaving the profession, and allow collaborative team members to explore alternative approaches of working more efficiently and effectively to the full scope of their practice.²⁰⁰ The multidisciplinary care models have the potential to offer women, especially women who live in rural and remote regions, the quality of care they are seeking.

¹⁹⁸ *ibid.*

¹⁹⁹ *ibid.*

²⁰⁰ National Birthing Strategy for Canada

It is true that pregnant women are often anxious to get to know the person who will provide their primary maternal care and attend their birth; however, it should also be noted that the majority of midwives in Canada currently work in collaborative teams of two to four to ensure a client has access to support twenty-four hours a day, seven days a week. Some practices assign a midwife to the client with others providing back up. Other practices share the care of each client among the team of midwives so that the women will get to know each midwife equally well, with two of the midwives attending the actual birth.²⁰¹ Hence, given the professional support for the ‘team approach’ by midwives, not to mention that the shortage of midwives is also contributing to the maternity care crisis in BC, maybe it would be beneficial, if not timely, to add the multidisciplinary element into some of these already collaborative teams. A government funded pilot study, as described in the NBSC, would likely generate much interest and curiosity of all those involved, women and their families, maternal health practitioners, and government officials included.

To conclude, the state of the health care system in BC received much attention in Gordon Campbell’s 2008 *Speech from the Throne*.²⁰² Campbell made some interesting proclamations. He suggested his government will ensure that health professionals who are certified to practice in other Canadian jurisdictions will be welcome to practice in BC and have their credentials recognized. This includes foreign-trained doctors. He also claimed that a new restricted license will allow internationally trained physicians to practice in their specific areas of qualification, and residency positions will correlate to the recent doubling of medical school spaces. Of particular note, naturopaths will be

²⁰¹ Hawkins, *The Midwifery Option*, p. 73.

²⁰² Speech from the Throne 2008 <http://www.gov.bc.ca/premier/2008_throne_speech/index.html>

permitted to prescribe medicinal therapies “as appropriate” and obstacles to their access to medical labs for prescribed tests for patients will be removed.²⁰³

Campbell also stated that midwives in BC would be authorized to deliver a broad range of services without a physician present to new and expectant mothers who choose to utilize midwifery services.²⁰⁴ That governments and decision-makers are increasingly recognizing midwives’ contributive roles may be another example of successful boundary work on behalf of midwifery political communities. To be sure, midwives in BC and indeed elsewhere are always political: midwives and their colleagues have long recognized that they need an organized political voice if they are to persevere in the biomedical domain. Midwives in BC today work to build organizations in their communities, join national and international midwifery organizations, and work within them for policies and legislation that support midwives and the mothers they attend.²⁰⁵ Importantly, midwives’ roles are increasing not because of their resistance to the biomedical organization in general, but because of their willingness to negotiate their boundaries, their practice, and their organization as a whole. Midwifery, as a political social movement in Canada, cannot therefore be compared to the likes of a typical special interest group. Rather, their boundary work sets them apart in this regard because of a commitment to their *ever-evolving* practice, their *clients*, and most of all: their willingness to negotiate and consider appropriate (political) action at all times.

But midwives cannot be expected to carry the weight of the crisis facing maternal care in BC; nor can they be relied upon to fill in the gaps of maternal health care, especially those affecting urban and non-urban areas in BC, for example. That said, as

²⁰³ *ibid*

²⁰⁴ *ibid*

²⁰⁵ Robbie Davis-Floyd, “Daughter of Time: The Postmodern Midwife”

government decision-makers work to define midwives' expanded scope of practice in clinical, hospital, and domicile settings, the shortage of birthing beds and quality maternal care will likely involve cooperation by primary users of the medical system, the increased blurring of fixed practitioner identities, a combination of science and politics, and above all: creativity. Again, it is the recognition of the political nature inherent to the development of these birth models, and an on-going commitment to boundary work that gestures towards higher standards of care for maternal clients in BC.

As diverse communities and marginalized groups are increasingly being consulted in decisions that affect them via referendums, community forums, and the like, the policy and decision-making arena is forced to change. At the same time, midwives and doctors incorporate their strategic boundary work to (re)establish their role in the biomedical domain not by sacrificing their organizational autonomy, but by (re)negotiating their roles in contributing to quality maternal health care. Productive and dynamic relationships can be established and maintained; multidisciplinary collaborative maternal care teams can “put scientific and political elements together, take them apart, establish and maintain boundaries between different forms of [birthing practice], and coordinate activities taking place in multiple domains.”²⁰⁶

Finally, the flexibility of boundary work might lead to confusion given the instabilities between what is called ‘science’ versus ‘non-science.’²⁰⁷ That said, science is not devoid of values prior to some politicization, nor politics of rationality, prior to any scientification. Both science and politics might be best understood as the negotiation of norms and practices in one enterprise in a way that mimics norms and practices in the

²⁰⁶ Millar, “Hybrid Management...” p. 487

²⁰⁷ David Gutson, “Boundary Organizations in Environmental Policy and Science: An Introduction” in *Science, Technology, & Human Values*, Vol. 26 No.4, Autumn 2001 399-408.

other.²⁰⁸ Recognizing the link between science and non-science and stabilizing some boundary work is crucial to creating more conducive relationships and public policy.²⁰⁹

But regardless, if BC can be recognized across the country for its excellent work in cancer research,²¹⁰ why can BC not also be recognized for its creative ideas in addressing the shortage of hospital beds, qualified maternal health practitioners, and the impending maternal care crisis more generally? To hold open other possibilities or, more specifically, to question how we might think about alleviating, even diverting, the current pitfalls in maternal care in ways that would open up new regions for childbirth is to truly embrace a challenge.

²⁰⁸ Ibid, p. 399.

²⁰⁹ One institutional means to stabilizing boundary work is the creation of a “boundary organization,” as illustrated by David Gutson in his insightful article titled: “Boundary Organizations in Environmental Policy and Science: An Introduction” in *Science, Technology, & Human Values*, Vol. 26 No.4, Autumn 2001 399-408. Also, the *National Birthing Strategy for Canada*, discussed below, indicates interest in developing a “Canadian Council for Maternity Care.” This would seem to fit the definition of boundary organization, as defined by Gutson.

²¹⁰ http://www.gov.bc.ca/premier/2008_throne_speech/index.html>

Past, Present, and Future: The ‘New’ Midwifery in Canada²¹¹

When Marilee Hare discovered she was pregnant she happened to be between family doctors.²¹² The twenty-seven year old woman from Port Coquitlam decided to use a midwife after learning of positive midwifery experiences from her friends. Marilee was caught off guard when she often found herself having to defend her decision – to friends, relatives, even people she meets on the streets: “I feel like some people think I’m kind of a radical for choosing a midwife.... People don’t realize that midwifery is licensed and regulated. They think it’s something hippies do so they can give birth...in the forest.”²¹³ Many people also assume, falsely, that Marilee is planning a home birth, not realizing midwives are permitted to attend hospital births in BC.

The recurring trope of the “traditional birthing attendant” may not be helping the New Midwifery movement in Canada. Contrary to the romanticization of the traditional midwife in the brief but moving vignette called “Midwife - A Heritage Moment,”²¹⁴ contemporary midwives are rarely sent for by young girls to alert the onset of birth; nor do most midwives ski over mountainous snowy regions to provide care to birthing women even in rural communities. In fact, not only are the majority of midwives currently accessed through urban centers, today midwives receive a phone call – sometimes a cell-phone call – or are even alerted by the beep-beep of a pocket-pager only to take-off in four-wheel drives in snowstorms with clinical gear close in hand.²¹⁵ Sure,

²¹¹ Conceptually speaking, ‘new’ midwifery refers to the refashioning of midwifery practice *post*-legalization.

²¹² “Bringing Up Baby – Spanking, C-sections, Midwives: We Check up on the Latest Research” in *The Vancouver Sun*, Saturday, February 23, 2008 A6-A7.

²¹³ *ibid.*

²¹⁴ *History by the Minute: Women: Midwife* <<http://www.histori.ca/minutes/minute.do?id=10185>>

²¹⁵ MacDonald, “Tradition as Political Symbol...” p.46-49.

when she arrives, there might be a warm fire crackling and tea on the stove, but there might also be classical music playing softly in the background.

The Heritage Minute does what many popular, historical, and anthropological representations do: it depicts midwifery as a tradition passed down from generation to generation, the domain of women and the domestic sphere, making the best of things under difficult circumstances. Indeed, while the history of midwifery has often been read as a tale of loss and endurance, there has been a tendency in popular accounts to essentialize traditional midwifery – even to represent it as the opposite of obstetrics. Even as community midwifery emerged as a social movement devoted to exploring and promoting low-tech, women-centred alternatives to routinized biomedical care, ideologically, this movement worked hard to reinvent women as competent birthers and attendants, to restore the definition of birth as a natural event, and to restore the location of birth to the home.²¹⁶

Yet contemporary midwifery in BC and other Canadian provinces has not been reclaimed or resurrected from the past so much as it has been reinvented in the present. Furthermore, the new location of midwifery within the health care system alters its status and meaning in a number of significant ways. In her analysis of the new midwifery in Canada, Margaret MacDonald goes beyond familiar analytical oppositions of tradition versus modernity and natural versus biomedical – categories that are often used to “place” midwifery. Through sharing and analysis of contemporary midwifery narratives, MacDonald suggests the new midwifery in Canada comes into view as a “complex and innovative cultural system in a phase of reinvention.”²¹⁷ Her central argument is that

²¹⁶ MacDonald, “Tradition as Political Symbol...” p. 49.

²¹⁷ *ibid.* p. 50.

midwives and birthing women in Canada are fashioning a new professional and cultural identity that incorporates a traditional midwifery of their own making – foregrounding some aspects of traditional midwifery while distancing themselves from others.

The relatively recent and dramatic changes involving midwifery practices across Canada continue to fuel many important discussions on legalization, regulation, public funding, and education. As MacDonald points out, the focus of both popular and scholarly analyses of midwifery has, to a great extent, shifted toward the midwife as a professional.²¹⁸ Consequently, birthing women are often situated as recipients rather than active producers of midwifery as a social and cultural phenomenon. As a case in point, consider the confession in the first paragraph of the final chapter in the text *Birth by Design* (2001):

We were well along in the planning of this book when it occurred to us that we had overlooked the most important actors in the drama of birth: mothers (to-be) and their families. In our effort to explain the variation in maternity care systems, we had set to work examining the influences of state policy, educational institutions, the professions, medical systems, and technological developments. In the midst of this flurry of academic research we somehow failed to ask how the preferences of pregnant women affected the delivery of care at birth.²¹⁹

The authors of the above excerpt contend that they acknowledge that the design of birth is the result of the desires of women, but are quick to add that these desires are the product of larger social currents and medical ideas. MacDonald, by contrast, argues the impact of birthing women on the new midwifery in Canada should not be assumed, and has yet to be fully explored. Interestingly, Betty-Anne Daviss suggests her research illustrates the complex interplay of relationships that influence and contribute to any decision made within the context of a modern society in which all consumers of the

²¹⁸ MacDonald, “Postmodern Negotiations with Medical Technology...” p. 246

²¹⁹ Raymond DeVries, et al. “What (and Why) Do Women Want? The Desires of Women and the Design of Maternity Care.” in *Birth by Design*. 243-266

health care system formulate and express her own systems of logic.²²⁰ Moreover, for Daviss each consumer assumes her choice to be “logical” and forms assumptions that ultimately establish their perception of risk and ideas about what is normal.²²¹ Daviss suggests the different categories of ‘logic’ encompass major social, political, and institutional elements of the health care system. The categorical logics to which she refers are scientific, clinical, personal, cultural, intuitive, political, legal, and economic.²²²

For Daviss, structural factors do not act directly but are experienced, interpreted, and made meaningful through specific cultural and ideological processes about morality, and beliefs about how pregnant women should behave. It is together that these structural factors and cultural processes shape the climates and contexts within which women’s reproductive activities are situated and take place. Although Daviss attempts to situate women as active participants in their health care decisions - even as they become collections of ‘logical beings’ set to personalize structural meaning and value²²³ - her research does not show how women and their practitioners are together refashioning maternal health care.

MacDonald suggests that even in highly organized, regulated systems of the type emerging in Canada, midwifery involves culturally productive interactions between midwives and the women in their care. She maintains that an analysis of the new midwifery must include serious consideration of the contributions that midwifery clients

²²⁰ Betty-Anne Daviss, “Heeding Warnings from the Canary, the Whale, and the Inuit: A Framework for Analyzing Competing Types of Knowledge About Childbirth.” In *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*: Eds. Robbie Davis-Floyd and Carolyn Sargent. Berkeley: University of California Press: 1997. p. 443.

²²¹ *ibid.*

²²² *ibid.*

make to its form and content.²²⁴ One of the key ways pregnant and birthing women are shaping midwifery and biomedicine is through their choices and attitudes with regard to medical technology. MacDonald suggests that due in part to the contentious status of medical technology in midwifery care, clients' negotiations with medical technology are key sites of cultural production.²²⁵

In other related scholarly work MacDonald operationalizes the term "culture" by looking to Pierre Bourdieu and his sense that culture is not a set of rules and static meanings but is manifest in every day human *practices*.²²⁶ Bourdieu's theory of practice marks an approach in viewing culture in terms of practices rather than essences. Founded on what he calls 'practical faith,' which underlies the motives of many specialists, Bourdieu refers to the ancient Greek term '*habitus*' to denote the state of adhering to the act of practice so closely that reaction becomes automatic; in other words, the body enacts what it memorizes through cultural training. For Bourdieu, of utmost importance is the need to focus on the "play-by-play logic of events as they occur in real time."²²⁷ It is the tempo – the rhythm – that provides the temporal framework for practitioners to make decisions and to carry out procedures.²²⁸ MacDonald couples Bourdieu's notion of culture with sociologist Beth Rushing's concept of ideology.

Rushing suggests change occurs on two primary levels – cultural and ideological. Rushing defines ideology as "a set of beliefs by which a social group makes sense of its environment and which these groups manipulate in order to project images of

²²⁴ MacDonald, "Postmodern Negotiations with Medical Technology..." p. 247.

²²⁵ *ibid*

²²⁶ MacDonald, "Tradition as a Political Symbol..." p. 53.

²²⁷ *ibid*.

²²⁸ Elizabeth Cartwright, "The Logic of Heartbeats: Electric Fetal Monitoring and Biomedically Constructed Birth" in *Cyborg Babies* eds. R. Davis- Floyd et al. Routledge: New York: 1998. p. 242.

themselves.”²²⁹ While ideology contributes to “occupational power,”²³⁰ Rushing suggests that ideologies are on-going social processes that are not fixed but are shaped also by the users to which they are put. For Rushing, feminism and science are the two major ideologies or ways of defining boundaries of midwifery and seeking professional legitimacy.²³¹ One of the most important general functions of ideology is the way in which ideology turns uncertain and fragile cultural resolutions and outcomes into a “pervasive naturalism” – that is, a process that reproduces ideologies among groups of individuals as they are contextualized within institutions.²³² As a case in point, obstetricians, as workers of the biomedical system, are often expected to embody an approach that is consistent with a biomedical interpretation of what constitutes a “normal delivery” – i.e., one carried out under the auspices of medical personnel, within an institution, using accepted technologies and treatments.²³³ The content of contemporary midwifery ideology, or “birthing culture” as it is sometime called, also gives value and meaning to both midwives and their (potential) clients/consumers.

MacDonald thus suggests that there is no essence inherent to the new midwifery in Canada per se; rather, as a practice that involves continuous interactions with clients, midwifery becomes a site of knowledge translation and shared decision-making through a certain reciprocity between midwife and client. Close examination of the new midwifery in Canada at the level of practice reveals a rich and nuanced space between neat analytical oppositions such as traditional versus modern practice. Indeed, when held

²²⁹ MacDonald, “Tradition as a Political Symbol in the New Midwifery in Canada” in *Reconceiving Midwifery* Eds. C. Benoit, et al p. 51

²³⁰ *ibid.*

²³¹ *ibid.*

²³² Cartwright, “The Logic of Heartbeats...” p. 247.

²³³ *ibid.* p. 247-248.

together in creative tension, tradition and modernity, or nature and medicine, become a lens through which to view the new midwifery in Canada. Although many midwives insist that the public image of midwives needs updating, they are also cautious of becoming “too modern, too bureaucratic; too technological.”²³⁴

Yet even as debates about the role of medical technology – including procedures and pharmaceuticals – in midwifery care are of long standing and have been exacerbated by the move of midwifery from a marginal social movement into the public sphere, midwifery clients/consumers are influencing the new midwifery in ways that not even all midwives appreciate. To be sure, the move from the margins into the mainstream health care system has brought many new challenges for contemporary midwives. Midwives must now contend with an expanded scope of practice; they use more medical technology both to fulfill their professional obligations and to respond to the choices of women. This and an increased accessibility to a wider clientele seem to work against midwifery as a critical, low-tech alternative to 'technocratic birth.' Midwives today are often faced with the notion that midwifery care is but one more consumer option.²³⁵ Midwifery practice in some circles has even been referred to as the “midwifery spritzer” or “midwifery á la mode.” That said, maybe no other principle has had a greater effect on contemporary midwifery in Canada than that of “informed choice.”

The principle of informed choice in midwifery is based on the notion that women can and should understand the rationale behind different courses of action during their midwifery care and, thus, be in a position to share the responsibility of making important

²³⁴ Ibid. p. 264.

²³⁵ Many midwives have had to contend with clients that have no previous knowledge of midwifery care or midwifery as a social movement; moreover, some of their clients regularly smoke cigarettes and consume alcohol during pregnancy.

decisions about their own care.²³⁶ Informed choice is an inherently politicized notion, given the centrality of choice as an organizing concept and goal of the broader women's health movement (of which midwifery is a part.)²³⁷ Thirty to forty-five minute appointments encourage the development of trust between the midwife and client and allow time for the client's own knowledge to emerge.²³⁸ Discussion of the latest scientific research and the importance of non-scientific information – a woman's own knowledge, feelings, and past experience about her body and previous pregnancies as well as her lifestyle and moral and religious beliefs – are common aspects of client interaction with midwives.²³⁹

An example of how women might temper their experience with medical technology via midwifery care the principle of informed choice is the maternal serum-screening test. This test attempts to predict the probability that Down's Syndrome or Spina Bifida might affect the fetus. One midwifery client indicated to MacDonald that she had the test for both pregnancies – the first with a physician, the second with a midwife. The difference is that with the physician the test was simply part of a routine visit to the doctor, whereas with the midwife she felt well informed and chose the test on the basis of what she believed was right for her.²⁴⁰

Even then, there is some debate within midwifery over how far informed choice should go. Consider, for example, the controversial *elective* caesarean section. Midwives promote the notion of informed choice for all their clients. Luba Lyons Richardson, vice chairwoman of midwifery at Victoria General Hospital, states “[if]

²³⁶ MacDonald, “Postmodern Negotiations with Medical Technology...” p. 254.

²³⁷ *ibid.* p. 254.

²³⁸ The prescribed duration for standard maternal appointments with a GP is fifteen minutes.

²³⁹ *ibid.* p. 255.

²⁴⁰ *ibid.* p. 253-254.

women have choice, then shouldn't they have that choice?"²⁴¹ Indeed, there are many confounding reasons for the rise in caesarean – both medical and cultural; but that does not prevent Richardson from suggesting that she would not be surprised if eventually women walk in cold with the first pregnancy and demand a caesarean for any reason they want: "Give it 10 years and I don't think [planned caesareans are] going to be that unusual."²⁴² Doctors are not ruling out the rate rising to 50 percent given the upward swing.²⁴³

A 2006 study of health professionals suggests there are a number of barriers to implementing shared decision-making in clinical practice as perceived by health professionals.²⁴⁴ Shared-decision making is defined as a decision making process shared by patients and their health care providers. It aims to encourage patients to play an active role in decisions concerning their health – the ultimate goal of patient-centred care. Thirty-one publications covering twenty-eight unique topics were included: eleven from the United Kingdom, eight from the United States, and four from Canada, all covering the period between 1990 and 2006.

With the vast majority of study participants physicians, the three most common barriers to implementing shared-decision making between patient and physician were: time constraints, lack of applicability due to patient characteristics, and lack of applicability due to clinical situation. The authors suggest that the implementation of shared decision-making will need to address a broad range of factors. They also suggest that on the subject of shared-decision making "there is very little known about any other

²⁴¹ "BC Experts search for solutions" *Times Colonist*, Sunday, July 29, 2007.

²⁴² *ibid*

²⁴³ *ibid*

²⁴⁴ Karine Gravel et al., "Barriers and facilitators to implementing shared decision-making in clinical practice: A systematic review of health professionals' perceptions" in *Implementation Science* 2006, 1:16

health professionals other than physicians.”²⁴⁵ While a parallel can be drawn between informed consent in the clinical setting and informed choice in midwifery, the ideal of informed consent is circumscribed by the way that medicine is typically practiced,²⁴⁶ whereas informed choice in midwifery care is underpinned by a philosophy that challenges both the authority of biomedicine and what is perceived as an over-reliance on technology.²⁴⁷

Midwifery in North America, as well as other parts of the world, was recently described as postmodern. “Postmodern midwives,” writes Davis-Floyd, “are educated, articulate, organized, highly political, and highly conscious of both their cultural uniqueness and their global importance.”²⁴⁸ Furthermore, they are “defenders of traditional ways as well as creative inventors of systems of mutual accommodation.”²⁴⁹ Such observations mark an analytic and strategic move away from positing certainties within cultural identities and practices. In social science studies of midwifery, more specifically, this also means a move away from portraying midwifery as fulfilling women’s natural, traditional relationships to childbearing.²⁵⁰

Over the years there has also been reference to a postmodern science more generally. Jean-François Lyotard suggests that science in general is less totalizing than it used to be. Citing examples ranging from quantum theory to catastrophe theory to studies of schizophrenics, he believes that modern science is increasingly interested in

²⁴⁵ *ibid.*

²⁴⁶ As discussed by Neil Postman (1992) in “The Ideology of Machines: Medical Technology” in *Technology: The Surrender of Culture Technology*. New York: Vintage, doctors themselves are also restricted and sometimes feel pressured by the requirement to use all available technology. They, too, are bound by obedience to organized practice, effected by the bureaucratic arrangements of which their profession often resides.

²⁴⁷ MacDonald, “Postmodern Negotiations with Medical Technology...” p. 254-255.

²⁴⁸ *ibid*

²⁴⁹ *ibid*

²⁵⁰ MacDonald, “Tradition as a Political Symbol...” p. 60.

studying not general regularities but singularities, incommensurabilities, and unstable rather than stable systems. Postmodern science – concerning itself with such things as undecidables, the limits of precise control, conflicts characterized by incomplete information, ‘*fracta*,’ catastrophes, and pragmatic paradoxes – is theorizing its own evolution as discontinuous, nonrectifiable, and paradoxical. It is changing the meaning of the word “knowledge” while at the same time attempting to express how such a change can take place. It is producing not the known, but the unknown.²⁵¹

But to think in this ‘postmodern’ way requires that we see our old way of thinking for what it is, that we understand its traditional shape and design. Deleuze calls this old way of thinking the “dogmatic image of thought” – that is, our template for conceiving the world in which we live (and birth): a template whose most central element is a *representation* that calls forward the passing and storing of specific borders, clearly marked boundaries.²⁵² “It is representation,” he says, “that fails to capture the affirmed world of difference. Representation has only a single centre, a unique and receding perspective, and in consequence a false depth. It mediates everything, but mobilizes and moves nothing.”²⁵³

Midwifery today is in a state of ferment and change. But so too are the modern maternity wards that once premised their scientific authority upon the ubiquity of authoritative medical knowledge and routine. Even as midwives and their clients negotiate with presently available medical technology, their futures come into play as always already populated with certain possibilities even as they are sometimes haunted

²⁵¹ David Hoy Couzens, “Foucault: Modern or Postmodern?” in *After Foucault: Humanistic Knowledge, Postmodern Challenges*, Ed. Jonathan Arac, New Brunswick, New Jersey, Rutgers University Press, 1991.

²⁵² Todd, *Gilles Deleuze*, p. 73

²⁵³ Deleuze, *Difference and Repetition*, p. 55-56.

by the past – hence, the weight of obligation towards the unborn.²⁵⁴ Like angels with progress caught in their wings, women and their families are “pushed toward a future into which they do not gaze, cannot gaze, but cannot not go, even as they look out over a past that they cannot redeem, even as they long to do so.”²⁵⁵ As birthing communities struggle together in and through various states of excitement and volatility, as they continue to (re)negotiate with institutional legacies and cultural instabilities, rest assured: “[t]he only way through a crisis of space, is to invent a new space...”²⁵⁶

²⁵⁴ Jacques Derrida, quoted in Wendy Brown, ‘Spectres and Angels’ in *Politics Out of History*, p. 152

²⁵⁵ Walter Benjamin, quoted in Brown, p. 159.

²⁵⁶ Fredric Jameson, quoted in Brown, “Postmodern Exposures, Feminist Hesitations,” in *States of Injury: Power and Freedom in Late Modernity*, p. 49.

Conclusion

I mentioned at the outset that my overall aim in writing this thesis was to show that the “politics of birthing” is better understood in terms of “boundary work” rather than as dichotomous, and relatively futile, interactions with domination/resistance. Together, the four sections of the thesis are designed to show that it is much more constructive, if not historically accurate, to assess the deliberations between physicians and midwives (and indeed, their practices) as instances of ongoing “boundary work” rather than acts of resistance to one another. In so doing, I traced the rise of biomedicine to Enlightenment theories of the body and nature. I also attempted to situate the female body on the continuum of various epistemological and ontological assumptions that seemingly fueled the emergence of the biomedical enterprise. I then moved to use the example of “the clinic” as described in Foucault’s *The Birth of Clinic* to illustrate how the medical profession advanced over time not entirely through scientific expertise and technological advancement, but also through political strategy and state alignment. Following this, I used the example of maternal health policy negotiations and the often-rocky relationships between midwives and obstetricians to show that interpretations within encounters such as theirs might better be described as “boundary work” rather than resistance. Finally, in coming together with the work of Margaret MacDonald, I suggest that perhaps midwifery clients’ negotiations with medical technology in BC are best described as a kind of critical repositioning rather than as either resistance or acquiescence.

In closing, I want to revisit the National Birthing Strategy for Canada (NBSC) in light of Foucault’s later thoughts on ‘strategy.’ Recall that the NBSC calls for multidisciplinary collaborative maternity care models to be guided and implemented

under a pan-Canadian framework. Meanwhile, for Foucault, every power relationship implies in *potentia*, a strategy of struggle in which competing forces are not superimposed, do not lose their specific nature, and do not necessarily become confused; rather, each constitutes for the other a kind of permanent limit, a point of possible reversal. Foucault maintains that between a relationship of power and a strategy of struggle there is a reciprocal appeal. At any moment the relationship of power may become a confrontation between two adversaries. Accordingly, a relationship of confrontation reaches its term, its final moment, when stable mechanisms replace the free play of antagonistic reactions.²⁵⁷

I think it useful to highlight the essential differences between a struggle to ‘reverse the side of power’ and the reversion of sides to make the right side become the left side or vice-versa, or even to invoke both sides together: simultaneously. The essential distinctions between Foucault’s strategies for struggle and the MCP² strategy for multidisciplinary collaborative maternal care models are important. The discussion Foucault brings forward seemingly casts struggle within a framework involving ‘ownership’ of an identifiable, dominating power that can be resisted in a number of ways. He sets up struggle as two adversaries trying to outwit each other, always already aiming to wield power over the enemy. Within this schema each adversary works relentlessly to identify the limits in the other in order jump on the moment that levels the reversion of power. To be sure, *power* is neither the referent which multidisciplinary maternal care teams would call into play nor the primary force underlying the concept of strategy currently at play here, now. Rather, I want to suggest that the NBSC be deemed a ‘struggle for strategy,’ rather than a ‘strategy for struggle’ in the Foucaultian sense.

²⁵⁷ Foucault, “Subject and Power” p. 346- 347.

An intellectual birthing struggle for strategy does not have to be about who holds the key to authoritative knowledge in multidisciplinary collaborative maternal care models; rather, and more importantly, the issue is *when, where, can, and will*, contemporary birthing climates thrive in their immanent ability to call into play a program that *immediately* comprises mixed-methods? At least three essential ingredients come to light as crucial to the contemporary birthing struggle for strategy: 1) childbirth practitioners do not struggle for control over maternal health care, yet they recognize that their practices are not superimposed by the other, are not lost to their specific nature, and are not confused by the effect of common struggle. These practitioners work in and though the immanence of their practice: midwives and obstetricians are not opposites; 2) birthing women continue their negotiations with birthing options while being rigorous enough to cut themselves off from outdated systems of reference so that they can at least be current, on the scale of what they wish to experience – past, present, and future; and 3) birthing communities – their families and their practitioners – together affirm each birth, each body, as unique – not as a passive force to be manipulated by stable forms, but as a dynamic which does not lose the multiplicity that constitutes it. In terms of collaborative care, therefore, these basic ingredients both highlight and invoke the importance of reciprocity and present circumstance, and might more adequately reflect the needs of pregnant and birthing women across Canada today. I believe that it is just a matter of time before new and exciting maternal care models will benefit Canadian birthing communities.

However, the point to make is that our common struggle might not be founded on resistive measures as much as on other, more active concepts such as *affirmation*:

To affirm is not to take responsibility for, to take on the burden of what is, but to release, to set free what lives. To affirm is to unburden: not to load life with the weight of higher values, but to create new values which are those of life, which make life light and active. There is creation, properly speaking, only insofar as we can make use of excess in order to invent new forms of life rather than separating life from what it can do.²⁵⁸

Struggles do not have to be about confrontation and the fixing of an object to become suspended and revered. Instead of emphasizing the manipulation of the line in a calculating manner to induce particular actions, those involved with an iterative birthing climate can be content with reworking the effect of their struggles in and through the moments that emerge at the margins of interruption and the creation new spaces. To turn such power-oriented discursive procedures in the direction of that liminal space between women's bodies and the birthing experience is to simultaneously move beyond outdated notions of 'us against them' and to reorient discussions with key players that are prepared to come together, negotiate, and bring to their practice the utmost of shared knowledge and experience.

Finally, what if there is something truly emergent in the excess of midwife-attended hospital birth today? What if the time is ripe for the provision of another birthing site option in BC, such as multidisciplinary collaborative birthing centres? Hence, the actualization of the *and/or*, a 'with and against' that provided elsewhere in Canada; no longer would the choice involve the dichotomous base between hospital and home, but another publicly available option complete with the necessary means for birthing and primary maternal health care. Such sites might even posit a reflective maternal health strategy that appears finally *for itself* - liberated from the frozen (though recognizably melting) cascade that previously locked within it all the dilemmas that made

²⁵⁸ Deleuze, in *Nietzsche and Philosophy*, quoted in May, p. 65

a reductionary maternal health policy possible in the first place. If it is the case after all that hospitals traditionally served as “enormous houses of confinement” – a space in which “biomedical births can never imagine being autonomous”²⁵⁹ – is it even possible for the hospital to be at one and the same time: the *and/or*? Is it time to experiment with the opportunities at the margins to “find an advantageous place within them, find potential movements of deterritorialization, possible lines of flight, experience them, produce flows, conjunctions, here and there, try out continuums of intensities segment by segment, have a small plot of new land at all times?”²⁶⁰ But then again, women themselves may be creating their own ‘and/or’ in their negotiations with medical technology and hospital births - even as they sometimes do through the ambiguous gesture of the *solecism*; hence, that paradoxical moment when “one arm holds off an aggressor while the other is held open, in seeming welcome....”²⁶¹

²⁵⁹ Jaimie Smith-Windsor, “The Cyborg Mother,” in *Life in the Wires: The CTheory Reader* Eds. Arthur and Marilouise Kroker. New World Perspectives/ CTheory Books: 2004. p. 190.

²⁶⁰ Deleuze, quoted in May, p. 25

²⁶¹ Deleuze, ‘Phantasm and Modern Literature’ in *The Logic of Sense*, p. 285

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