

Exploring the Challenges of Incorporating Holistic Midwifery into the
University Midwifery Education Structure in Ontario and British
Columbia

By

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Abstract:

The development of University Midwifery Education Programs (UMEPs) has been a key component of the midwifery professionalization process in Ontario and British Columbia. The choice to develop UMEPs has set a standard for professional midwifery training which it is anticipated subsequently legislated provinces in Canada will follow. The goal of this study is to highlight the gendered struggles of midwifery, as a female-dominated and historically marginalized occupational group, in its attempt to integrate into preexisting hierarchies of the university structure. This analysis has suggested that other similarly located marginalized groups attempting integration into a university structure are likely to experience similar exclusionary strategies related to factors including gender, sexuality, ethnicity and race. Evident from this study are specific challenges of this process including tensions around inter-professional collaboration and faculty sharing with dominant disciplines such as Health Sciences and/or Medicine, enculturation of masculine/feminine professional characteristics, struggles to value practicum learning components, visibility/obscure within the university, struggles for achieving diversity in the student/client population, gendered dimensions of earnings potential and labour mobility. Recommendations from the findings of this study encourage future education design committees to take into consideration the economic, cultural, material and ideological barriers and challenges facing women in the context of practice as the predominant applicants, professionals and clients for this profession.

Dedication

This thesis is dedicated to the women faculty of the Mount Saint Vincent and Saint Mary's Inter-University Graduate Program in Women's Studies. It is with the support, mentoring and guidance of these phenomenal women that I have been motivated to take on and complete this study.

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Chapter 1- Introduction

An Introduction to the Status of Midwifery

The online content of university midwifery education, designed as a recruiting tool, available to the public, potential applicants and students is representative of the content of university midwifery education as well as having the potential to alter the composition of women recruited to become midwifery professionals in Canada. The recruiting practices of the university including the type of applicant being appealed to and promoted as ideal, as well as the philosophical underpinnings of this text have specific implications for the professional future of women clients of midwifery and women as midwives in Canada. Despite recent progress in professional recognition and legislation of practice for midwives in specific provinces in Canada the ability to incorporate an holistic midwifery philosophy and practice into the university structure is questionable. Utilizing data of publicly available text on university midwifery education programs (UMEPs) in Canada, gendered challenges are apparent to the incorporation of holistic philosophy and practice of pre-legislation midwifery into recently developed UMEPs in Ontario and British Columbia.

This study begins with an introduction to the status of professional midwifery, the range of maternity care choices available and university midwifery education as an education model in Canada. I proceed to document the impetus for this study, the contrast between medicalized and holistic maternity care, and the gendered issues related to professional university education programs. An introduction to the gendered nature of this profession related to university education, the holistic composition of the pre-

legislation midwifery philosophy and a definition of the features of patriarchal-capitalism identified to be a framework structuring the university institution initiate this study.

My interest in education options and professional status of midwifery came to the forefront in 2001. I was pregnant in 2001, living in New Brunswick, I wanted to have a midwife throughout my pregnancy, labour and postpartum, which proved to be impossible in N.B. at that time. I knew that Ontario and British Columbia had legislated and regulated midwifery and midwives used their skills to attend home births as well as hospital births, this situation in comparison to the complete lack of access in N.B. prompted me to question the status of midwifery across Canada. I discovered that midwifery is a regulated profession in the NWT, British Columbia, Alberta, Manitoba, Ontario and Quebec.

The University Midwifery Education Programs (which I will refer to as UMEPs throughout this study), became the key point of interest for me as I had a very difficult time reconciling my mental image of an apprenticeship trained midwife, whom I had wanted to provide advice and care to me through pregnancy and childbirth, with the mental image of a university graduated midwife. I wondered what recruitment looked like and the how the segment of the population of women interested in practicing midwifery would be recruited and incorporated into that structure. I considered how the traditional skills of midwives would be welcomed into the discipline as it would exist adjacent to medicine in the university. I also premised that an evaluation of the advantages and disadvantages of the UMEP model could be used to inform the development of an education program for midwives once midwifery became legislated in

Atlantic Canada. I am pleased to confirm this evaluation is now possible as midwifery has been successfully legislated in Nova Scotia as of Thursday Nov. 23, 2006.

With this in mind, the following goals have been adopted as research objectives for this study:

- discern the continuity and/or discontinuity of a holistic philosophy of midwifery upon integration into the university
- highlight the gendered implications of integrating holistic midwifery into pre-existing hierarchies of the university structure
- Illustrate the advantages and disadvantages of the UMEP model for specific communities, marginalized population groups

Discerning the continuity of a holistic philosophy of midwifery is an important goal as midwifery is renowned for preserving an holistic model of maternity care which includes methods which are empowering and non-interventionist. Women deserve to be able to continue to benefit from this traditional holistic knowledge, having choices and options in maternity care. Highlighting the gendered implications of integrating holistic midwifery into the pre-existing hierarchy of the university structure is also relevant as midwifery is a female-dominated profession and equitable participation in the professions in Canada has consistently been limited by gender. Women's access to professional education, equitable earnings and professional expectations which respect feminine characteristics has been tenuous. Illustrating the advantages and disadvantages of the UMEP model for specific communities and/or marginalized population groups is important in order to establish an inclusive professional and client population for midwifery. Structuring UMEPs to include marginalized communities will enable midwifery professionals to

bring childbirth back into Aboriginal, Francophone and MicMaq communities, for example.

Contrasting Medicalized and Holistic Maternity Care

The early 20th century marks the decline of midwifery practice and associated entrenchment of a patriarchal industrial capitalist state which had the effect of establishing maternity care as a public rather than private responsibility. This allowed physicians to assert their authority over maternity care using male dominated public institutions such as professional physician organizations, government and hospitals. The medicalization of childbirth in Canada is characterized by high rates of caesarean section surgeries, technological intervention into the birth process, forced separation of mother and baby and using a biomedical framework to pathologize the normal birth process (Morgan, 1998). Medicalized childbirth is characterized by caesarean section rates of 20% or more (depending on the region), operative vaginal deliveries of 14%, episiotomy rates of 16%, and extended hospital stays beyond 24 hours for almost 98% of patients (Atlantic Centre of Excellence for Women's Health, 2006).

Midwifery has continued to develop and sustain itself through women's demands for holistic maternity care in response to these and other negative features of medicalized childbirth. Midwives approach maternity care from the perspective that pregnancy is a healthy time in a woman's life and birth is a normal and natural event. The holistic approach of midwives is careful to recognize the physical changes which occur during pregnancy while balancing the interpretation of these events with the individual socio-cultural, spiritual and emotional needs of clients. In comparison with medicalized maternity care, expanded access to midwifery care has resulted in significant

improvements in maternal and child health. Clients receiving midwifery care in Ontario since its regulation in 1993, have almost 10% lower caesarean section rates, half of the occurrences of episiotomy incision, one quarter of the rates of operative vaginal deliveries, and breastfeeding rates almost 20% higher than in medicalized maternity care (Atlantic Centre of Excellence for Women's Health, 2006).

Recognizing the existence of a pre-medicalization and pre-regulation holistic midwifery education style and philosophy has been necessary to inform the methodological component of this study. The decline of midwifery education and practice, is key background to preface the argument that there is a hierarchy in the university, medicine is a dominant discipline and has become dominant through the advantages given to medicine by the patriarchal-capitalist system, and that midwifery is a marginalized occupational group facing gender-specific challenges through the process of university incorporation.

The theoretical framework informing this study is the theory that patriarchal-capitalism structures the university system thereby impacting the midwifery professionalization process. Patriarchy and Capitalism are systems which perpetuate interlocking oppression by promoting a profit-oriented, market-based economy and male dominated socio-economic and political system under which women are primarily negatively impacted (Mies, 1998). This feminist theoretical perspective is particularly relevant to midwifery as a female-dominated profession within the university and health care systems.

Prior to the establishment of UMEPs in Canada, holistic practice has meant that women could take up the craft of midwifery, regardless of their education background,

requiring only a willingness to care and to learn through experience, reading, observation, and/or apprenticeship (Mitchinson, 2002). The home-birth or natural birth movement in Canada in the 1970s developed in response to dissatisfaction with medicalized maternity care. Midwifery task forces were formed in Montreal, Toronto and Vancouver in particular as a part of this movement. The re-emergence of midwifery in Canada began with this process and a return to self-training, apprenticeship and neighbourly midwifery practice in Canada. This movement expanded into a professionalization movement following the death of a baby during a midwife-assisted birth in Ontario in 1985. In British Columbia, a sympathetic NDP government and midwifery-supportive minister of health pushed forward the professionalization process for midwifery in 1993. This process culminated in the creation of UMEPs as part of the regulation process, in Ontario in 1993 and British Columbia in 1997.

The pre-legislation emphasis on holistic¹ practice is relevant to the means by which women come to the post-regulation practice of midwifery including recruitment and education models, philosophy of practice and professional opportunities. Midwifery is renowned for preserving holistic, empowering and non-interventionist methods of care in a model that is reflective of a time before the pervasive use of and reliance on sophisticated medical technology. The holistic midwifery model of care has the potential to continue to grow in a positive, powerful and independent direction. Research studies have illustrated that home birth involving the practice of a holistic model of midwifery care is as safe as hospital birth and clients are predominantly completely satisfied with their care (Janssen, 2002). Midwifery in Canada has been practiced from the standpoint

¹ Holistic midwifery care is defined as woman-centred emphasizing emotional, physical, diverse spiritual and cultural well-being, recognizing childbirth as a normal, natural and empowering event in women's lives (Benoit, 1991).

that women's power is the emphasis in their own care, families are valued, women's psychological, physical, spiritual and emotional well-being is considered in reference to the care and support needed (Benoit, 1991).

This study will explore how midwifery has functioned as an holistic and empowering maternity health care option and the gendered challenges of attempting to incorporate an education model reflective of this philosophy of practice into the university structure. A specific method of feminist textual content analysis will be used to attempt to identify and draw out indicators of holistic elements in the program text of Ontario and British Columbia UMEPs. A discussion of the health benefits of holistic practice for women professionals, potential students and clients will inform this process.

My initial premise upon reviewing the social historical and professionalization literature on midwifery is that the status of midwifery professionals is vital to expanding the profession and to increasing access to midwifery services. Upon further reading, I realized that it was the university education model that was allowing a particular type of professional to practice and receive professional accreditation. The university structure in and of itself poses significant challenges for the practicum and experiential component of midwifery education. It is this experiential component which has strengthened midwives confidence in normal childbirth. I began to wonder if this university educated professional was the midwife that I would want to approach for holistic maternity care. My questions began as to whether this university educated midwife would be the same midwife that has been practicing in Canada pre-legislation or would she be a new species of midwife, practicing a much more rigid and medicalized midwifery? Would midwives

practice at home or in hospitals, as part of a medical team or as independent practitioners?

The recently created UMEPs have thus become the point of interest in this study. University midwifery education is a determinant for the future direction of the midwifery profession. The design and content of university midwifery education determines the education and practices of future midwifery professionals. Recruiting practices and university structure affect the demographics, skills and diversity of applicants and the composition of future midwifery professionals.

Regulation of Midwifery

This is an interesting period of transition in midwifery history to analyze the accessible data on UMEPs in Canada. Midwifery has endured a process of professionalization in British Columbia, Alberta, Manitoba, Saskatchewan, Quebec, Ontario and the NWT in a decade from 1993-2003. The professionalization process for midwifery has varied by province in Canada. The professionalization process as a whole has been characterized by the creation of regulatory colleges to govern the practices of midwives, UMEPs for emerging students of midwifery, prior learning and education assessment (PLEA) models, the extension of hospital privileges, and health care system funding for services of midwives. UMEPs have been created as the chosen method and standard to educate and train midwives, effectively legitimizing this newly established profession among the health professions (Bourgeault, 1996). UMEPs exist at the University of British Columbia, Ryerson University, Laurentian University, McMaster University and the Universite du Quebec a Trois Rivieres. Regulation of this profession determines the only legal and acceptable route to practice midwifery to be through

graduation from a recognized UMEP followed by registration with the College of Midwives of ones' respective legislated province, a PLEA process available only in specific provinces or an exemption to practice midwifery in an Aboriginal community. Entry to this profession is primarily limited by the structure of the UMEPs and associated license requirements as this route to practice will train the most professionals.

The alternative routes to practice available include obtaining permission to practice midwifery through a Prior Learning (Education) Assessment (PLEA) examination, offered by the individual Colleges which govern midwifery practice and the International Midwifery Pre-Registration Program (IMPP) offered by the Continuing Education Department at Ryerson University. These options have been created in order to assess the skills and competence of pre-legislation practicing and foreign-educated midwives. These alternative routes to practice are also accessible to women who choose distance education as an option over attending a Canadian UMEP.

At the origin of the professionalization process for midwifery in both Ontario and British Columbia in the late 1980s and early 1990s, there was considerable discussion concerning client accessibility to midwives. Vicki Van Wagner, midwife and activist, has been quoted as stating that midwifery care comprised two-tier health care in Ontario previous to professionalization, "...accessible only to a well-educated group of women motivated to seek an alternative care giver and affluent enough to pay for services" (Mason, 1990). This realization became part of the process and justification for professionalization which included promoting midwifery as a federally funded health care service. This two tier health care arrangement continues in provinces such as Alberta which does not fund midwifery services under the health care system, despite

considering midwifery services to be a cheap alternative to physician-assisted birthing care (CBC News, 2005). There is a belief that professional midwifery services which are covered by the health care system provide a more accessible midwifery practice for clients in Canada.

In both Ontario and British Columbia, UMEPs have been chosen as the ideal education form for the midwifery profession. There was some debate in Ontario at the onset of the professionalization process as to whether college or university would allow the greatest accessibility and community focus (Bourgeault, 1996). In the beginning Ryerson was the chosen university setting allowing for part-time enrollment as well as the prospect for future graduate programs for midwives in order for the research of midwife professionals to be used to inform their own evidence-based practice. This was subsequently extended to create the McMaster, Laurentian, Ryerson consortium (Bourgeault). A curriculum design committee and an outreach committee under the direction of the Association of Ontario Midwives and the Midwifery Task Force of Ontario were created to develop university midwifery education (Nestel, 2000). It has been argued that the work of these organizations and the interests of these groups excluded minorities, disregarding both foreign trained midwives and midwives of colour (Nestel).

In British Columbia a similar process of university midwifery education design and implementation occurred. At the onset of this process the issues considered relevant by those involved in a social movement in support of midwifery in B.C., were access to midwifery care and preserving the spirit of midwifery. In this context, advocates of professionalization were concerned with ensuring that midwifery services were available

to a more diverse and expanded population group. This concern for accessibility was not limited to clients, affirming that “Midwifery education too, needs to be accessible to ensure a future supply of midwives” (Rice, 1997). The pre-regulation professionalization environment in B.C. included several elements which denoted the political nature of midwifery and activist culture in B.C.. Midwives in B.C. have been described as ‘activist-midwives’; purporting feminist values, anti-technology values, and being pro-alternative medicine (Rice).

A process of othering those not blindly supportive of and directly involved in the professionalization process has occurred in some literature. Post-professionalization discussions of concerns for loss of holistic philosophy and practice are labeled only “legitimate detractors concerns” (Benoit, 1997). The term ‘detractors’ initiates a process of othering those who have questioned various aspects of the process of professionalization and evolution of midwifery practice and philosophy in Ontario. Benoit lists the issues for ‘detractors’ as, “co-optation by medicine; bureaucratization of reproductive services, emergence of a professional ideology and practice separating the midwife from those she serves, and loss of continuity of care” (p.94). These concerns are implicated in the form, content and accessibility of the education system that midwives are able to experience.

Midwifery education has developed from primarily apprenticeship education to a prestigious four year UMEP standard. The ability for the midwifery profession in Canada to continue to define itself as holistic and empowering for both clients and professionals while also legitimizing and mainstreaming practice and recruitment is being tested at the 2003 post-integration phase of this study.

Midwifery education has come of age as has the profession in specific provinces in Canada. The best case scenario is for UMEPs to engage in sharing the values, practices and beliefs of an holistic and empowering maternity care to women and families in legislated provinces in Canada.

Patriarchal-capitalism is evidenced as having a controlling influence on the social and professional development of midwifery through institutions which structure regulatory schemes and education. UMEPs exist within this larger social framework. It is through the UMEPs that the language of midwifery is learned, the boundaries for professional practice and behavior are en-cultured and reinforced. Upon graduation from a UMEP the existing Colleges of Midwives enforce the values of the system. These regulatory bodies are structured for the purpose of ensuring that all members comply; whereby they follow the rules and subtle yet definitive limits for behavior and practice that have been enculturated during their UMEP experience.

The university programs of interest in this project provide an opportunity to study the continuity and/or disjuncture of the holistic values and practices of pre-legislated midwifery in Canada. The university both streamlines legitimate practitioners of midwifery through recruitment and admission policies as well as shaping the practice of future professionals through specific choices in the education of accepted students. As women comprise the majority of practitioners as well as forming the clientele, a feminist perspective on the continuity of values affecting women through the professional education of midwives is particularly relevant.

One of the greatest values and promoted strengths of midwifery has been its holistic philosophy. Incorporating emotional, physical, and spiritual aspects into birthing care

has been a defining feature of midwifery. This holistic perspective has included the empowerment of childbearing women, a non-interventionist approach encompassing the well-being of the whole person, family, and community, respect for cultural and spiritual diversity and philosophy which centers on childbirth as a normal and natural event.

There are many concerns arising out of the current context of midwifery professionalization in Canada, identifying those most relevant and/or prevalent to the holistic representation of university midwifery education to the public and potential applicants in Canada is key to this study. The presentation of university education through online recruiting content should provide a valid representation to the public and potential applicants of the values of UMEPs in Canada. This information is what potential applicants may be using to decide whether or not to pursue midwifery education at a specific university. It is particularly important for recruitment information to be properly targeted, accurate, and representative. The values presented in this text may also have an impact on a woman's choice to access midwifery care. Therefore, textual content related to UMEPs as a point of reference will inform the decisions of women interested in becoming involved in providing and receiving midwifery care.

Chapter 2- Theoretical Overview

Patriarchal Capitalism

Implicated in a university offering of midwifery education is a consideration of the potential effects of patriarchy and capitalism. Universities as social institutions are not immune to the influence of patriarchy and capitalism². Patriarchy and capitalism create numerous situations in which women's autonomy as students, professionals and as clients is threatened. One objective in this study is to question what, if any indicators of capitalist-patriarchy exist in the structural and content dynamics of the UMEPs. These overarching ideologies tend not to be conducive to a holistic education and practice of midwifery. The ideal patriarchal-capitalist system supports market competition which prioritizes profit and efficiency over quality and care, competition for knowledge dominance in university classroom dynamics favouring masculinist assumptions of biomedicine and competition for professional status in the context of status hierarchies informed by patriarchy.

² Patriarchy and Capitalism coalesce in modern Canadian civil society and institutions to create a dual patriarchal-capitalist oppressive force. Capitalist-Patriarchy for all intents and purposes is a system perpetuating interlocking oppressive tendencies of accumulation promoting a profit-oriented, market-based economy and male dominated economic and political system under which women are primarily negatively impacted. Mies (1998) defined capitalism as the most recent development of the patriarchal system. Mies states, "It is my thesis that capitalism cannot function without patriarchy, that the goal of this system, namely the never-ending process of capital accumulation, cannot be achieved unless patriarchal man-woman relations are maintained or newly created." (Mies,1998, p.38).

Gender and Establishing Professional and Philosophical Integrity

Accessibility to the professions in Canada, and likelihood of success within these professions is particularly constrained by gender. The openness of professional education and practice has been limited by gender, race and class. This has particular implications for female dominated occupations and professions, such as midwifery, with a history of feminist activism and open and diverse participation (Barrington, 1985; Mason, 1990).

In terms of the ability for women to equitably participate in the professions, the education required for a woman to perform her profession of interest must be accessible.

University education in the Canadian context is offered as privilege and not a right.

Therefore, questioning the integration of a holistic midwifery philosophy and practice into a UMEP within the university structure is an objective of this research. How has the structure of the university integrated midwifery? What do the education options look like in terms of accessibility, admission requirements, pre-requisites and so forth? Is there a consideration of the pre-legislation demographic composition of midwifery professionals and continuity in terms of access, philosophy and recruitment? Will women who have worked to promote holistic values and practice of midwifery continue to be valued as midwifery professionals post-regulation?

From a feminist perspective considering women's historical experience of unequal access to professional accreditation, the values and structural design of UMEPs must be questioned in terms of accessibility to *all* women who would be interested in pursuing this profession. Accessibility of UMEPs to diverse groups of women students will diversify the client population as these women whether from rural areas or marginalized communities begin to practice in their representative communities, health and access to

midwifery services will improve. Accessibility for students is particularly constrained by education setting, program design, the language used to promote the program, as well as the support systems which may or may not exist for students. These varied factors make it very difficult to ensure that accessibility is a value which is carried through midwifery professionalization for both potential midwives and clients.

As the professional underdogs in maternity care, midwives may be required to prove their professional competence and adhere to standards predetermined by those in positions of authority in the hospital and university systems. In the hospital and university setting for example, biomedicine has been the preferred ideology informing maternity care. Dominant disciplines such as science and medicine, having a strong historical foundation in the university pose a challenge for the integration of UMEPs. Those educating future professionals in obstetrics work within established dominant biomedical paradigms experiencing an elevated social status based on self-perpetuated authority, research, and monetary value of services.

Gender directly affects the success that particular professional groups are able to attain which reinforces and is reinforced by the epistemological privilege of their knowledge base. Nurses, in particular, working in a female-dominated profession have been relegated to a semi-professional social and occupational status (MacPherson, 1996). In light of the historical struggles of female-dominated health professions to attain and maintain status and integrity, the independence of an holistic midwifery practice and philosophy within the university and health care systems is questionable.

The specifics of the continuity and /or disjuncture of an holistic philosophy and practice of midwifery evident upon analysis of Ontario and B.C. UMEPs is relevant to

both practitioners and clients of midwifery services. The implication of this analysis is the development of a deeper understanding of the gendered issues of accessibility to professional education and status for marginalized groups. In this case the issues include access to UMEPs, cultural diversity and inclusion of the UMEPs, university resources dedicated to a recently established UMEP, enculturation of UMEP students, co-existence of the UMEP with dominant disciplines in the university.

The ideal function of a UMEP includes an openness to a diverse population, promoting gender inclusiveness and equity, independent funding, faculty, education and enculturation mechanisms to maintain a holistic midwifery knowledge and practicum resistant to both biomedical and interventionist philosophy and practice.

The main objective of this study is to substantiate the continuity and/or disjuncture of a holistic midwifery knowledge and practicum through the process of incorporation of UMEPs in Ontario and British Columbia. The ideal implication of this study is that perhaps future and/or current provincial task forces and/or education/curriculum design committees planning to establish UMEPs or alternative education programs may take a specific interest in analyzing the needs of the community of women and families the programs will serve rather than blindly replicating existing program structures and content for the purposes of efficiency.

Chapter 3- Literature Review

Overview of Historical Foundations of Canadian Midwifery Education Style and Philosophy

On the basis of the literature available, a background to the struggle for professionalization of a predominantly female midwifery occupation, in the context of women's reproductive health, prefaces the issues of the integration of this occupation into university and health care systems in Canada. The integration of midwifery into the structure of universities and professional medical sphere in Ontario and British Columbia brings the future of the epistemological development of midwifery into question. Issues at stake include the status of professional midwives within an efficiency-driven, cost-cutting focused health care system and integrity of an holistic midwifery philosophy in the structure of a capitalist-patriarchal Canadian university system.

A review of existing literature that documents the historical development of midwifery and obstetrics in Canada supports this research by substantiating the epistemological, social and political development of midwifery and obstetrics as separate professional and ideological entities in Canadian society. The following literature explores the status of midwifery in Canada from 1698-2003. Debates center around examining the dynamics of power between midwives and general practitioners offering maternity care as well as emerging and established obstetricians.

The origins of Canadian midwifery practice and philosophy, documented as early as 1698, gives a contextualized introduction to the practices, beliefs, struggles and partnerships between female midwives and male practitioners of emerging obstetrics. The recruitment and immigration of European midwives to Atlantic Canada is also

documented in the literature available, as informing the practices and philosophy of the midwifery occupation in Atlantic Canada.

The medicalization of childbirth coinciding with a decline in midwifery knowledge sharing and practice in 20th century Canada informs the historical debates on midwifery development in Canada. The resultant struggle for professionalization of midwifery, initially in the provinces of Ontario and British Columbia, is illustrated by literature documenting the actions and philosophy of the alternative birth movement, highlighted in the 1970s. This literature is evidence of the initial phase of seeking legitimization for the practices of midwives in Canada. Subsequent literature exploring the 1980s and 1990s process of integration of the occupation of midwifery as a profession finalizes this chapter.

The limitations of the social and political power available to women working in reproductive health care can be clearly illustrated beginning in the 16th century as the sacred feminine aspects of midwifery practice began to be demonized by a patriarchal church and secular state giving favour to masculine professional identities in the public sphere. The solidification of a patriarchal social structure allowed medical technology to become a symbol of power and prestige, allowing for the successful marketing of a new male dominated obstetrics in emerging capitalist economic regimes. Technology, historically developed by men and initially used only by men became a vital instrument for the suppression of femininity as well as the inhibition of female-only attendance in midwifery practice.

The time period from the early 16th century onward in England is particularly relevant to this study as this is the point in time in which a precedent was set as women were

excluded from formalized professional medical education, denied the ability to obtain licenses and limited in social mobilization and political power thus unable to formalize their own professional associations (Witz, 1992). The influence of patriarchy on female-pioneered midwifery can be seen as early as 1512, when Henry VIII of England established the *Medical Act*, prohibiting women from practicing medicine under the justification that women belonged to an “undesirable” group of persons. Henry VIII, succeeded in creating a gendered biological differentiation of the human ability to perform medical acts, obtain medical knowledge, skills or expertise which greatly favoured male practitioners (Clarke, 2000). This patriarchal act set a legal and social precedent causing faith in women’s knowledge of healing and midwifery as a feminine practice and skill to subsequently erode. This act also created a standard by which exclusionary strategies or methods of exclusion began to develop. Although primarily originating at the level of gender discrimination, exclusionary strategies also include race, nationality and social class characteristics. The patriarchal nature of society made it impossible for women in particular to garner the social power necessary to organize and oppose the development of male dominated medicine and maternity care.

Patriarchy created a prime social environment for the development and justification of medical technology to be used only by men (Evenden, 2000). The use of new technology, including forceps was marketed under the capitalist system for use on pregnant women’s bodies, without ever consulting women concerning its design, use or intent allowed men to begin to formally and exclusively dominate in birth attendance, knowledge formation and legitimization (Evenden, 2000). Practice involving the use of

prestigious equipment and credentialed practical techniques in appearance seemed revolutionary and improved in comparison to the traditional practices of midwives.

The question of regulation for midwives has been and continues to be a contentious issue, fraught with gender discrimination in professional, economic, political, social and education systems. This issue is intensified by gender evidenced in the marginalization of female-pioneered midwifery by male-dominated birth attendance and obstetrics, and the associated disempowerment of women involved in feminine healing practice through historically documented witch hunts. The resulting male dominance in the healing arts and particularly in birth attendance resulted in formalization of male birth-attendant authority in the seventeenth and eighteenth centuries in Europe.

However, the 17th century status of midwifery in Canada was far different from that being experienced in Europe. Trained midwives arrived as settlers to Canada from France and England, occasionally summoned to practice in established settlements. Midwives were beginning to solidify their practice and knowledge in the early developing Canadian society first documented in New France in the late 1600s. Male birth attendance did not become common in Canada until the middle of the 20th century (Bourgeault, 2000).

Prior to the 16th century, for the most part, women practicing midwifery was extraordinarily common and uncontested, at least as far as the literature illustrates. Female midwives prior to the 16th century in England have been considered the rightful and knowledgeable authorities on birth (Rushing, 1988). Midwives whom settled in Canadian provinces brought this valuable knowledge with them and shared it with other women in their communities. Midwives learned their craft from the texts available as

well as in apprenticeship education style, and in schools designed by midwives for midwifery training. The texts available for midwives who were literate in this era were strongly influenced by the writings of Louise Bourgeois of France. Bourgeois practiced in the Royal Court, delivering the infants of Parisian royalty for over twenty years. Bourgeois's first work in 1609, *Observations diverses sur la sterilité, perte de ruict, foecundité, accouchements et maladies des femmes et enfants nouveaux naiz*, contributed greatly to the development of midwifery knowledge in Europe. Her philosophy was non-interventionist relying on the assumption of birth as a normal and natural event. Bourgeois is also credited with contributing to The Compleat Midwife's Practice, a British training text. This text reveals some of the practices of midwives at this time including podalic version and other external versions and warns of the dangers of 'man-midwives' (male physicians/barber-surgeons with limited experience). Additional training manuals for midwives included the later written English text, Jane Sharpe's The Midwives Book (1671). Self-education from this type of medical literature was generally accessible only to those of the upper classes who could read well. These texts provide some insight as to the early midwifery philosophy and practice which was available to inform the practices of Canadian settler-midwives and their apprentices.

However, most midwives in 16th to 17th century England were self-taught. For the majority of practitioners midwifery education came in an informal manner, ranging from experiential learning to knowledge passed down from mother to daughter (Witz, 1992; Evenden, 2000). Knowledge of midwifery was passed down in the oral tradition from one midwife to another, often from mother to daughter. Often these women served "lengthy informal apprenticeships in which the educational experience was entirely of a

practical nature,” (Evenden, p.6). Practical or hands-on education would have been far more useful at this time in history as the literacy rate for women was extremely low.

Midwifery education differed from the medical education of barber-surgeons, physicians, apothecaries and so forth, as it was more practical, common-sense oriented and feminine. The teachings of male-dominated medical professions during the 17th century were devoted to Galenic, Aristotelian, and Hippocratic teachings that were more superstitious than practical (Evenden, p.13). Medical science is often associated with Hippocratic teachings on rational medicine, which includes the argument that , “it is nature itself that finds the way; though untaught and uninstructed it does what is proper” (Durbin, 1984, p.8). The Roman Galenic model, on the other hand is far more inventive and “characterized by a reliance on theory and scholastic learning, complex, exotic polypharmacy at the expense of simple native pharmacy, and the infallibility of the doctor” (Durbin, 1984, p.8).

Evenden (2000), describes midwifery philosophy and practices in her examination of parish documents in England pertaining to midwives practicing from 1641-1720. Midwives equipment at this time consisted of a kit containing maps, saddlebags, aprons, medicine bottles, spare nightgowns, linens, towels and napkins. Some midwives carried medicines with them for use in the case of gastric pains, extended labour, and items to use as perineal oils to prepare and stretch the perineal area for the birth.

Midwife philosophy at this time is claimed to be based on the following premise, derived from Catholic faith in God’s purpose and intention. The midwife philosophy was such that, “She ought, moreover to know that God hath given to all things their beginning , their increasins, their Estate of perfection, and declination: Therefore the said

midwife nor any of her assistants must not do anything rashly, for to precipitate or hasten nature” (Evenden, 2000, p. 83).

The practices of midwives during these times reflected the importance of this non-interventionist philosophy. The midwives in most cases would make a bed for the woman in labour, give her a smock or a waist coat to wear and get ready for the baby on a stool or a chair positioned lower than the woman. Women in labour were empowered to kneel, sit, stand, lay down or find any position that was comfortable for them to give birth. The midwife would check the woman’s abdomen for the position of the baby and may do an internal exam with her hand anointed with fresh butter or oils to determine the amount of cervical dilation. The midwife would massage and stretch the perineum with oils when it came close to the time for the baby’s head to emerge. The midwife would then *catch* the baby after waiting patiently, according to their philosophy, for the baby’s arrival. The midwife would then determine the baby’s sex, place the baby on the woman’s stomach, proceed to cut the umbilical cord and determine that the baby was normal. If the baby was not breathing the midwife would attempt resuscitation using many different methods, from rubbing the baby to blowing smoke in the baby’s nose. The baby would also be cleaned with oils or warm water. The baby would be encouraged to nurse when the mother or wet-nurse was ready. The midwife would then proceed to deliver the afterbirth without force and ensuring that nothing was left behind (Evenden, 2000).

If midwives in this time period had exhausted every effort to encourage the baby to be born after a lengthy labour and the mother’s life was in jeopardy, the barber-surgeon would be called in to cut out the baby. This often resulted in the death of both the mother

and the baby and was a last resort only. Evenden (2000) states that, “ The overwhelming majority of births was normal and did not require the intervention of medical practitioners whose services were restricted to medical emergencies” (p. 75).

Aboriginal and First Nations midwives practiced extensively in early Canada providing women of these and surrounding non-Indigenous communities with much-needed maternity care. Aboriginal women in Canada provided much of the midwifery services available to women in early Canadian frontier settlements and other isolated communities. There is historical data to suggest that First Nations people were the main healers and midwives in northern areas of British Columbia and Newfoundland and Labrador (Rushing, N.E., 1988). These predominately women midwives served their own communities as well as white settler families. These midwives were trained in the apprenticeship style providing culturally and spiritually meaningful maternity care. This tradition and knowledge was passed down among generations of women and men healers. Mitchinson (2002) quotes one Inuk woman describing this history in the aboriginal communities, “Back then, the women had the knowledge to take care of a woman in labour.... We were informed by our elders what to do and what not to do”(73). It is unfortunate that the names of these important healers and midwives of the past are not well-known. It is unfortunate that a phenomenon of midwife-namelessness is specific to mainstream historical discussions of midwives. The names of the majority of Aboriginal midwives practicing in Canada and Anglo-Saxon midwives practicing in London and early Canadian settlements are unstated in archival records (Evenden, 2000; Mitchinson, 2002). The first mention of a midwife’s name in Montreal records is

Catherine Guertin, who was elected to be the community midwife in Montreal in 1713 (Rushing, N.E., 1988).

As the population increased and settlements expanded, the importation of midwifery knowledge and midwives to Canada occurred most often in conjunction with French and British immigration. Midwifery knowledge of the European influence tended to come to Canada through British midwife immigrants. British settlements such as the Lunenburg, Nova Scotia settlement are stated to have employed midwives. The French settlement of Ville-Marie in Quebec was also supportive of midwifery employing a midwife to serve the community. Midwifery in this province followed church governed licensing procedures.

Early Canadian midwifery influences can also be traced most prominently to the United Kingdom and France in terms of midwifery education sought there by Canadians as well as a substantial number of immigrant midwives from the United Kingdom and France who brought their particular form of midwifery to Canada from the 17th to the 20th century (Rushing, N.E., 1988). There is evidence of midwives arriving among settlers to New France as early as 1698. Some later midwife immigrants to this area may have been educated at the Hotel Dieu in Paris. The crown in New France subsidized midwives who were trained in France in the 1720s and 30s to come to New France to practice (Burtch, 1994). From the literature available on early Canadian midwifery history (Benoit, 1991; Burtch 1994; Kuusisto, 1980; Mitchinson, 2002; Rushing, N.E., 1988; Mitchinson, 2002;) it can be stated that particularly in Toronto, Montreal and Newfoundland, European immigrant women, primarily from France and the UK, came to Canada to practice as midwives.

Women in Newfoundland in particular went abroad to the United Kingdom for midwifery training and returned to their home province to practice (Benoit, 1991). There is also some historical evidence of British midwives working in Nova Scotia as well. Maria Moser and Maria Tatteray are documented as working in Lunenburg, as well as un-named midwives working in Shelburne and many others in Halifax, Nova Scotia (Rushing, N.E., 1988). Kuusisto (1980) describes early Canadian midwifery practice as including female midwives who were certified by the Nova Scotia Provincial Medical Board until the 1920s and 1930s who continued to practice with and without doctor's support. An example of British foreign training is also revealed by a study of ten Halifax midwives who practiced from 1873-1900, four of whom were trained in either Edinburgh, Aberdeen and/or Dublin (Daniels, 1997).

An 18-month midwifery training program available at the St. John's Grace Hospital in Newfoundland in 1924 was modeled on the British midwifery system and licensed midwives were attending births at home and in small cottage hospitals throughout the province (Benoit, 1991). Apprenticeship to physicians or other midwives occurred frequently. The status of midwives throughout Newfoundland in the 20th century illustrates how formal education combined with limited technology has the potential to result in a quality and successful midwifery practice. Benoit (1991) reveals that many midwives had unfavourable working conditions in isolated rural clinics in Newfoundland, with little support, cultural familiarity, privacy or comfort. There was little occupational prestige as compared to that of doctors. However, midwives did have good working conditions and what Benoit considers to be ideal workplace autonomy in the cottage hospital system in Newfoundland. Newfoundland provides an excellent example of how

midwifery thrived in Canada in what those in larger towns would refer to as isolated communities.

Lay midwives, some of whom were self-taught and some apprenticeship-trained worked steadily in Newfoundland throughout the 20th century. Benoit (1991) describes four categories of midwives that filled the occupation in Newfoundland: the first were homebirth midwives, the second were midwives who worked in rural clinics, the third were those who worked in cottage hospitals from the 1930s to the 1960s and the fourth were hospital workers who were midwives. The cottage hospital midwives seem to have had the most favourable working conditions and occupational autonomy as compared to other practicing midwives in Newfoundland. This is apparent as these midwives were able to secure a thorough education, trained through a combination of practical experience and specialized formal knowledge of pregnancy and childbirth (Benoit). These particular midwives often had access to vocational training resulting in a government license to practice midwifery in the province of Newfoundland (Benoit).

Although 'cottage hospital' midwives had access to formal training this training did not result in medicalized or oppressive birthing practices. There was very little technology available and there was a personal approach to care which did not allow for the dehumanization that often accompanied technological medical training and practice. The use of obstetric birthing technology tends to be the catalyst for dehumanization of the birthing experience that often accompanies obstetrician-assisted hospital birth. This may be a result of what theorists such as Caroline Flint, Sheila Kitzinger and Sally Inch have termed the 'cascade of intervention', which begins with oxytocin induction technology and progressively increasing intervention (Murphy-Lawless, 1998).

The shift from midwife to physician attendance at births in Newfoundland occurred slightly later than in other areas of Canada. In 1963, the final license was granted to a midwife in Newfoundland. Independent regulated midwifery in Newfoundland had officially ended. Nurse-midwives continue to practice but only under the supervision of doctors in hospitals as their union contract requires (Daniels, 1997).

There are several alternatives to formal education and hospital practice of midwifery which are relative to an overall concept of holistic midwifery practice pre-regulation in Canada. There have been and continue to be women who learned midwifery through experiencing their own births and the births of others, learning by experience and reading alone. These women may or may not have called themselves midwives but helped other women with their births. Many of the midwives in Canada were “granny” midwives or neighbours of women who assisted births with non-surgical techniques of encouraging the baby to be born and assisting to catch the baby. This type of traditional midwife has been called many things, from a ‘granny’ to a ‘healer’. However there is a broad definition which most will agree on which is, “a woman, who is not a physician, and helped other women in childbirth” (Mitchinson, 2002).

Some of the specific techniques used by traditional midwives in Canada include massaging the uterus from outside to help turn babies that were in a breech position, squatting positioning and “quilling”, which encouraged the mother to sneeze and thus push hard as cayenne pepper was blown up her nose through a quill. Burtch (1994) also discusses the practices of these self-trained or ‘granny’ midwives in his research. He argues that, “Women were discouraged from labouring alone. Female kin and neighbors often assisted in birth, providing what midwives today refer to as ‘continuity of care’”

(Burtch, p. 74). Unlike physician practices, women in birth accompanied by these midwife assistants were encouraged to use any position comfortable for them in labour and to move around during the labour. Most would agree that choosing to have a home birth with a neighbor woman or a 'granny' midwife at this time was a good choice, if the birth was relatively straightforward, considering the risk of infection, sepsis, and intervention in hospitals in early 20th century Canada. There is also documentation to support the contention that lower maternal mortality rates occurred in a midwife-attended home birth than those managed by physicians in hospitals (Burtch, 1994). Some physicians worked as partners with midwives and were supportive of home birth allowing midwives to apprentice with them. Barrington (1985) argues that the early Canadian midwives had very diverse backgrounds but were usually older, had children of their own as well as having previously held different careers. Bourgeault (2000) states that "Many began as assistants to home birth physicians and were self-taught, often drawing on the assistance, expertise and experience of others in study groups" (p.225).

Medicalization of Childbirth: Politics of the Decline of Midwifery

Knowledge Sharing and Practice in 20th Century Canada

Numerous researchers have contributed to the body of knowledge examining the historical development, decline and resurgence status of midwifery in Canada. Some of this knowledge will be examined here in order to illustrate how midwifery has been marginalized by male dominated medicine, first in Europe and later in Canada, resulting in the development of a distinct midwifery philosophy with values important to a female-dominated occupation outside of mainstream medicine. A review of the literature on regulation of midwifery also allows one to trace historical attempts at regulation by both

the church and the state. Regulatory schemes have affected the development of this occupation and the status of midwifery professionals. Regulatory schemes in the case of midwifery have proven unsuccessful at counteracting the rise of science and technology, which has been used as a tool to successfully market the man-midwife (subsequent obstetrician) and his (later, her) services.

The employment of science and technology by male dominated and patriarchal medicine has allowed it to gain prominence and popularity. Patriarchy created a social environment in which it has been very challenging for women midwives to organize politically or socially in order to formally oppose, or even compete in the birthing care market. The highly evolved patriarchal-capitalist social and economic structure of post-industrial society contributed to the takeover of birth by obstetrics due to the purposeful limiting of women's social power, access to economic capital, political and citizenship rights.

There are several theories which attempt to explain the reasons for the transition from midwife to physician maternity care. Witz (1992) argues that this transition occurred as a structural transformation of a new era of medicine and a new means of social control affected women's participation in the healing arts. She argues that the shift from medicine as a family business to medicine as a public institution as part of the market economy cut women off from participation in healing work. Women had no means of collective organization in order to secure occupational power, nor did they organize to collectively represent their interests in the market economy (Hartmann, 1979). Physicians also garnered a greater share of the market as General Practitioners claimed to

be able to perform all of the duties of many practitioners, from the surgeon and pharmacist to the midwife (Witz, 1992).

Kuusisto (1980) is another feminist researcher who, using a social historical perspective specifically analyzes what accounted for the shift in attendance from midwives to physicians in 20th century Nova Scotia. Kuusisto argues that a market shift as well as a shift in cultural preference of those in higher class social positions influenced women's choices to have a midwife or medical man attend the birth of their child/ren. Kuusisto (1980) cites the choice of Queen Charlotte to have a male physician assist her in childbirth as a turning point and asserts that, "...crucial element in the ultimate decline of midwives and their authority was the redefinition of birth from a private to a public event" (p.5). By this, Kuusisto is referring to a changing belief system which coincided with a strengthening patriarchal-capitalist state structure. Within this system, birth became an event which was considered better taken care of by professional physicians in public hospital institutions. Kuusisto states the situation as, "Hospitalized, attended by a collection of specialists, each with his or her own area of expertise, the parturient woman became a patient, defined as ill, and subject to the controls and definitions of the medical man and his institutions"(p.6). Feminist study of early midwifery practice in Nova Scotia reveals that midwifery has been involved in a power struggle with both midwives and physicians attempting to reinforce their knowledge forms for succession and survival of a profession (Kuusisto, 1980). In the context of Nova Scotia, the development of the industrial-capitalist state influenced the decline of midwifery. The creation of gender differentiated spheres of responsibility with the onset

of the public/private divide had the effect of changing the nature of control over birthing from women's domain to men's sphere of authority.

On the other hand, Ehrenreich and English (1973) and Starhawk (1982) argue that it was the patriarchal domination of the church and the burning of women healers as witches, rather than the emergence of a new modern state which encouraged this transition and robbed women of their healing authority over childbirth.

There are variances in each of these explanations. Ehrenreich and English (1973) argue that,

“Women healers were people's doctors, and their medicine was part of a people's subculture. To this very day women's medical practice has thrived in the midst of rebellious lower class movements which have struggled to be free from the established authorities”(05).

Yet, these women were unable to collectively organize to oppose the interests of male healers; perhaps reflective of their gender, class status and limited access to social and political power of the ruling male elites.

Witz (1992) argues that some of the steadily practicing women midwives were upper class women healers, such as the 'Ladies Bountiful', who provided community medical services. However, with the advent of professional obstetrics, legally enforceable education requirements and licensure requirements were limited to men. Therefore, this class of women healers also became significantly repressed in their scope of practice.

Patriarchal institutions of civil society such as the colleges of physicians, formal medical associations as well as educational institutions, such as universities, have been (and have the potential to continue to be) used to exclude women from medical practice and to undermine women's ability to practice midwifery. According to this perspective,

midwives were unable to succeed in establishing professional occupational autonomy in the formalizing stage during the 19th century because of the patriarchal nature of civil and state institutions which denied legitimacy to female midwives on the basis of their gender and their direct competition with medical men. Legitimacy for healing arts and science were thus conferred upon medical men who had access to civil and state institutions (Witz, 1992, p.107).

Witz (1992) focuses almost exclusively on state control as the means by which female-pioneered midwifery was marginalized. Evenden (2000) offers yet another explanation for this transformation. She argues that the 18th century transformation can be linked to a number of phenomenon:

“The Church’s declining role in the process of licensing, the availability of forceps to male practitioners, and their promotion by men who were motivated by the desire to enjoy some of the monetary rewards of child delivery, the intellectual climate of the “Enlightenment” generally receptive to the claims of scientific knowledge, and most important, the advent of the lying-in hospital, all contributed to the demise of the complex and effective system in which London midwives proudly functioned in the seventeenth century” (Evenden, 2000).

Midwives had been obtaining licenses to practice from the hundreds of parishes under the control of the Church of England from 1640 to 1721 (Evenden, 2000). In order to receive these licenses midwives had to be born Catholic, and have people to vouch for their skills as a midwife and make certain promises to the Church of England. The midwifery oath that midwives were required to swear included specific duties and obligations to the Church of England. In the 16th century midwives were required to state their name, swear to bring cunning and knowledge given by God to their work, assist both rich and poor women, inform on bastardy, not switch babies, use no sorcery, nor

instruments to harm or mutilate the baby, correctly perform baptism and inform the curate of baptisms she has performed (Evenden).

Evenden (2000) is very supportive of the role that the Church of England played in licensing midwives. She presents evidence to the effect that midwives were actually respected and esteemed, loyal members of the Church of England. She also argues that the Church of England encouraged the licensing of midwives throughout the 17th century because of their concern for the safety of women in childbirth and for their concern that women have competent midwife attendants (Evenden). This evidence however, contradicts with evidence describing the midwife's necessity to report what the church considered socially deviant behaviour or that which was not under the church's control, including witchcraft, midwives practicing without a license and convert midwives practicing with licenses. Despite church licensing however, Evenden admits that there were many midwives practicing outside of the licensing scope of the church functioning as self-regulated professionals. These women became likely targets for witch hunters.

The authority of midwives was threatened by the church and the state. Serious threats to the survival of this profession came in the form of witch hunts, limits on practice through regulations and licensing and competition from male physicians. There was however, a loophole in the law which allowed a few upper class women to engage in the professional provision of medical services in the 19th century. Women were able to legitimately practice as physicians if they inherited their father or husband's practice upon his death (Witz, 1992). This loophole accomplished nothing however, for the hundreds of midwives who were no longer able to get independent licenses to practice. The last independent license issued by the Church of England to a midwife was in 1721.

There is some indication that the transformation from home to hospital birth and from midwife to physician attendance in birth has been linked to the development and support of technology. Harley (as cited in Marland, 1993) argues that it was the use of forceps, accompanied by the promise of a live mother and intact child, as well as the development of the syringe which had an impact on the increase of attendance by man-midwives. Harley argues that even at this early juncture in scientific and biomedical progress of the 18th century it was the appeal of science and technology that offered male physicians the cutting edge in maternity care. The biomedical model of maternity care differs significantly from that of the female midwife in the seventeenth to nineteenth centuries.

However, lacking similar experience that women midwives had gained through years of apprenticeship training and experiencing their own births or the births of neighbours and friends, physicians tended to be far less successful in their results (Evdenden, 2000). Many women and babies died at the hands of physicians wielding instruments and spreading disease in unsanitary lying-in hospital conditions (Harley as cited in Marland, 1993). Despite these failures, medical practice by male obstetricians, as they became known, continued and dominated. These new birth attendants overwhelmingly demanded that women give birth in the lithotomy position only and encouraged women to give birth in hospitals (Harley). Professionalization of medicine and professional medical education allowed doctors to distance themselves from their clients with what they considered to be a god-like authority and expertise that was not available to any woman. The first female doctor Elizabeth Blackwell was registered in 1858, followed by Elizabeth Garrett in 1865. These women encountered numerous challenges to receiving their education and being licensed and registered. They also received tutoring that was

designed in a very patriarchal, obscene and condescending manner in regards to women (Witz, 1992).

Physicians employing an interventionist biomedical model of maternity care have and continue to dominate through the suppression of women-centred knowledge. The advanced patriarchal capitalist Canadian state and its institutional spawn, until the early 1990s, has been supportive of male dominated obstetrics alone as means of reproductive health care.

Physician dominance in maternity care in Canada has included the repression of Aboriginal midwifery practice placing limitations on the choices of aboriginal women. These limitations include(d) the type of care and choice of birthplace as well as geographic location of their birth experience. Understanding the repression and resurgence of Aboriginal midwifery is both politically and culturally relevant to the history of medicalization and the present and future of UMEPs in Canada. Othering of Aboriginal traditions by white medical authorities, traditions which were vital to the continuation of Aboriginal communities and to the pride of Aboriginal women, paired with a spontaneous decision to parity Aboriginal women's health care with the health care of white women in Canada forced the transformation from home to hospital birth for Aboriginal women (Hawkins & Knox, 2003). Mitchinson (2000) suggests that it was due in part to racism that Aboriginal midwives practiced for so long and to a greater degree among Aboriginal populations in Canada. Midwifery was, and likely continues to be, considered an inferior and cheaper health care option for birthing women. This cheaper option is what the Canadian government chose to provide to Aboriginal women until the 1960s when they were forced to leave their homes to go to hospitals. These women often

had to travel by airplane, miles from their homes, families and support persons for weeks at a time in order to give birth in a hospital with a physician attending.

The medicalization of childbirth in Canada has coincided with male professional dominance as well as the use of exclusion strategies, wielded by men and male dominated institutions against women, by which the means to a profession, namely access to professional education, has been restricted. In the case of midwifery, ensuring that only male physicians were to have licenses to assist at a birth and give advice to pregnant women, as well as excluding women from medical school successfully preserved this lucrative and now dominant occupation for men. Women were excluded from medical school in Canada in the 18th and 19th centuries (Burtch, 1994). Formal patriarchal medical institutions began to define their scope of practice and to dominate the area of female-pioneered midwifery as early as 1879, when the Quebec College of Physicians and Surgeons, effectively setting a precedent, issued 95% of the licenses available for midwifery to male physicians and surgeons.

Bourgeault (2000) argues that the mid 20th century marked the real transformation from midwifery assisted birth to physician assisted birth in the hospital as midwifery assisted birth hit an all-time low in Canada. Medicalization of childbirth was successful. The question remains, how was it successful? And how was it contrary to the values and practice of female-pioneered midwifery?

Physicians began to successfully market the hospital as the only safe place to give birth. This allowed physicians to develop a monopoly over childbirth in Canada. By the 1940s women in Canada were persuaded by propaganda, publications, professionals and culture that hospital birth was the only safe and responsible choice (Kitzinger, 1988).

Midwives in Atlantic Canada were targeted with propaganda which depicted them as dirty, ignorant, coarse and so forth created a market advantage for physicians in lying-in hospitals (Kuusisto, 1980). These labels were perpetuated by physicians, who were competing in the market to provide maternity care to Canadian women. Kuusisto (1980) takes this argument even further as she posits that the use of a physician to assist one in childbirth became a symbol of opulence and status. This propaganda correlates with a progressive and ever-increasing use of extensive technology, initially by male physicians, in hospitals in Canada from the 1940s onward. The use of technology such as an oxytocin drip, EFM, epidurals, forceps, vacuum extractors, surgical techniques and so forth, to intervene in the birth process, while being marketed as safe, greatly decreased women's faith in and reliance on midwifery knowledge. The language of birth had changed, the place of birth had changed and attitudes concerning safety and the value of technology had been successfully altered in favour of professional medicine in the market. It has been argued that the result of all of this development is that the birthing technology gave rise to the need to encourage greater efficiency, thus narrowing the role of the midwife and the definition of normal birth, further devaluing the knowledge of midwives (Lay, 2000).

As physician practices in hospitals began to treat pregnancy as a disease, childbirth has become medicalized and over-medicalized. Practices chosen by physicians sometimes implemented by nurses in the hospital management of birth, included the use of IVs, EFM, forceps and related medical technology, C-section, chloroform and routine episiotomies (Burtch, 1994). The medicalization of childbirth has been further defined by those in support of midwifery as

the use of specific birthing techniques which are considered “macabre”, such as stirrups, forceps, unnecessary C-sections, complications from the overuse of drugs, shaving, enemas, episiotomies and forced separation of the mother and infant (Hawkins and Knox, 2003).

The choices of women as maternity care consumers in 20th Century Canada were driven by perceptions of status while choices of consumers in the 21st century may be significantly different, perhaps based on personal values, lifestyle, or group affiliation. The man-midwife had once been feared as the bearer of death and dismemberment (Kuusisto, 1980), called in only as a last resort, yet in the 18th century he was able to redefine his image under patriarchal-capitalism, equipped with technology and a professional education. The male physician’s attendance at births by the mid 20th century became a symbol of a family’s wealth, status and good moral choices.

Despite an overall decline in midwifery practice nurse-midwives were able to continued to provide maternity care, particularly in Newfoundland (Benoit, 1991). However nurse-midwives have the same degree of authority over birth that obstetrical nurses have. They have only as much authority as a physician allows them to have. Nursing has been labeled a ‘semi-profession’, a ‘second-class profession’ and a ‘dependent profession’ because of this subordinate relationship to the physician (McPherson, 1996). McPherson (1996) theorizes that nurses, as a female dominated profession, have never been able to achieve the same professional autonomy as medicine, for example. Nurse-midwives are in the same power positions. Therefore comparing the practice of nurse-midwifery with independent midwifery is not always particularly useful.

The debates on the explanation as to the success of medicalization of childbirth in Canada and resultant decline of midwifery are diverse. Rushing (1988) theorizes that market and ideological factors are responsible for the ‘disappearance’ of midwifery in Canada and the loss of workplace autonomy for midwives in Europe. Devries (1996) and Benoit (1991) argue that it was technology and the prestige of technology and science which allowed medicine to succeed midwifery in the emerging capitalist Canadian society. Burtch (1994) echoes Kuusisto (1980) arguing that it was also, propaganda from medical authorities, portraying midwives as dirty and ignorant, effectively establishing that home birth itself, the midwives mainstay of practice was dangerous.

The creation of lying-in hospitals in Canada, similar to the situation in 18th century England, also had an effect on who provided women with care and what kind of care women received. The hospital has a particular protocol based on capitalist models of efficiency and production, consequently limiting the birthing experience. The theoretical framework defining the structure of an institution, whether a hospital or a university has an influence on that which inhabits the institutional system.

The combination of capitalist-patriarchy and male control of science contributed to the development of a male-dominated biomedicine and a male dominated obstetrics. This in turn led to subordination of women in two ways: 1) as scholars; patriarchy allowed men to declare that women’s natures were unfit for scholarship; 2) male physicians declared the state of pregnancy to be truly in need of mastery, as women in this state, according to male-dominated science, are far too susceptible to their natures,

and the natural is exactly what male dominated science was designed to control, subdue and master (Keller, 1996).

Contemporary Debates: Resurgence of Midwifery Practice, Professionalization, Legislated Regulation of Midwifery and Establishment of UMEPs

Midwives continue to practice on the margins of society in unregulated provinces, without legal protection, occupational prestige or government funded services.

Midwifery in the unlegislated provinces is accessible for those who can locate a midwife through a network or organization, who can afford this second-tier health care service and those in rural or isolated areas of Canada who must pay for this service by bartering or paying on a sliding scale. Benoit's (1992) description of midwifery practices in Newfoundland illustrate how the vast landscape of Canada itself, with midwives being trained to work in rural and northern areas, contributed to the continued success of midwifery in Canada until the middle of the 20th century.

In response to this unequal access to care, some women have taught themselves the techniques of midwifery effectively initiating a social movement in response to the medicalization of childbirth in Canada (Bourgeault and MacDonald, 2000; Hawkins and Knox, 2003 and Mason, 1990; Sharpe, 2001). The home-birth or natural birth movement in Canada developed as a response to what feminists and birthing women from all walks of life considered to be oppressive and violating maternity care practices by physicians in Canadian hospitals. This was, and likely continues to be, a very diverse group of women who simply did not want a medicalized birthing experience and were looking for a better, more empowering way of experiencing birth. Women in the 1970s in Canada began to question their loss of power in the birthplace. Women began to read books by Raven

Lang and Ina May Gaskin and subsequently to question male physician domination of childbirth and the ever-increasing and intensifying medicalization and intervention in pregnancy and birth. This movement was considered to be part of the counter-culture movement, yet it was also a religious movement, a feminist movement, an anti-colonialist movement, a homebirth movement and a traditional birth movement.

Midwifery task forces were formed as feminist political leaders emerged among birth activists in Montreal, Toronto and Vancouver in particular. These activists argued that licensing midwives would establish a new monopoly and midwives would end up with the same practices as physicians. These midwifery activists were more open to ideas of alternative methods of maternity care delivery and decriminalizing home birth and midwifery attended birth. The re-emergence of midwifery in Canada began with this process and the return of what Mason (1990) refers to as 'the neighbourly midwife'. This woman was not likely formally trained; she may have read some books, delivered her own baby and helped friends to deliver their own babies. She was also called the 'counter-culture' midwife (Mason, 1990). Mason states the 1970s counter-culture of midwifery was a marginal enterprise in the sense that these women were poor, often uneducated, extremely unfashionable and politically marginal. Contrary to arguments made by Vicki Van Wagner (as cited in Benoit, 1997) that midwifery care was inaccessible to poor women contributing to a two-tier Canadian health care system if not funded by the state, Mason argues that midwifery re-emerged among the poor, immigrant women and teenage mothers. In Nova Scotia for example, there has been a sliding scale for midwife fees as well as a bartering system to which each woman pays what she can.

There is evidence of skepticism in debates around regulated and legalized midwifery in Canada. Mason (1990) suggested that midwives would come to professionally manage childbirth as government employees in a manner which would not be empowering for women. As well, Mason states that the plan for midwifery education that began to develop in the 1980s was contradictory to the non-medical birth culture that midwives had known but was constructed as a curriculum “at times indistinguishable from any other progressive medical curriculum” (p.4). Devries (1996) expresses concern that licensing midwives would relegate midwifery practice to hospitals which he believed would create the same structural constraint issues surrounding efficiency which are faced by obstetricians in the hospital setting. Benoit (1992) argued that in order to “...recapture the true art of midwifery, midwives must be free to train and socialize new recruits outside of the dominant medical paradigm” (10).

Nestel (2000) and Bourgeault (2000), document their perspectives on the development of professional midwifery in Ontario in their separate yet equally relevant PhD dissertations. The professionalization of midwifery began to gain public and government attention in September of 1973, when the Ontario Nurse Midwives Association and foreign trained, white British midwives lobbied the Ontario government for midwifery care to be included in the health care system (Nestel, 2000). The movement expanded throughout the 1970s and early 1980s and really took centre stage when the media reported on the tragic death of a baby which occurred during a midwife-assisted birth in Ontario in 1985 (Nestel).

The Health Professions Legislation Review, which had been formed in 1983, decided that it was time to seriously pursue regulation following this tragedy. The Health

Professions Legislation Review (HPLR) was a committee formed by the Ontario government for the purpose of reviewing legislation pertaining to all health professions in Ontario (Bourgeault, 2000). This committee received numerous presentations from consumer and advocacy groups and rallied with public support for regulation and professional education until December 31, 1993 when the Ontario legislature legalized and formalized midwifery in Ontario (Nestel, 2000). The most successful among the groups which made presentations to the HPLR were the Ontario Association of Midwives and Ontario Nurse Midwives Association (later- Association of Ontario Midwives), as well as the Midwifery Task Force of Ontario (Bourgeault).

Coinciding with professionalization, a direct-entry joint four year BHSc University Midwifery education program was developed in 1993 for McMaster, Ryerson and Laurentian. McMaster, Laurentian and UBC each offer a full-time four year program, while Ryerson offers a part-time 3-7 year program as well.

British Columbia has been the site of a similar process toward professionalization of midwifery. A sympathetic NDP government and the support of female politician and Minister of Health, Elizabeth Cull, greatly influenced the legislation approval for professionalized midwifery in B.C. Upon ensuring that midwifery services would add no greater cost to the government health care budget, it was announced at the International Confederation of Midwives 23rd International Conference in Vancouver in 1993 that midwifery would be officially legal and regulated in B.C. (Rice, 1997). In 1998, midwifery was officially legislated in the province. Coinciding with this legislation, a four year B.Midf degree in midwifery was created at UBC.

The corresponding legislative bodies which have been developed to regulate the profession of midwifery in B.C. and Ontario and to mainstream UMEPs are the College of Midwives of British Columbia and the College of Midwives of Ontario. The institutions that have been created and claim to provide professional support and liability insurance for the profession of midwifery are the Association of Ontario Midwives and the Midwives Association of British Columbia.

The College of Midwives of Ontario and the Association of Ontario Midwives at Ryerson have a great deal of structural importance to the university midwifery programs in Ontario. The Midwives Association of British Columbia as well as the College of Midwives of B.C. have powerful responsibilities to the midwifery profession and midwifery education at the University of British Columbia. The responsibilities that have been given to these professional institutions, including the regulation of the midwifery profession, the standardization of the university education programs for midwifery and the provision of liability insurance, make these organizations part of the education program function and direction as well as vital to the structure of the profession. Therefore the presentation or public information data links to these organizations available from the university education programs being analyzed will also be included in this analysis. The following chapter will introduce a feminist method of analyzing the implications for a holistic philosophy and practice of midwifery upon integration into the UMEP system in Canada.

Chapter 4- A Feminist Method of Analyzing UMEPs

Introduction to the Data Sample: UMEPs in Ontario and B.C

The chosen data for this study is the online, print and publicly available content of UMEPs in Ontario and British Columbia. The four universities which offer English-language university midwifery education programs whose texts comprise the data sample I will be analyzing are Ryerson University, Laurentian University, McMaster University, and the University of British Columbia (from this point on referred to as Ryerson, Laurentian, McMaster and UBC UMEPs).

The choice to create UMEPs in Ontario and B.C, setting a national baccalaureate standard for midwifery education, provides a unique opportunity to analyze a recently created women-centred education program from a feminist perspective and utilizing a feminist methodology. Unfortunately, this analysis includes English language UMEPs in Ontario and B.C. only as my French-language comprehension ability at this time would not adequately support a dual-level content and textual analysis of French-language text.

Twentieth century researchers have employed numerous methodologies in order to analyze periods of development, regulation and decline of midwifery from biblical times onward. Most of this research has been performed from the perspective of midwives, clients, supporters of midwifery and marginalized groups of midwives and potential midwives excluded from the professionalization process. (Nestel, 2000). It is my intention to include potential students and the interested public in the perspectives category of women to whom UMEPs as a product of midwifery professionalization is relevant. The methodology I have chosen will use the perspective of potential students and the public to perform a dual-level content and textual analysis on the data universities

use to present UMEPs to this audience. For this study, the chosen method for gaining insight into the continuity and/or discontinuity of holistic midwifery in the UMEP system is by performing a dual-level qualitative content and textual analysis of the selected text. An additional outcome of this process is the development of a feminist theory on the integration of historically marginalized professional groups into the university system.

This specific research project has been designed to understand how patriarchal capitalist systems of oppression act on UMEPs as a product of a predominately female professionalization project. The values which are prevalent in the presentation of this program to the public and potential students, as well as the themes which are most repeated and given the most attention will be identified in this analysis. The text which has been selected for this analysis is the online, print and publicly available content of UMEPs in Ontario and British Columbia which includes Ryerson, Laurentian, McMaster and UBC.

The data sample is comprised of the content university midwifery education in Canada from the aforementioned institutions which is presented to potential applicants and the public via online web page content, course outlines, course listings, faculty information, text lists, application forms and any other information pertaining to UMEPs which is accessible to the public and potential applicants. Ideally this content is representative of the substance of the UMEPs. The immediate implication for this content is the impact on those utilizing this information to decide whether or not to pursue midwifery education through UMEPs in Canada. If for some reason the findings from this analysis turn out to be very different from the perception designers of UMEPs have intended, I would suggest careful attention to accountability and inclusion.

Using the data sample previously described, this analysis attempts to determine the level of saturation and commitment and/or resistance to the problematic social condition of patriarchal capitalism and its cohorts of exclusion, obstetrics, biomedicine, science, and medical technology. I will further explain how this theoretical framework informs the feminist dual-level content and textual analysis method chosen for this study.

Patriarchal Capitalism: Theory on the Structure of University Institutions

The theoretical keystone for this project, which entails determining the potential effect the university education structure may have on the profession of midwifery and ultimately on women as potential clients and professionals, is the belief that Canadian society is dominated by the collusive omnipresent systems of patriarchy and capitalism (Hartmann, 1981). Biomedicine can be identified as one product of patriarchal capitalism. This is relevant to midwifery as female dominated professions tend to be faced with pressure to conform to guidelines or standards set by male dominated professions such as medicine, which conform to biomedical standards of practice, design and association (Witz, 1992). Theoretically, understanding the dominance of biomedicine and science within the university midwives within UMEPs may be under pressure to adopt or conform to a biomedical paradigm or model of practice. If successfully incorporated into the midwifery profession a modified model of practice closer to the biomedical end of the spectrum of maternity care would compromise the established holistic philosophy of pre-legislated midwifery in Canada.

Coinciding with this issue of conformity to biomedical standards are the issues of legitimacy, status, competency, professional reputation and public perception of

midwives as newly legislated and predominately female professionals. Hearn, (1982) argues that not only are female-dominated professions expected to conform but there is also a process of masculinization that is initiated by professional incorporation. The effect of patriarchy and capitalism, as intertwined social systems implicated in gender oppression (Eisenstein, 1979), is relevant to understanding how midwifery will be able to secure and maintain professional status as both a female-dominated and women-centred profession. An analysis of the values prevalent in the texts presenting university midwifery education to potential applicants will result in an illustration of the influence of, or resistance to patriarchal capitalism in the UMEPs. This illustration may provide further information as to the potential for women to maintain their distinct philosophy as midwifery students and professionals and the opportunity for maintaining and building upon the holistic component of midwifery in Canada.

A Feminist Methodology: Textual Analysis of UMEP Content

The methodological approach I have chosen is significantly different from methodologies used by other researchers, of whom I am aware, in the area of midwifery. This approach entails utilizing a dual-level analysis of the presentation data that a potential applicant would have access to if planning to apply to a UMEP in Canada. This method includes a content analysis of the text which includes thematic categories developed for the purpose of measurement with the historical foundations of holistic midwifery and the ideology of biomedical science in mind. The second level of analysis is a textual analysis comprised of specific questions designed to elicit implicit information from the text that would otherwise be overlooked with a content analysis alone. A dual-level analysis is utilized in this study in order to determine the values that

are most prevalent in the presentation of UMEPs Canada. This analysis has the potential to lead to conclusions as to the existence of and/or resistance to oppressive structural elements and ideology of patriarchal capitalism within UMEPs.

My approach to content analysis as a feminist method is very similar to the approach taken by Campbell and Schramm (1995) in their examination of the presence of discussions of feminist research methods in psychology and social science textbooks. Campbell and Schramm developed a coding manual which consists of two major dimensions as well as several sub-domains which are elaborated on with examples to guide the work of coders. Campbell and Schramm also added qualitative examples in the summary of their quantitative content analysis findings in order to present the data in a 'richer' format.

The selection of this specific text and the choice of methodology in this instance also demands that one make specific choices as to how the rigors of data organization will be undertaken. Holsti (1969) recommends that in preparation for a content analysis one chooses a unit of content such as a word, theme, character or item which will be coded and each appearance will be given equal weight when using a frequency indicator. Holsti (1969) argues that frequency counts are, "a valid indicator of the concern, focus of attention, intensity, value, importance and so on" within a given text (p.122). The unit of study that I have chosen for this content analysis is 'theme', which may represent itself as a paragraph, line, word or symbol for the thematic category being searched for. The text will be coded by paragraph, if a paragraph is unavailable then by line, and if a line is unavailable then by word or symbol.

I have chosen specific themes to code for which illustrate the level of attention given to feminist political consciousness, empirical or holistic health, patriarchal biomedical positivism and capitalism, and exclusion. The system of enumeration I have chosen to use is frequency (Holsti, 1969). I have chosen to consider the number of thematic references and compare them with one another. I am thus able to draw conclusions as to the favoured or prevalent theme(s) within this text.

The following categories have been developed to form the coding manual for this content analysis. Community, Economic, Elite, Empirical Health or Holistic Health, Individual, Omissions, Power, Scientific Rationality, Medical Technology, Symbol, Tone, Visual demographics. These categories will be slotted into their thematic areas of concern when evaluations and comparisons are made. These thematic areas to be measured and compared are patriarchal biomedical positivism and patriarchal capitalism, feminist political consciousness, exclusion, and empirical or holistic health.

I have devised a notation method in order to be precise about the amount of attention given to a theme as well as whether this attention is negative or positive. The thematic reference will be marked with the value 1 and a P for a positive reference or N for a negative reference. This is possible as the use of a frequency count enables one to give equal weight to all appearances of the unit of content. In the case of symbols, tone and visual demographics alternative methods of notation are used. The pictographic symbols are recorded and described (See Appendix I). The symbolic relevance and conferred meaning of the symbols and pictographic images is further investigated through a more qualitative textual method. The visual demographics are recorded according to such factors as approximate age, nationality, race, and physical ability of the subject(s). The

implications of the visual demographics are explored through a qualitative textual analysis.

Weber (1990) states that content analysis procedures, "...create quantitative indicators that assess the degree of attention or concern devoted to cultural units such as themes, categories or issues"(p.70). The language used to construct meaning in this text will be used as a primary signifier for the identification of values and priority issues. A content analysis of the language used in this text should provide a useful method of discerning the presence of dominating patriarchal and biomedical values and/or feminist and holistic health values.

The selected text in this thesis has the potential to reveal what the midwifery program designers view as a valuable potential applicant and also what the program looks like from the perspective of a potential applicant. A content analysis should bring to the surface what is most important, relevant, and repeated in this text. My intention is to identify what is highlighted and/or underrepresented in appearance of theme in the current presentation of UMEPs in Canada. Weber (1990) theorizes that "...the more a text contains mentions of a particular category, the more it is concerned with it"(p.72).

Content analysis has traditionally been used in studies of the relationship between symbolic systems, between a recorded text of some type and forms of consciousness attitudes and states of mind (McCormack, n.d., p.3). Lasswell and Berelson figure as the first prominent content analysts. In approximately 1935, Lasswell developed a single word symbolic method of text reading which led to the development of the Lasswell symbol dictionary (McCormack, n.d., p.12). In 1945, Berelson developed a rule book which states that content analysis had to be used for the purpose of media studies,

remaining 'objective', quantitative, and used for the reading of 'manifest' content (McCormack, n.d., p.12). In 1959, while examining Nazi propaganda George theorized that a more qualitative content analysis was as useful as the strict quantitative analysis favoured by Lasswell and Berelson (McCormack, n.d., p.18). Content analysis was able to broaden its horizons and has been used by academics in a variety of disciplines, on a range of topics by researchers including psychologists, sociologists, political scientists, anthropologists and feminists (McCormack, n.d., p. 02).

In comparison to approaches to content analysis used by other disciplines, a feminist approach to content analysis takes into consideration the gender-based social impact of the text being analyzed, and often the gender implications of the research process. Both the guiding philosophy on the nature of knowledge or epistemology as well as the process by which research or methodology is created are implicated in defining research as feminist. Through this process it is argued that feminist research seeks to respect, understand and empower women (Campbell & Wasco, 2000).

The qualitative textual analysis aspect of this methodology as the second step in the dual-level analysis will be carried out in order to attempt to balance the qualitative assessment of the text that may result from a content analysis alone. Upon making the decision to provide equilibrium to this analysis, I proceeded to develop specific questions that I deemed important to the formation of conclusions concerning the values apparent in the presentation of the midwifery program to the public and potential applicants. The impact of patriarchal capitalism in accordance with my thesis question serves as a basis for the more specific determination of values within the data sample. In order to find conclusions in this research, a textual analysis of the data is performed by a careful

reading of the documents and answering specific questions. These questions have been designed specifically to seek out the perhaps implicit information that could be overlooked by content analysis alone. This method has been chosen in order to avoid what Silverman (as cited in Denzin et al, 2000) refers to as one of the disadvantages of content analysis, that it creates a “powerful conceptual grid from which it is difficult to escape...deflecting attention away from uncategorized activities”(p.825).

Textual analysis is a qualitative analysis which involves the use of a well-defined research question and a thematic reading of the data sample (Palys, 1997). In this case the theme of the research question is the presence or absence of the values of *patriarchal capitalism* exemplified by *biomedicine*. One task of this research is to identify values specific to this text and, in particular, to identify the presence or absence of a biomedical model and exclusionary tactics which are also associated with patriarchal capitalism. This approach is not original as Palys argues, “More qualitatively oriented researchers often approach the analysis of archival materials through less structured and more thematic means” (p.233).

The specific questions I have chosen in accordance with a thematic reading and elucidation of values are: What comes to mind when one is reading the course and program descriptions?; What associations are made?; How is this text presented?; What are the explicit and implicit messages that are being transferred by means of this midwifery curriculum data?; What is considered valid knowledge in the context of this curriculum?; What values are being produced and reproduced in this text?; How effectively does a historically rooted midwifery philosophy or biomedical philosophy come through in this text?; What does the use of this text imply for midwifery as a

feminist knowledge form?; Who is the intended audience of this text?; What is the tone of this text?; What seem to be the priorities of this text?; What seems to be missing or blatantly omitted?; Where is this text located in the context of the university?; What are the qualifications or curriculum vitae of the instructors? These questions are only guidelines and are adapted to fit the specific theme that emerges while reading this text carefully. The qualitative approach outlined here is paired with the quantitative content analysis previously described in making conclusions, suggestions and recommendations regarding future research and development.

While my choice of method may be significantly different from feminist methods used by other researchers on the topic of midwifery, utilizing a theoretical framework which accounts for the oppressive systemic influence of patriarchal capitalism on reproduction and specifically midwifery as a female-pioneered professionalization project is not entirely original. There is a large amount of research from which I have been able to develop a very in-depth analysis for the selected sample text.

An excellent research field exists which evaluates the regulation, development, decline, philosophy and history of midwifery in both Canada, the United States, and internationally. Included in this area of study is research which is more specifically descriptive of professionalization and the way in which midwifery has been both successful and unsuccessful in attempts at professionalization. I have utilized some of this research to extrapolate terms, ideas and themes in establishing a coding manual for the content analysis that I use to examine the data sample. Further study of midwifery has contributed to my greater understanding and formulation of the thematic textual analysis aspect of this research study. Relevant specific topics include describing the

social context in which midwifery is employed, the effects on midwifery and birthing women of the hegemony of a male-dominated science and patriarchal capitalism and substantiating the lack of empowerment as a goal of biomedicine in comparison with midwifery.

I would like to clearly describe from which researchers I was able to extrapolate certain ideas which assisted in the formulation of my dual-level analysis and also to describe how my analysis differs from those previously used. Research on the subject of midwifery has tended to fall into the following categories in terms of methodology: in depth interviewing (Bailey, 2002; Bourgeault, 2000; Nestel, 2000), qualitative social historical analysis (Benoit 1991; Burtch, 1994; Devries, 1996; Ehrenreich and English 1973; Evenden, 2000; Lay, 2000; Mitchinson, 2002; Rushing 1988; Starhawk, 1982; Witz 1992) midwife and/or client personal narrative (Gaskin, 1978); cross-cultural analysis (Devries R., Benoit C., Teijlingen E.R., Wrede S., 2001; Kitzinger, 1988); postmodern approach from the perspective of midwifery clients (Klassen, 2001); criticism of male-dominated science, biomedicine and/or technology associated with patriarchal-capitalism (Keller,1996; Martin,1989 ;Simonds, 2002); and critique of midwifery and midwifery licensing, utilizing participant observation techniques (Mason, 1990; Sharpe, 2001).

The in-depth interview and participant observation methodology utilized by Bourgeault (2000) is contextually located in Ontario. Bourgeault interviewed 39 people whom she identifies as 'key informants' in the midwifery professionalization process. She includes "key consumers, midwives, nurses, physicians, and state officials" (Bourgeault, p.175). Bourgeault also uses her participant observation experiences in the

midwifery community during the time of regulation proposals as part of the data for her research. She utilizes primary and secondary source material to substantiate her analysis of the effects of professionalization on this predominately female occupation. Bourgeault adheres to a liberal feminist framework to analyze her results and thus is limited in her ability to critique the structural dimension of professionalization or the hierarchical nature of the medicalized hospital birthing system. Despite these limitations Bourgeault's work contributes significant details adapted to fit with my methodological approach as to the inherent tendencies of female-pioneered professionalization projects and the case of midwifery in Ontario.

Bourgeault (2000) reveals the importance of community to midwifery by defining midwives who are not nurse-midwives as community midwives who, according to Bourgeault, are practicing community-based midwifery. Inclusion of this category in the methodology for this research study will measure the commitment to this idea of *Community* in the text of university midwifery education. This theme is not only representative of Bourgeault's idea of community-midwifery as opposed to nurse-midwifery but also defines midwifery philosophy in Canada as closer to the holistic side of the maternity care continuum.

The biomedical paradigm as defined by sociologists Denzin et al. (2000) is described as rooted in a patriarchal positivism from which grows many premises, one of which is an "emphasis on individual autonomy, rather than on family or community" (p.610) . Therefore determining the level of commitment to family and community is vital to determining whether the values espoused in the UMEPs reflect a biomedical or holistic end of the birthing philosophy continuum. Words and phrases which fall under this

category can illuminate both the importance of *community* and *family support persons* to midwifery which ultimately supports women as clients and as citizens of communities.

The importance of a non-authoritarian partnership between the midwife and the woman and her family to whom care is provided is important to this category. Using phrases such as *we* and *relationship* or providing *choices* and *friendship* denotes this type of theme. Bourgeault's (2000) focus on the non-hierarchical midwife-client relationship as a primary signifier for midwifery care as opposed to obstetrician care is an important point. I have expanded on this in my content analysis to include the theme of egalitarianism under the heading *Community*. This category also includes associated terms such as *equality*, *empowerment*, and *enabling*, which denote a political commitment to contradicting the authoritarian relationship types that obstetric physicians are encouraged to develop with their clients

Similar to the work of Bourgeault (2000), Bailey (2002) utilizes a personal interview methodology as well as a social historical review of literature available on midwifery to establish her conclusions. However, Bailey's theoretical framework allows her work to stand out. She utilizes Marxist and Feminist Standpoint theories to analyze her data. Bailey uses Standpoint theory to effectively justify including large portions of interview narrative as text in her thesis, thus enabling the voices of the women midwives she interviews to be heard. After reading Bailey's research I was driven to look more closely at the socio-economic issues in attaining university midwifery education and how these are presented in the text under scrutiny. Bailey acknowledges the power of capitalism to influence midwifery in terms of the issue of childbirth as unpaid labour having an effect on midwives working under capitalism.

The patriarchal and capitalist systems become a duo when there is an opportunity for these systems to intersect to cause oppression. In the case of midwifery, the marginalization of women in this occupation can be attributed to the successful marketing of biomedicine, with its incumbent technology, hospital facilities and medicalized techniques employed by predominately male physician technicians in ideologically male dominated institutions. The patriarchal system reinforces biomedicine as it favours male control, privilege and prestige through medical professionalism and exclusivism. Even though women have been admitted to medical schools in the 20th and 21st centuries, medical education continues to be dominated by a pathology-oriented medical practice that has been oppressive to women by often unnecessarily medicalizing and attempting to manage women's bodies during experiences of pregnancy and childbirth.

As such, determining the level of devotion to the values of capitalism and patriarchy in this text has become an important aspect of this analysis. Witz (1992) uses primary and secondary source documents to determine how midwives were historically left out in the cold in terms of professionalization resulting in the challenges midwives currently face with professionalization. It is Witz's concept of "exclusionary strategies" which I have included to identify yet another successful defining element that biomedicine has relied on through patriarchal capitalism. Witz employs both feminist and sociological perspectives in her analysis of the gendered aspects of professionalization strategies pertaining to physicians, nurses and midwives through the use of historical primary and secondary source documents. The goal of Witz's (1992) work is to illustrate how class and gender interrelate to fortify professional and occupational hierarchies.

Patriarchal capitalism has been defined by theorists Witz (1992), Eisenstein (1979), and Hartmann (1981) as a social system of oppression based on the interrelationship of capitalism and patriarchy resulting in a power dynamic in which women, because of their gender, are economically and socially dominated as men control and limit women's access to resources, power in the labour force and women's expression of their own sexuality. This oppression is evident in the prevalence of such phenomenon as 'exclusionary strategies' by which social institutions such as universities, professional associations, technical schools and so forth limit women's access to resources including skills, knowledge, entry credentials, or technical competence. This restriction of access precludes women from entering and practicing an occupation (Witz, p.46).

Another example of oppression Hearn (1982) claims occurs in the context of predominately female professionalization projects within patriarchal capitalism is a process of masculinization that ultimately leads to the new and subordinate profession mimicking the practices of the dominant profession.

The collection of work discussed here has allowed me to develop a clear concept of what it means to be defined as a profession versus a semi-profession and also the value of patriarchal ideologies and masculine qualities for professional success. If, as Hearn (1982) argues, newly established female professionals will be forced to mimic their male rivals in order to avoid being labeled semi-professionals, then it will be the biomedical ideologies of obstetricians and physicians that will be emulated by female professional midwives.

The ideology of biomedicine is clearly defined by Denzin et al. (2000) as well as alluded to by numerous other researchers included here. Denzin et al. argue,

“The dominant biomedical paradigm is rooted in a patriarchal positivism; *control through rationality and separation is the overriding theme*. The biomedical model is typified by the following nine basic premises:

1. Scientific *rationality*
2. Emphasis on *individual autonomy*, rather than on family or community;
3. The body as machine, with emphasis on physiochemical data and objective numerical measurement;
4. Mind/body separation and dualism;
5. Diseases as Entities
6. Patient as object and the resultant alienation of physician from patient;
7. Emphasis on the visual;
8. Diagnosis and treatment from the outside;
9. Reductionism and the seeking of universals” (Denzin et al, p. 610).

In many ways this depiction of the biomedical paradigm by Denzin et al has served as a skeleton for the development of a coding scheme for this analysis. The work of several other researchers, however, has also informed this analysis.

The concept of the biomedical model as well as the arguments of researchers Witz (1992) and Hearn (1982) have aided in the development of the coding scheme for the content analysis used in this study. The ideals of biomedicine and patriarchal biomedical positivism are coded for while ideals closer to the holistic end of the birthing philosophy spectrum such as *Community* and *Holistic or Empirical Health* are also included. In response to the research of Witz, Hearn and Denzin et al. (2000), the categories *Individual*, *Power*, *Technology* and *Scientific Rationality* have been developed in order to identify the presence of a patriarchal biomedical positivist theme in the sample text.

The work of Mitchinson (in Burt, Code & Dorney, 1993); Wolf (2001); Mason (1990) Devries (1996) Kitzinger (ed.) (1988); Katz Rothman (1982) and Simonds (2002) all inform these coding categories which can fit into the overall division of identifying

attention to patriarchal biomedical positivism in the text studied. Katz Rothman connects *scientific rationality* with patriarchy and technology as she states that the medical paradigm is used to refer to women's labour and pregnancy as disease orientated or fraught with the potential for disease. A discourse of *pathology* emerges through the use of language such as *sick, disease, illness, condition, unwell, 'body as machine', symptomatic* and so forth. Katz Rothman argues that it is the combination of ideologies of technology and patriarchy in biomedicine which allow the male body to be considered the standard, while the female body, particularly during pregnancy, birth and postpartum is viewed as a pathological aberration in need of technological management and increased safety measures.

Katz Rothman (1982) and Mason (1990) both discuss how system language has become a procedural aspect of the *scientific management* of pregnancy, labour and the postpartum period. The themes *illness, neonate, disease, intervention, abnormal, sick(ness), management, timing(hours, minutes etc.), measurement, efficiency, and patient* belong to this system language. Katz Rothman juxtaposes the midwifery birthing ideology in which the phrase '*birthing babies*' is used with the biomedical model in which the phrase '*delivering neonates*' is used.

Mason (1990) is skeptical about legalized midwifery, particularly because she equates professionalism with managerialism. For women in childbirth, managerialism can infringe on women's control of their own reproductive experience. *Technology, scientific rationality, scientific management* and *power* are all intricately connected in this theoretical model. Mason argues that she sees a system language and management language emerging in professional midwifery, illustrating a shift from protecting women

to protecting the midwifery system. Mason developed this perspective in response to her own participant observation experiences in the midwifery community in Ontario throughout the 1970s and during the midwifery professionalization process of the late 1980s and early 1990s. This shift that Mason saw emerge can certainly be substantiated by one response that I received to requests for course outlines from midwifery faculty. This particular response was overly protectionist concerning the university midwifery education program; the respondent was more fearful of criticism of the program than of the potential for positive change through research (personal e-mail communication, March 30, 2004).

Mitchinson (2002), a social historical researcher using primary and secondary source data as well as interview research to substantiate her work, has also contributed to the categorical classification in the areas of *scientific rationality*, *power* and *technology* in the methodology used to study the sample text in question. Mitchinson (in Burt, Code & Dorney, 1992) states that the term *management* as part of the scientific rational came into use in reference to labour and childbirth as physicians began to assert their expertise and control over childbirth. Mitchinson argues the medicalized model of childbirth has a specific language form and is predicated on the assumption that the reproductive system of a woman is prone to disease. The use of specialized terms such as *neonate* or *patient* reinforces the power differential favoured in the medical model between the physician and his/her *patient*. The scientific concept of *managing* one's *patient* in itself creates a dominant/subordinate relationship in which there is one party in the relationship being *managed* while the other is the *manager*. Not only has this concept of *management* contributed to the development of condescending relationships between dominant

physicians and subordinate *patients* but the increased use of *technology* and unnecessary physician *intervention* has also allowed obstetricians to achieve an omnipresent status.

There seems to be a common perception in current society that machines do not make mistakes, and that the increasing amount of and use of technology in hospitals is justified by claiming it creates greater “safety” for patients. This is particularly relevant to women as clients, considering the increased safety measures which have been advocated in pregnancy, birth and the postpartum experience in obstetrician-provided hospital maternity care. Technology advocated for the stated purpose of improved safety in maternity care, however, has been proven in some instances to be inaccurate and in other situated uses can be described as degrading, invasive and tyrannical. In a book titled *Misconceptions: Truth, Lies and the Unexpected on the Journey to Motherhood*, Wolf (2001) reveals how studies have proven that the use of EFM or Electronic Fetal Monitoring Technology results in a slippery slope to intervention, caesarean section and other invasive procedures which increase the risk of infection and complications. The use of increased technology for safety justifications is illogical as in actuality the use of such technology beginning at the onset of labour, as well as technology such as maternal serum sampling during pregnancy, tends to increase the amount of intervention necessary from the point of first use onward. This exponentially increases the actual material risks of the procedures and the birth experience in particular. Wolf cites Arms (1994) *Immaculate Deception II*, in which she quotes statistics illustrating that EFMs are inaccurate 40-60% of the time. There is extensive literature in support of this finding that EFM, although efficient and seemingly convenient, creates an unrealistic perception of heightened risk and fetal distress often leading to unnecessary caesarian section surgery.

This literature includes, Prentice and Lind in R.E. Davis-Floyd,(1997) *Childbirth and Authoritative Knowledge, Cross Cultural Perspectives* and Bracero, Roshanfekar, Byrne, *Journal of Maternal and Fetal Medicine* (2000) 9.3:181-85.

Technology that has been developed for use in biomedical maternity care has been designed to serve the efficiency and managerial standards of patriarchal capitalism. It has been designed by male inventors, used first by male doctors with its use understood through a patriarchal education system. This technology has been developed and used to promote efficiency more than it has been used to make birth a more empowering or less 'risky' experience. If anything, technologies like EFM have increased the amount of risk by increasing the perceived risk and thus increasing the amount of intervention undertaken and heightening the material risks. Although not an exhaustive dictionary, the language of patriarchal positivist technology, techniques and ideologies which are associated with a biomedical model of care include: *instruments, testing, "body as machine", "body processes", mandatory IVs, mandatory episiotomy, C-sections (mandatory for VBAC), induction, pitocin, amniotomy, forceps, and anesthesia.*

The culturally sanctioned medicalization of childbirth which has occurred under obstetrician watch in hospitals in Canada has meant an increased use of technology and physician intervention. The physician in concert with this increased use of technology has also been elevated to a higher status as a perceived technocratic expert while the patient occupies a subordinate status position (Mitchinson as cited in Burt et al,1993).

In an article titled *Watching the Clock: Keeping time during pregnancy birth and postpartum experiences*, Simonds (2002) analyzes the approaches taken in texts available on the subjects of pregnancy, birth and postpartum care in reference to time or efficiency

discourse. Simonds examines texts ranging from *William's Obstetrics* (1971-1992); *Spiritual Midwifery* (1977, 1990); to the *The Womanly Art of Breastfeeding* (1991). Simonds' thesis is that maternity care literature which is obstetric in orientation has a greater tendency to address women in efficiency discourse than does midwifery oriented literature or literature associated with the alternative birth movement. Simonds provides a clear conception of how the use of technology in obstetrics as part of a *scientific management* model creates "rigid time standards" for women in pregnancy and childbirth. Simonds argues, "the discourse of obstetrics now manages pregnancy and birth by institutionalizing rigid time standards, carving procreative time up into increasingly fragmented units, which are imbued with the potential for danger" (p.560).

Murphy- Lawless (1998), also argues that there is no one uniform definition of risk. Measurements of risk are inaccurate indicators of safety and/or danger of home as compared to hospital birth as birth outcomes can never be completely predicted. One issue that critics of biomedicine such as Murphy-Lawless illustrate is that there is no such thing as complete control and complete certainty in childbirth. Yet this is a foundational tenet of biomedicine. In order to attempt complete prediction and control, biomedicine has deconstructed and quantified every aspect of a woman's body and pregnancy which could arguably dehumanize and mechanize women, their bodies, and the birthing process. Risk assessment has the effect of deconstructing the female body into a series of potentially faulty mechanisms. This deconstruction plays into preserving efficiency, as every aspect of the process of pregnancy, birth and postpartum can be quantified and standards or, more accurately, deadlines are put in place for women to attempt to meet.

In terms of women's bodies in the event of reproduction, efficiency has implications for both professional practice and cost-efficiency. Cost-efficiency in particular, is an argument which has been effectively used to promote midwifery in the eyes of government. Evidence of this phenomenon can be found in articles such as *Integration of Midwifery Services into the N.S. Health Care System* for example, where the Midwifery Coalition of Nova Scotia and the Association of Nova Scotia Midwives argue in a submission to the Blueprint Committee on Health Reform in February 1994 that midwifery is a cost-efficient alternative to obstetric care, which is used as a selling point to government (Midwifery Coalition of N.S.1994). It seems that in order to compete with obstetrician recruiting and practices, university midwifery education is attempting to claim their training and services to be equally competitive in the capitalist patriarchal market environment. This may result in embodying or embracing some of the values of capitalist patriarchy in order to effectively compete in the market.

The efficiency discourse relevant to obstetric and midwifery practice is clearly described by Simonds (2002) as well as Ritzer (1996). Simonds reveals from her research how the use of technology in birthing care maintains standards of time that women are encouraged to achieve. She argues that it is the *scientific management* model, what I refer to in my content analysis as the ideology of scientific rationality, which allows for the employment of efficiency discourse and rigid time standards. Ritzer attributes the efficiency ideology of scientific rationality which is reinforced by obstetricians to the drive for efficient production which is part of the capitalist agenda. Ritzer argues that birth is not exempt from the influences of McDonaldization- defined as born in scientific rationality and characterized by dehumanization, standardization,

efficiency-driven, product-oriented, routinized, control and predictability-oriented practice. Ritzer describes efficiency as finding and using the *optimum* means to an end.

In the case of birthing care in a Canadian capitalist patriarchal context *optimum* care has been considered the use of technology and intervention by obstetricians in a hospital setting. Women as the recipients of this type of care come to be reduced to their machine-bodies whose production in the labour process is subject to inefficiencies and failure which is then assessed and treated in a mechanized manner.

This research reinforces the choices that I have made for content analysis categories in terms of dividing them according to the themes *scientific management*, *technology* and *power*. These categories will serve as measurements for values associated with biomedicine as a product of patriarchal capitalism. It is particularly easy to use these themes as signifiers for biomedicine as the midwifery model is described as embracing a significantly different set of values.

An important theoretical aspect of this content analysis is questioning whether 'exclusionary strategies' are evident in this program information and what demographics are affected by these strategies. Patriarchal capitalism is dependent on 'exclusionary strategies' as a means of social stratification, as well as reinforcing masculinist values of individualism and competition. 'Exclusionary strategies' are evidenced by systematic, ideological and direct exclusion of women from access to a social institution (Witz, 1992). In this instance, women may be prevented from access to university midwifery education. Exclusionary strategies can be implicit, yet effective. For example, creating requirements making it extremely difficult or unwelcome for a single mother, poor

woman, black woman, or lesbian woman to enter into this program, is considered exclusionary in this context.

The conception of an ideal candidate for university midwifery education within a university system susceptible to patriarchal capitalism is dependent upon factors including exclusion, elitism, and philosophy of care which are implicated in the pursuit and recruitment of candidates. Demographic forms of exclusion as well as ideological exclusion and moral authority is significant to this analysis as a determinant of the influence of the exclusionary strategies associated with patriarchal capitalism and system structure. Demographic forms of exclusion are not consistent with an empirical/holistic health philosophy or practice of midwifery.

For the purpose of this content analysis I have designed specific categories to determine the emphasis on 'exclusionary strategies in this data set. These categories are *Elite*, *Economic* and *Individual*. Emphasis on the *individual* as a patient or a student rather than emphasis on community, family or rights-based groups is important to illustrate capitalist discourse. I can speak about exclusion because as a society we have determined that rights discourse occurs most effectively as persons identify themselves with particular minority or demographic grouping in society. Therefore, an emphasis on individualism can be a hindrance to access based on a minority or oppressed group affiliation.

Individualism is a masculinist and capitalist construct which allows for social isolation and discrimination of certain individuals while elevating others to positions of optimum status, wealth and privilege. This is justified by a capitalist emphasis on individual enterprise and the perpetuation of a myth that it is possible for any individual

to be wealthy if one only tries hard enough. This myth ignores actual barriers to success that are evident to persons who experience group-based rights violations and oppression.

Exclusion, however, may come in a variety of forms including demographic exclusion in terms of a lack of consideration of diversity, economic exclusion in terms of the amount of financial capital or support needed to be successful in this program, and elitist exclusion in terms of the experience, education or class background desired of applicants to this program.

Nestel (2000) reveals that during the process of initial incorporation for midwifery, racialized discourses and practices led to the marginalization of foreign-trained and non-white midwives in Canada. In her PhD thesis titled, *Obstructed Labour: Race and Gender in the Re-emergence of Midwifery in Ontario*, Nestel interviews non-elite and excluded midwives and potential midwives in Ontario. Hierarchical structuring of society which has been useful to the profit agenda of patriarchal capitalism is implicated in the politics of exclusion that have been evidenced during midwifery professionalization (Nestel). Nestel also describes elements of *elitism* in the context of midwifery professionalization as the demand for midwifery students to be *on-call 24 hours*, or *rational* rather than *spiritual*, dressed in a corporate style rather than *hippie* style, visual and physical elitism, and a reverence for a “corporate culture image” requiring *white midwife* mothers to put their work before their children and families. In response to this evidence, *elitism* and *economics* is coded for in this content analysis. The importance of class and financial ability is determined by emphasis on such themes as *wealth*, *money*, *capital* and so forth.

It should be noted here that the devised categories juxtaposing midwifery and biomedical models of care are archetypal in design. As such there are exceptions to these ideal types and certainly there are ideologies, actions, techniques and practices which fall somewhere in between these two models or even those which extend beyond the boundaries of the models described here. Yet every field of inquiry has its own specialized language with which it can distinguish itself from other fields of inquiry. Therefore it is relatively straightforward to posit that particular discourses and themes belong to one archetypal type of maternity care as opposed to another.

Ina May Gaskin is a pioneer in holistic midwifery philosophy and practice in the United States. This philosophy encouraged an alternative birth movement in the 1970s and has been accepted by many midwives as the primary midwifery philosophy. Gaskin (1978) observes that midwives use intuition, touch and instinct as valuable tools in their partnership with women in labour. Gaskin's philosophy is that a woman's mind and body are one and that using particular phrases or expressing certain feelings can change the way that a birth progresses. Gaskin also reaffirms the spiritual aspect of birth that was part of the sacred feminine and pagan traditions before patriarchal organized Christianity and law dominated and subordinated women. Gaskin observes that, "The *spiritual* midwife, therefore is never without the real tools of her trade: she uses millennia-old, God-given insights and intuition as her tools-in addition to but often in place of, the hospital's technology, drugs and equipment" (Gaskin, p. 283).

Simonds (2002) argues, "the midwifery model respects time and sees women's bodies as capable actors rather than machinery to be sped up"(p.565). In many ways the *Empirical or Holistic Health* midwifery approach to childbirth contradicts the *scientific*

rationality approach of biomedicine. Much of the language of a holistic midwifery approach is very accessible to the client. The language of a more holistic philosophy is identifiable by its emphasis on *normality* as opposed to *pathology*.

Barrington (1985) in a social historical analysis initiated by her participant observation experiences, reveals the status of midwifery in Canada and the practices, philosophy and experiences of midwives and their clients. Barrington is very clear about the concept of midwives ‘catching’ babies and allowing mothers to be in control of their birthing experience. According to Barrington the midwifery care model is exemplified by a focus on the ‘*normal*’ in birth; a *natural* normalcy which is far more flexible than the standards of physicians.

This philosophy is reaffirmed by current literature developed in accordance with UMEPs and guidelines set forth by the College of Midwives of British Columbia. The College of Midwives states that, “Midwifery Care is concerned with the promotion of women’s health. It is centered upon an understanding of women as healthy individuals progressing through the life cycle. It is based on respect for pregnancy as a state of health and childbirth as a normal physiologic process, and a profound event in a woman’s life” (College of Midwives of B.C., 2003).

Citizens for Midwifery, an advocacy group, has a similar description of midwifery care in Canada. This group argues,

“The Midwifery Model of Care is based on the fact that pregnancy and birth are normal life processes. The Midwives Model of Care includes: Monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle; providing the mother with individualized education counseling; prenatal care; continuous hands-on assistance during labour and delivery; postpartum support; minimizing technological

interventions; identifying and referring women who require obstetrical attention. The application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section”(Citizens for Midwifery, 2003).

Some themes which emerge in this context signifying a holistic approach are *well-being, hands-on, client, baby, normal, spiritual, mental health, emotional health, empirical, holistic, natural, cultural, healthy, life-cycle, empowerment*. As Barrington (1985) argues,

“The list of techniques is infinite. The tools and remedies used by midwives are an array of creative responses, some pre-eminently practical, some emotionally experimental. They do not always have to make rational sense. For a midwife to adopt a practice it just has to work and, above all, to do no harm” (p.49).

Visual and qualitative textual elements, specifically symbols, glaring omissions, and tone, are textually relevant to this process. The second-level textual analysis aspect of this methodology which I have described earlier as a thematic reading of the text is performed with all of the information that I have gathered as to discourses of holistic midwifery and patriarchal capitalist biomedical maternity care in mind. Open-ended questions and an overall impression of the purpose, audience, target, philosophical loyalty and ideal candidate for this text are used to facilitate this textual analysis.

The final considerations in the textual analysis are *symbol, omissions, and tone*. I have chosen to examine the history and meaning behind all symbols used in this text. I have also chosen to add specific items to the omissions category if they are expected to be in the text yet are absent. The themes that I would expect to be in the text as signifiers for the philosophies being examined are listed under the categories in the coding manual. The tone of the entire text is determined for the program information for each university

program. This is important so that it is apparent whether the program information is more *academic, political, scientific* or *feminist* in focus.

Limitations of Methodological Approach

Despite careful planning and strategic development of a feminist methodological framework, expanding the data sample in this study has illustrated the limitations of this approach. This attempt at retrieving further documentation has also highlighted the role that gatekeepers are able to play in the university structure.

After contemplating the reliability of the selected text to this methodology and to the thesis question being asked, I decided that obtaining copies of course outlines or syllabi for midwifery courses being taught in the 2003-2004 year in those universities offering midwifery programs would be considerably useful. I feel that including this type of data would provide a more in-depth picture of the values and content of UMEPs. Gathering this information however, proved to be far more arduous than I had anticipated.

In an attempt to further substantiate the content of courses in the UMEPs, I contacted professors responsible for all courses being offered in order to ask permission to obtain and analyze a copy of their course outline in my research. This was a very unsuccessful process. University faculty seem to be very protective of the course outlines, and the director of the program, in at least one instance, seems to have the power to determine whether professors are permitted to offer their course outlines or syllabi to potential students or the public. This reluctance to provide such data to a researcher or even to an interested potential applicant begs questions as to the motive behind this protectionism. Is this a result of protectionism in terms of perceived intellectual property rights? Is this example of fear of criticism from researchers a reflection of a 'culture of secrecy'?

resultant of a lengthy history of persecution, criminalization and exclusion of this occupation and its members? Do faculty members consider these outlines to be their own personal property or is there something they would like to be concealed from the public, researchers and potential applicants?

The responses that I did receive as to my requests for course outlines and syllabi were mixed. There is some strong opposition to feminist research in one response while another is very positive about the research and offered the material readily. Yet another author of course outlines is very skeptical about the intent of this research, concerned that it would not be used to further the agenda of UMEPs. This response seems to have developed from an assumption that only research which furthers the agenda of a particular system should be performed.

Contact information is listed for two faculty members of the three listed as responsible for teaching some of the ten courses available for students in the midwifery education program at Laurentian. Faculty members responsible for five of the courses are listed as 'To Be Announced'. Of the five courses for which faculty are listed in the data sample two are part-time faculty members, one with contact information the other without, and the only other listed faculty member is the Program Director. I made telephone calls to the Laurentian UMEP to enquire about contact information for midwifery part-time faculty and those teaching the courses listed as 'To Be Announced'. The receptionist referred me to the program director. The following is the response received to a request for course outlines:

"I will happily send you course outlines - I believe I have most in electronic format. I think however, I am a little hesitant with just this level of information about your thesis. We have been badly burned

in the past by enthusiastic graduate students who have accessed programme materials with the purpose of criticizing the programme. While we are all interesting in ways of continuous improvement, we also know that the written word is often scarcely a good representation of all that happens in the programme and can be interpreted in ways that can be damaging to the profession and our relationships with other disciplines (both professional and academic). Perhaps you could provide me with a little more information about your thesis proposal. Thank you.”
(Personal e-mail communication, March 30, 2004)

I absolutely agree with the writer of this correspondence that to completely understand the program one must experience it. However, there is also a personal bias that develops while experiencing an education program first hand which could potentially limit the perspective available to researchers. Also, not all researchers have the *privilege* of access to personal experience as a means of research data collection. Therefore, sometimes it can be useful and interesting to perform research from an outsider standpoint. I responded to this e-mail describing specifically the goals of my thesis project. I have not received a reply. Since I was directed to contact the program director for any requests regarding faculty contact information, I was also prevented from any further requests for course outlines.

The response I received to my requests for course outlines from McMaster was mixed. I e-mailed all faculty whose names were listed corresponding with courses available for the 2003/2004 year. I was able to contact seven of the eight faculty responsible for teaching fourteen midwifery courses at McMaster in 2003/2004. I received one negative response denigrating the value of feminist scholarship. Alternatively, I received one positive response in regard to these requests as well. The negative response I received reads as follows:

“As an academic I find the bias evident in these missives appal[l]ingly poor scholarship. A hypothesis which is the basis of good study should be open to all outcomes. There is not the slightest hin[t] that this is the case and I have every suspicion that the data will be filtered through a feminist lens. As a male, a father and proud of both jobs I find the attitude that all evil arises from the supposed "patriar[chal], capitalist" complex insulting and inaccurate given the history of the last 30 years and perhaps longer. If for no other reason because this complex produced the oral contraceptive and the concept that a person's abilities are more important than race, religion or sex. These do not exist anywhere else but in Western Capitalist cultures. Our medical school evolved within "the paternalistic capitalist" society and is predominantly female. Graduate across the country schools are approximately equal in male and female students. Graduates from these schools already predominate, or will shortly predominate, in the power structure. Whether they will do any better of course remains to be seen. The most vicious paternalistic societies are not capitalist and heaven forbid that the likes of Al [Qa'ida] should ever overcome our societies that you so decry. When people start migrating out of the capitalist countries rather than risking their lives to enter them I will begin to take seriously the need for this type of work.”
(Personal e-mail communication, April 05, 2004)

This response was very interesting as it illustrates the complex nature of inter-professional co-operation and faculty sharing within UMEPs. Inter-professional relationships can be both useful and difficult to negotiate. Certainly there seems to be some tension in this inter-professional relationship between midwifery and biomedical science in conflicting philosophies. Midwifery students are likely to be taking feminist courses in the area of women's studies while at the same time taking a course, such as pharmacotherapy, from a professor who may be opposed to feminist scholarship. It is on the recommendation of one of the midwifery faculty that midwifery students sit in on lectures by professors who specialize in specific medical fields such as anesthesiology and pharmacotherapy in order to fulfill the requirements of the UMEPs. (Personal e-mail communication, April 05, 2004)

The positive response which I received from McMaster University provides some valuable data and includes a message stating, “Good luck with your research” (Personal e-mail communication, March 31, 2004). This was a helpful and methodologically expected response to my request for outlines. This was the only response which proceeded as I had expected.

Ryerson provided barriers in accessing data as contact information is available for only one part-time faculty member of the UMEP. I did not receive a response from this faculty member in regard to my request. Other part-time faculty did not have direct e-mail or phone contact available. Contact information is listed for all full-time faculty members. Yet there lacked a correlation between faculty members and assignment of responsibility for the specific courses being offered. I contacted the UMEP general enquires section to place my request for course outlines and a list of faculty members responsible for courses. I was not able to access this information.

Contact information for professors in at UBC UMEP is similar in. When searching for contact information in the main university faculty database, information for only the director of the midwifery program is available. It appears as though the other faculty members do not exist. On the midwifery main faculty page, a phone number is listed for the director of the program as well as a staff member. I made calls to both of these numbers and there failed to be an answer after four attempts on separate days. I was able to find e-mail contact information for two of the four faculty members listed with course information on the student services course availability page. I did not receive a response from either of these persons contacted, one of whom is the program director. In addition, the professor who teaches the most courses in midwifery and another professor do not

exist at all according to the faculty database listings at UBC. Only one staff member and one faculty member have contact information available on the faculty page and one of the professors teaching courses is not even listed on the faculty page for the program.

This data gathering expedition was not a complete failure, although I did not gather enough information to include it as part of my content analysis as it would not be representative. I have learned some interesting things about these institutions and the university system function under patriarchal capitalism. The location of midwives adjacent to dominant health professions within UMEPs creates particular challenges. Midwives are able to access equipment and resources which allow for training relevant to working in hospitals yet this training entails inter-professional co-operation with faculty whose ideologies fall into the realm of patriarchy and biomedicine and who may not be supportive of feminism. There are also some independent thinkers in this field who are willing to provide data to researchers. There are also gatekeepers who warily guard the content of UMEPs against to those who may be in a position to criticize it, however rightly or judiciously.

In terms of this research, the ethical approach was chosen to request course outlines from the course instructors. It is difficult to determine as well whether the outlines in many cases are considered the property of the students who have possession of them once fees are paid, of course instructors or of the overall UMEP. However, thwarted access to the data in this case may also be resultant of a general protocol within the university administrative structure to refer researchers automatically to program directors or other administrators in order to defray potential criticism and increase efficiency by allowing

faculty to avoid what may be considered by the university as time consuming and wasteful co-operation with researchers. This limitation

Using the dual-level analysis that I have described, combining both a qualitative textual analysis and a quantitative content analysis, to examine the presentation data for university midwifery programs in Canada will provide valuable information in answer to the question of the potential impact of patriarchal capitalism on women as potential applicants and potential professionals attempting to access university midwifery education through the university system and attempting to attain employment in the health care system. The impact of the context and content of the midwifery university education programs in question will be experienced by women as clients of the professionals who are graduated and practicing.

The amount of attention given to matters of a feminist political nature, biomedicine, patriarchal capitalism, exclusion and diversity are examined in a content and textual analysis of the sample text (Please see Appendix II for Coding Manual). As well as answering more implicit qualitative questions through textual analysis of thematic content such as the placement of the program information within the university and access to faculty (Please see Appendix III for Textual Analysis Manual). All of this information leads to conclusions concerning the impact of patriarchal capitalism on university midwifery education and ultimately on a professionalized midwifery in the health care and university systems in Canada. The data used to present university midwifery education to the public and potential applicants through this analysis, reveals some important information concerning the values of these programs by highlighting

what is most important, relevant, or repeated as well as noticeably absent or underrepresented.

Chapter 5- Findings of a Feminist Textual and Content Analysis of Ontario and B.C. UMEPs

Introduction

UMEPs have been chosen as the favoured model of education for midwives in Canada. This choice provides the opportunity to examine the continuity and or disjuncture of an established pre-professional holistic midwifery philosophy with the transfer of midwifery education from predominantly community based apprenticeship to within the university. The four UMEPs of which content is analyzed in this study are: the Laurentian , Ryerson and McMaster consortium and the independent UMEP at UBC.

The data for this analysis has been retrieved in 2003/2004, at the fifth year stage of the development of the British Columbia UMEP and fifth year stage following the first graduating class of the Ontario UMEP. At this stage in the development of this profession, university educated midwives are on the verge of forming a critical mass within the occupation based on the numbers of potential graduates from UMEPs alone (College of Midwives of Ontario, 2005; Tyson as cited in Kornelsen, 2002). The type of care provided by these predominantly female professionals to women as clients will reflect the socialization and education experiences of university educated midwives overall. The potential for providing care that is culturally sensitive and appropriate, representative of diversity within the ranks of midwifery students/professionals/clients, holistic in content and practice which empowers and supports women will be exacerbated and/or limited by this education model. Future university education programs in Canada have the ability to replicate and or deviate from the design of previously created programs. University midwifery education is in the process of developing and identifying itself as a legitimate form of professional training in Canada. At the same

time, midwives and supporters of midwifery continue to work toward both regional and national legitimization of midwifery practice, occupational standards and professional status.

The broader context of health care system restructuring in Canada has specific implications for development, legislative approval and support for midwifery across the country. Observations emphasized within the Romanow Report, calling for economic efficiency and sustainability of the Canadian health care system through targeted health care service delivery (Romanow, 2002) creates a favourable environment for the establishment and/or expansion of legislated midwifery services. Fiscal conservative pressure on Canadian federal and provincial governments to streamline health care systems and services emphasize managing health care with increased economic efficiency.

Midwifery as a profession requiring little additional infrastructure and/or technology to provide comprehensive home birthing care is reflective of an economically efficient health care service which has the potential to garner increased support on this basis alone. The limitations of this shift in support for midwifery will be explored in relation to the development and legitimization of the midwifery profession within the university system structure. The necessity to legitimize this previously marginalized occupation by conferring a university degree exhibits a specific value for the professional accreditation of a university degree within the reproductive health care sector. The simultaneous necessity to maintain the valuable and empowering feminist roots of knowledge in midwifery practice otherwise known as a holistic philosophy of care is central to this

assessment of the progress of midwifery within the UMEPs in Ontario and British Columbia.

The utilization of a feminist analysis in this study allows for a gender and diversity component which provides an opportunity to inform the future progress of the midwifery profession in Canada and the continued expansion and availability of accessible and appropriate high quality midwifery care, education and services for women of diverse communities in Canada and internationally. The findings of this analysis provide evidence as to the components of a holistic midwifery philosophy surviving incorporation into the university impacting prominently both the status of midwifery students/professionals and accessibility of midwifery education and services.

The consortium UMEP comprised of Ryerson, Laurentian and McMaster universities began recruiting students and accepting students, culminating in the offering of a Midwifery Education Program in the fall of 1993. The first students in this Ontario Midwifery Education Program graduated in 1997. As of the end of 2005, 255 midwives have been registered and practicing within the province of Ontario (College of Midwives of Ontario, 2005).

The Ontario UMEP has the potential to graduate 30 students per year, enabling a potential 240 university graduated students to be practicing as professional licensed midwives in legislated provinces in Canada or internationally. There is a documented rate of attrition however which slightly reduces the potential number of UMEP graduate midwives who would be practicing. Tyson (as cited in Kornelsen, 2002), in a document based on a presentation to the National Invitational Workshop on Midwifery Research in Canada in 2001, argues that students leave the Ontario university education program at a

rate of 15 % per year and claims a 15 % attrition rate exists for graduates in the five years following the completion of their degree. Factoring in this rate of attrition reduces the potential number of Ontario university graduated midwives practicing professional midwifery in Ontario and/or other legislated provinces in Canada or internationally from 240 to approximately 204. Despite accounting for this rate of attrition, students of UMEPs have a much greater influence on the profession of midwifery in Ontario through sheer numbers alone.

The University of British Columbia began offering their midwifery education program in 1997. As of the end of the 2005 year, 88 midwives have been registered and practicing in the province of British Columbia (College of Midwives of British Columbia, 2005). The UBC UMEP graduates approximately ten students per year (UBC MEP, 2003/2004) resulting in a potential of 50 graduates of this education program to be licensed and practicing as professional midwives in British Columbia and/or other legislated provinces in Canada or internationally as of the 2003/2004 time period of this study.

A significant majority of the practicing midwives in Canada are graduates of UMEPs. The integration of this group of graduates from UMEPs into the profession allows these individuals to have the collective power to create sustained influence and change through a shared belief system and in this case a shared practical knowledge, educational socialization and skills level. Therefore in this context it must be considered that midwives with a background from Canadian UMEPs have a significant influence on the overall philosophy, practice and direction of the midwifery profession in Canada.

Findings from this analysis of the Canadian UMEPs allows for a comparison and contrast of common emergent elements including: professionalization and university resources as highlighting elements of the continuity and/or disjuncture of a holistic philosophy of midwifery upon established incorporation into the chosen UMEP structure; challenges from science and medicine / biomedicine; issues of accessibility and cultural diversity within both student and client populations. Data collected from the four universities in this study will be compared and contrasted along these thematic elements found within the UMEP content. A concluding assessment as to the current status and future potential for holistic midwifery philosophy and practice in Canada for women as both clients and professionals of midwifery as a primary reproductive health care service is based on the following assessment of the dominant thematic features of these UMEPs.

A cross comparison of the acceptance requirements for each university text is included in this section in order to allow for a discussion of the accessibility of these UMEPs as a component of holistic philosophy and practice.

Regulation and Existent UMEPs

Midwifery is regulated in the Northwest Territories, British Columbia, Alberta, Manitoba, Ontario and Quebec. Regulation has specific meaning in terms of the education and qualifications required of midwives in order to practice as well as requirements for clients which are specific to each province. One legal and acceptable route to practice midwifery in the regulated provinces is through graduation from a recognized UMEP at Ryerson, McMaster, Laurentian, UBC or Universite du Quebec au Trois Rivieres. Alternatively, those already trained in the art of midwifery can apply to existing Colleges of Midwives in their province to have their skills recognized by a PLA

(Prior Learning Assessment) or PLEA (Prior Learning and Education Assessment) program, or complete the PHC (Primary Health Care) Transition program in Manitoba. One option for foreign-trained midwives is to be recognized by the IPP (International Pre-Registration Program) offered through the Centre for Distance Education at Ryerson University. There are specific exemptions which enable Aboriginal midwives to practice outside of the scope of regulation governing non-Aboriginal communities. Some Aboriginal and First Nations communities have chosen to design their own routes to established practice within Aboriginal communities. Comprising a legislated culturally diverse population, with a history of differential consideration within the reproductive health care sector, Aboriginal and First Nations women have an interest in bringing birth back to Aboriginal and First Nations communities both culturally and geographically.

Aboriginal Midwifery Education Programs

For Aboriginal communities there are three Aboriginal midwifery education models which are specific to the cultural values and practices of Aboriginal communities; one AMEP (Aboriginal Midwifery Education Program) at the University College of the North in Manitoba; a three year Aboriginal Program at the Tsi Non:we Ionnakeratstha Ona:grahsta' Six Nations Maternal and Child Care Centre in Ontario; and a three year apprenticeship model serving primarily northern Inuit communities at the Innuulitsivik Health Centre in Puvirnituk, Quebec. Access to professional accreditation and jurisdiction to practice varies provincially. Aboriginal midwives in Ontario are legally empowered to care for Aboriginal women and their families, without having to submit to any non-Aboriginal Ontario government testing or licensing procedures, while Aboriginal

midwives in Quebec are required to limit their jurisdiction of practice to the Northern Territories specifically.

It is within this context of regulation and UMEP design that the potential for endurance of a holistic philosophy and practice of midwifery is able to be determined. The future of professional midwifery in Canada will be impacted by the philosophical beliefs as well as the practices of its newest professionals. The structure, design, and appeal of the university midwifery education system has the potential to impact the profession of midwifery and women who are both professionals and clients in this system. Universities are structured to function as systems which both create and reinforce the production, dissemination and application of knowledge. The theoretical perspective that a capitalist patriarchal society endorses systems of oppression, under which women are negatively impacted, is relevant to midwifery as a profession within the university system as well as the health care system within which women will have social interactions. The nature of these interactions, whether they are likely to be empowering or oppressive, is a feminist consideration in this analysis.

Maternity care working groups, curriculum design committees and/or legislative committees established in the not yet legislated provinces have the opportunity to either replicate or differentiate from the structure and content of UMEPs in text content, program design, accessibility, funding structures, course content and so forth. Therefore, the not-yet legislated provinces have the potential to avoid some of the less positive features of previously created texts and structures in the UMEP system if this education program type and setting is decided upon. The discourse, requirements, exclusions, inclusions and challenges within an education program text that have the potential to

negatively impact women as potential midwifery students, professionals and clients can be avoided.

Professionalization of Midwifery in the Context of Available University Resources

At the fifth year stage of development, Ryerson had listed its UMEP under a Health Sciences Department heading, however this program is actually administered by the Faculty of Community Services. The midwifery text of this university is organized descending from the Bachelor of Health Sciences Department Heading to include, program information, admission requirements, course content, curriculum, student support, application, tuition and financial, faculty listing, FAQ section , a ‘Why Ryerson’ section and mission statement and vision (Ryerson UMEP, 2004).

The significance of organizing this UMEP to be administered by the Faculty of Community Services is illustrated in the following excerpts highlighting the holistic vision and goals of the faculty in relation to the midwifery program,

“This innovative program reflects an emphasis on health promotion and supports women’s participation in their health care.” (Ryerson UMEP, 2004).

This structural placement of the program suggests the UMEP at Ryerson shares the vision of the Faculty of Community Services. This relationship is described as follows,

“A leader in education in research for the advancement of progressive, collaborative professional practice. The Midwifery Education Program is

committed to providing student's education within the framework of the Faculty of Community Services Mission Statement." (Ryerson UMEP, 2004)

The mission statement of the Faculty of Community Services included in the UMEP content is described according to specific common goals:

- “1. We prepare practitioners who have the knowledge, dispositions, and skills to create inclusive environments that optimize health and social well-being.
2. We facilitate learning by emphasizing innovative, interdisciplinary education opportunities in collaboration with a wide range of public, private and voluntary organizations.
3. We generate knowledge that informs our disciplines and shapes policy and practice.
4. We integrate research and scholarship into education and practice.
5. We ally and work with community partners to advance excellence in progressive professional practice.” (Ryerson UMEP, 2004)

Despite sharing the goals of the Faculty of Community Services, students of midwifery are awarded a Bachelor of Health Sciences (BHSc) degree upon completion of this program.

The Laurentian component of the Ontario UMEP consortium includes midwifery under a list of professional programs along with Commerce and Administration, E-business service, Human Kinetics, School of Education, Native Human Services, Social Work, Nursing and Sports Administration (Laurentian UMEP, 2003) . Laurentian, unlike the other three UMEPs which are assessed in this study, has included midwifery as a separate but equal professional program rather than within a specific pre-existing department. The professional program link for midwifery at Laurentian brings one's attention directly to the Midwifery Education Program site content (Laurentian UMEP, 2003). The calendar description of the midwifery program at Laurentian contains information equivalent to that provided within the program site. The program site for

midwifery at Laurentian is extremely visual in orientation containing 59 pictures and several symbolic depictions while the calendar description is entirely textual. The degree conferred by this university as part of the joint Laurentian/ McMaster/ Ryerson consortium is also a BHSc degree in Midwifery. There is a French language instruction option at Laurentian, unavailable at any of the other universities studied in this research. The University of Quebec in Trois Rivieres, not included in this study, also offers the only other full French language UMEP in Canada.

The McMaster component of the Ontario UMEP consortium introduces the midwifery program at this institution through a Health Sciences Faculty Page (McMaster UMEP, 2003). Through the Health Sciences page one can access an overview of the midwifery program under the Academic Areas section. McMaster University offers a BHSc degree in midwifery. The faculty at McMaster is multidisciplinary and thus includes faculty involved in midwifery, biological sciences, and social sciences as instructors. The Midwifery Program home page is linked through the Faculty of Health Sciences home page (McMaster UMEP, 2003).

Tri-university co-operation has specific advantages in the province of Ontario which will become apparent as accessibility and cultural diversity components of the various programs are discussed. The rural and urban diversity as well as northern and southern features of the Ontario population have been addressed by choosing to place midwifery education programs in diverse locations, intending to appeal to various diversity groups within the Ontario population. For example, Laurentian provides a French language option and northern access component to the tri-university consortium to enable access to midwifery for both students and clients within northern communities. Ryerson provides

an urban accessibility option, and a part-time option which may appeal to those less affluent and/or having family responsibilities. McMaster offers a more traditional university structure, more rigidly encapsulated within the Department of Health Sciences, emphasizing options to include biomedicine components, and interdisciplinary in terms of instructor options and course content.

An alternative structural option has been chosen as a means of incorporating a midwifery program into the University of British Columbia. The UMEP at UBC is included within the Faculty of Medicine. It is immediately apparent from the table of contents listing of department sections where it was decided that midwifery belonged within this university. The Table of Contents lists the Department sections as follows: 1. Introduction, 2. Doctor of Medicine, 3. Doctor of Philosophy, 4. Bachelor of Medical Laboratory Science, 5. Bachelor of Midwifery, 6. Postgraduate Education, 7. License to Practice Medicine, 8. Medical Council of Qualifying Examination, 9. Academic Staff (UBC UMEP, 2003). The degree granted to students of this program is a Bachelor of Midwifery Degree (BMw).

The section of the website content in which the UBC UMEP is located also describes the university sanctioned options for medical education and offers information about how to obtain a medical license to practice. Absent from this list of information is a link to the College of Midwives and/or information with regard to licenses to practice midwifery. Subsuming midwifery within this medical education section yet excluding licensing requirements reveals an emphasis on value of medical licensing over midwifery licensing.

The choice to include midwifery within the Faculty of Medicine at UBC, administered by the Faculty of Community Services at Ryerson University, listed as a Professional Program at Laurentian University and included within the Faculty of Health Sciences at McMaster University is a point of interest in its multiplicity. The various choices made by each institution as to how best to incorporate this program and where the most logical place to fit this program makes a statement about the visibility desired for and value of a midwifery program and of midwives as professionals within each of these universities. These choices also provide evidence as to the desire of each university institution for diversification of student and client populations as with the French language and Northern applicant components of the Laurentian UMEP and the urban part-time option provided by the Ryerson UMEP.

In terms of visibility, the UBC UMEP is the one which is most cloistered within the university as it is subsumed within the Faculty of Medicine. The practical application of midwifery is undermined by the exclusion of licensing information within the Faculty of Medicine. This structural design has also meant that faculty for the midwifery program, who are midwives specifically are almost completely inaccessible and invisible. At the time of this research, the contact information for midwifery faculty under the Department of Family Practice, Faculty of Medicine is incomplete. There was only one contact person listed, the Director of the Midwifery Program, whom was not readily available for contact. There is a gap in contact information for the acting head of the Midwifery Department and no other midwifery faculty are listed as course instructors. A lengthy search of course offering information reveals that the group of core instructors for this program were comprised of three registered midwives, two with a nursing background

and one having a social sciences undergraduate degree. The invisibility of this program within this university is reinforced by the fact that there is not a listing for degree colour in the graduation section for this program, nor is this program included in the university *Establishment and Constitution* listing of 'courses of study and degrees' (UBC UMEP, 2003).

University midwifery education not only legitimizes a model of practical knowledge and clinical style but also teaches a model of appropriate professional behaviour and interaction between care providers and clients. The model of interaction between students and faculty will inform the development of appropriate interaction between midwives and their clients. The gendered nature of the professions is relevant to the resources a university is willing to provide to support a midwifery education program as well as staffing choices and placement of the program within the university department structure. The domination of patriarchal and capitalist-driven programs within the broad university structure has particular implications for midwifery as a female dominated profession with holistic and caring ideals.

Educating (Teaching) a Culture of Practice

Enculturation into this profession occurs as midwives are educated and socialized in a manner which reflects the dominant culture of this profession. Professional socialization is an aspect of every university program, in this case stemming from a need to prepare midwives for the realities of professional practice. Evidence of the need for this type of preparation is apparent in the time commitment required of students in the UMEPs, the economic demands on students, and the necessity for a personal interview during the selection process. Professional socialization for midwifery students within the examined

UMEPs is emphasized in a section discussing *Academic Learning Style Considerations* where “students must be able to integrate the knowledge, skills and professional behaviour learned in the academic component of the program with the skills and proficiencies required of the clinical component” (UBC UMEP, 2003, para.) and in another example the UMEP text suggests “students must also present tangible evidence of ability to cope with the programme at Ryerson” (Ryerson UMEP, 2004, para.).

Reflection on the ideal candidate for this profession provides an indication that recruiters and recruitment strategies are aimed at attracting a particular kind of individual to this profession. An individual who will easily adapt and accept the ideology and function of both the UMEP and built-in guidelines of professional practice. Analysis of the data suggests that the ideal candidate for these UMEPs is one who is very different from the stereotype of the pre-professional “lay” or “hippie” midwife identity. For example, the Laurentian UMEP text reinforces this conception of a renovated professional identity for midwives. The text in question includes the statement that, “midwifery education must provide the base for sound professional practice” (Laurentian UMEP, 2003 para.). Professional elitism is emphasized as a component of this text which serves to differentiate midwives from their supposed unprofessional predecessors while attempting to elevate the image of the “new” midwife to the status of the obstetric medical professional.

The history of the semi-professions and the distinctions between professional spheres on the basis of gender should serve as a reminder as to how to approach the definition of the values of the midwifery profession. The strengths emphasized and considered valuable in the recruiting aspect of the UMEP texts has the potential to value masculine

archetypes. An important consideration in the UBC UMEP text is physical strength as opposed to more archetypal feminine strengths such as intuition, manual skill, empathy, and caregiving. One example of this tendency is the statement that, “midwifery students should have the capacity to withstand long working hours/days in varied physical environments and the physical strength to move and position a pregnant woman” (UBC UMEP, 2003, para.).

Gender is, and has been, a deciding factor in the way that professional projects are explored as well as the level of success that newly established professionals are able to attain (Witz, 1992). Midwifery is a predominantly female profession which has many of the gender segregatory characteristics of semi-professions, yet it has thus far resisted the semi-professional label. A “cost-efficiency” argument for midwifery incorporation has the potential to lead down a path to employment ghettoization and semi-professionalism. The argument in Canada that the provision of midwifery services can be viewed as a move to increase the efficiency of maternity health care service delivery is a discourse which is likely to carry over into midwifery training and professional regulatory expectations.

The argument has also been made that regulation of midwifery in Canada has meant an improvement in midwives working conditions (Devries et al., 2001). The chosen professional model on the other hand could be criticized as being overly masculinist and inconsistent with the reality of women’s daily lives in terms of home, work and childcare commitments. For example, it has been stated that, “like all flexible workers, it was hoped that the “new” midwife would be highly trained, consumer-focused, committed, autonomous and flexible in time commitment” (Devries et al., 2001, p.). The “new”

midwife is portrayed as genderless -an image reflective of a midwifery attempting to separate itself from its history and in the process reinforcing the masculinist ideal of the professional as an economical, efficient service provider without significant family responsibilities who is fully available 24 hours a day. This elitist image of a professional is not encouraging in terms of attracting women students to university midwifery education, nor is it supportive of the day-to-day realities of women's lives.

The UMEP texts in this analysis reveal an emphasis on cost-efficiency criteria. The Ryerson UMEP content provides evidence to the effect that midwives, as “known care providers” have “results (with) greater client satisfaction and fewer costly interventions” (Ryerson UMEP, 2004). One difficulty that arises with the use of this language is that to promote midwifery as a cost-saving measure can be extremely dangerous to the social and economic value of midwifery professionals. Midwives run the risk of being promoted as cheap labourers. This argument fits perfectly with the cost- reduction measure of a patriarchal-capitalist society. However, this may be harmful to how professional midwives as predominantly female workers are perceived. Labour which has a greater economic reward generates greater prestige. As such, the labeling of midwives as cheap labourers may lead to their being perceived as second-class professionals dependent upon a capitalist efficiency discourse in order to continue to market their “cheap” and “efficient” services.

The cost-efficiency agenda of government has the potential to be particularly unsavoury for a group of predominantly women midwife professionals as the wider patriarchal capitalist social structure tends to attribute value to professionals based on their economic performance. A cost-cutting agenda has emerged in government

management of the health care system in Canada (Romanow, 2002; Cohen & Cohen, 2004). Cost-cutting has the implication of limiting the access that midwives as predominantly female workers will have to competitive wage rates and benefits. Female workers occupy a tenuous social position, in a newly or recently established profession, depending on the region, at risk of occupying a semi-professional job ghetto in a neo-conservative economic environment.

Gender and race hierarchies in prosperity and earnings potential suggest that university applicants will be unlikely to apply if the economic standards and requirements of a specific program are set up as a deterrent, earnings potential is not as great as male-dominated professions; and economic support systems are not in place. The UMEP texts give evidence to a program design which has features insensitive to the choices and time commitments of women as mothers and women as flexible workers in a society of high financial demands. For example, in 1993 at the time of the incorporation of the UMEP in Ontario, women employed full-year, full-time earned only 74% of their male counterparts. (Women's Employment Outreach, 2002).

The time commitment associated with the "new" midwife professional identity and required within the UMEPs is a 24 hour on-call commitment to which students are expected to adjust immediately. It is suggested that, "all students need to carry a pager and be on-call from the beginning of the programme. It is therefore very difficult for a student to hold onto a steady job during courses and impossible once placed in a clinical placement" (Laurentian UMEP, 2003). Another similar warning is also included in this text which emphasises the economic requirements of the program on the part of the student. This statement reads, "...students may have to relocate or travel for clinical

placements. Travel and living arrangements and expenses are the responsibility of the student” (Laurentian UMEP, 2003, para.) and again “all clinical courses require students to be on-call and available for the duration of the course. Off –call time will be determined for each course” (UBC UMEP, 2003).

Midwifery students are trained to replicate professional behaviour and interactions in their classroom education and clinical practice components which will certainly impact the overall progress and reputation of the profession in Canada. Replication of the models of interaction and practical techniques used within the UMEPs is likely as students enter practicum/preceptor situations, graduate, become registered with a College of Midwives and begin taking on clients individually or within a midwifery practice/collective. Professional style of relationships fostered within classroom and clinical settings are expected to be reproduced in future professional practice. The culture propagated within the university has specific implications for the types of relationships midwives are likely to develop with future clients and other professionals.

Professional identity is an important element of the system of patriarchal capitalism within the UMEPs which determines a level of elitism. Interprofessional collaboration is highly valued and emphasized in the UMEP texts. This emphasis is illustrated by specific statements including the desire for midwives, “as health professionals to be highly competent in inter-professional collaboration” in addition to emphasis in the Laurentian Midwifery Care Clerkship course (MIDW 4024) description stating, “The tutorial component uses problem situations from all phases of childbirth, and the problems integrate content related to inter-professional relationships and the organization

of the health care system, the legal, ethical, and professional responsibilities of a midwife and the critical evaluation of practice” (Laurentian UMEP, 2003).

Yet, interprofessional collaboration comes with its own set of problems and deficiencies. The legitimate potential conflicts which may occur between the practice of holistic midwifery and obstetric science in the context of interprofessional collaboration are not alluded to in this text. One omission apparent in this text which plays into the control that patriarchal capitalism has to define the future of this profession is the under-emphasis of advocacy, empowerment and politicization as valuable principles in this text. There is little effort to single out midwifery from other OB-type care and inter-professional collaboration seems to justify and reinforce this omission. There is a lack of recognition of the consequences of inter-professional collaboration with faculty and professionals unsupportive of independent midwifery. Interprofessional collaboration and shared teaching in particular will impact the epistemology of midwifery knowledge in Canada. Those who are supportive of a biomedical paradigm may not be conducive to the continuation of an independent midwifery knowledge form and practice in Canada nor supportive of activist activities or home birth. Instead, this type of co-operation may be more likely to lead to more challenges, hostility and/or co-optation than to the supposed intended conflict resolution between mainstream medicine and midwifery. There is certainly not a clear discussion as to the professional rivalry and hostility students may experience in professional practice, yet there is significant discussion as to the economic and time constraint challenges of the UMEPs. This is a very inconsistent indicator of the experience that students may come to have as midwife professionals, or even during their time as midwife students in preceptorship situations. In this same

context, this is also a negligent omission in terms of the frustration clients may have over the discrimination they may receive when accessing care from an obstetrician or family physician provider in conjunction with midwifery care.

There is a particular emphasis on inter-professional collaboration in the UMEP texts that creates an overall *professional* tone as opposed to an academic or political tone. The professional tone taken in the McMaster UMEP text is evidenced by such discussions as, “the profession and its rewards”, the value of university midwifery education in the context of “providing a base for sound professional practice” and discussion of competency in professionalism as “midwives must have thorough and rigorous academic training” (McMaster UMEP, 2003). There is less discussion of hands-on or experiential learning although this type of training is provided through the clinical placement requirement stated to comprise one half of the time of this program. The “health related institutions” located on the McMaster campus are stated to serve as learning sites for those in the UMEP at McMaster (McMaster UMEP, 2003) and preceptor sites for the Ryerson component are stated vaguely as offering both hospital and midwifery clinic experience, Laurentian offers community placement options in intensive care nurseries, genetics clinics, or tertiary level obstetrics in regional, national, or international settings while UBC offers physician/community placements of no specific location.

The primary maternal health values of a patriarchal capitalist university system in Canada have emphasized biomedical birthing knowledge. The university system has the power to legitimize and/or undermine the authority of midwives, physicians and other health care experts as teachers and givers of valid knowledge. Those considered within the UMEPs to have valid knowledge of midwifery are women midwives. It is believed

and promoted that midwives alone are the most skilled individuals to teach students in the UMEPs. Evidence of such is best exemplified within the Laurentian UMEP text to the effect that, "...the program supports the belief that midwives are best equipped to teach the professional practice of midwifery, and attempts to foster partnerships between midwives and other healthcare providers for the benefit of students and women who seek midwifery care" (Laurentian UMEP, 2003).

Registered Midwives in Canada are not yet provided the opportunity within the University structure to obtain advanced professional degrees in midwifery which would allow for evidence-based practice and teaching opportunities. However, inter-professional collaboration, advanced nursing degrees, science and epidemiology training are examples of training faculty have chosen as a means by which to fill this gap.

The McMaster component UMEP provides further evidence as to the value of inter-professional faculty affiliations for UMEPs. There is a particular emphasis on inter-professional collaboration in the UMEP texts as evidenced in the midwifery education program *selection procedure, statements of beliefs and goals* as well as in the *background and expertise* of midwifery faculty. Evidence of this value is initially apparent in the descriptions provided including the description listed under the *Statement of Beliefs and Goals* section. This statement is: "we believe... that midwives are the best persons to teach the professional practice of midwifery but we believe.. that the educational programme has a special responsibility to foster partnerships between midwives and other care providers for the benefit of students and women who seek midwifery care" (McMaster UMEP, 2003). The faculty listings for the midwifery department at McMaster specifically illustrates that a commitment to interprofessional collaboration is

carried out through a reliance on faculty trained in numerous areas including biological sciences, social sciences and midwifery. It is stated that the McMaster UMEP program includes a dual-level faculty consisting of two groups. One group is referred to as the midwifery faculty and the other group is referred to more generally as experts in research, social, health or biological sciences (McMaster UMEP, 2003). The McMaster UMEP also includes a component of evaluation to reinforce the value of interprofessional collaboration to this system which is the *Selection Procedure* information emphasizing competency in three specific areas including: 1)health education; 2)counseling; 3)interprofessional collaboration. Following this it is stated, “applicants to the program will be assessed for their ability to exhibit and further develop these important personal/professional qualities” (McMaster UMEP, 2003).

Beyond placement, administration, faculty and degree considerations, the potential for professional growth is relevant to the structural organization of UMEPs in Canada and to the professional status and earning potential available to midwives. The potential for UMEPs to develop independent research departments has been a stated goal from the outset of the professionalization process for midwifery (Bourgeault, 1996). Access to meaningful, best practice evidence to inform midwifery practice and education; independent research and education funding sources, financial support for students; and the opportunity to grant advanced Master’s and PhD degrees in midwifery are options along this theme which are not existent at the developmental stage in midwifery education which this research has examined. Evidence confirms the value of creating these opportunities as, “advanced professional degrees empower their recipients to teach, to start new programs, to effect changes in legislation, and to carry out research on client

needs and various aspects of midwifery care.” (Benoit as cited in Devries et al, 2001, p.353)

The system of relationships within the university among faculty and between faculty and students is illustrative of a particular culture of professional interaction. The relationships fostered between professors and students within the university are susceptible to establishment under a formal hierarchy which is easily translated into the practicum/clinical stage of education and practice. This is the point at which the resources available within the university to provide appropriate course instructors, diversity in student/faculty population and funding to inform an holistic education content and practicum component, are important to this equation.

A primary tension is evident in the professionalization process in Ontario and B.C. during which attempts were made to integrate an holistic midwifery philosophy into the university system while simultaneously attempting to avoid marginalization and stigmatization as a recently established and female-dominated profession. Avoiding being slotted into predetermined patterns of patriarchal domination within the university institution which is conditioned to replicate such hierarchies, both in structure and teaching style is a key counter-strategy necessary to the preservation of a holistic midwifery philosophy.

Coexistence of Holism, Biomedicine and Patriarchal Capitalism in UMEPs

Midwifery preceptors, professors, program administrators and students are faced with the dominance of science and biomedicine, more evident in certain institutions than in others. In these situations the program is challenged with attempts at relegation to second class status, cloistering within the university and being disguised in biomedical science. Relevant to this discussion of dominating ideologies are placement within the institution, visibility, symbolism, prerequisite requirements and biomedical discourse.

An assessment of elements of an holistic UMEP is particularly relevant to the structure of the admissions process. Admission requirements for the UMEPs are relatively standardized, emphasizing science and biology as well as structured to screen out specific types of applicants whom are lacking a biomedical background. Applicants applying directly from high school are encouraged to complete 6 grade 12 University preparatory and/ or OAC courses including English, Biology/Chemistry, one grade 12 course in Canadian world studies or social sciences and humanities. A 70% average is required in each of the courses of study. The screening process begins with a personal letter component detailing an applicant's background experiences and personal attributes. The second aspect of the screening process is a personal interview wherein the applicant is assessed for three components which are key to determining the philosophical perspective of the applicant and the likelihood of the applicants' success within the program. The criteria the applicant is expected to meet in the interview are illustrated by the Ryerson UMEP example: a) that the applicant have sufficient motivation to become a midwife; b) an awareness of midwifery in Ontario; c) career goals d) a willingness to submit to a writing skills test (Ryerson, UMEP, 2003). Similar requirements are evident

in the remaining Ontario consortium universities as well as in the UBC UMEP. The Laurentian UMEP admissions process appears to be slightly more challenging than other midwifery programs described in this study. The requirements for admission are similar to other universities described including three university level courses in Biol/Chemistry, English, and one social science with an average of 70% being preferred. However, there is a discouraging three-stage admission process which has the potential to create unnecessary hardship for some less affluent persons who would otherwise be interested in this program. The stages of admission are listed as, “Stage 1. Assessment of academic eligibility Stage 2. Review of personal letter, each applicant must address four items in a typed submission, detailing background experiences and personal attributes which make one suitable for a career in midwifery. Stage 3. Personal Interview, in which interviewers evaluate applicants in areas such as: motivation to become a midwife, awareness of midwifery in Ontario, and career goals” (Laurentian UMEP, 2003). The personal interview aspect of this selection process as well as the personal letter component imply that an applicant would be culturally familiar with midwifery professionalization, status and so forth in Ontario as well as financially affluent enough to attend an interview session at the university. While this structure seems to have been designed to prioritize northern applicants over other applicants, the process is reflective of the dominant biomedical admissions process. The admissions process for UMEPs includes specific requirements which serve to limit accessibility to the programs. For example, the inclusion of a personal interview component, with the stated intention: “to ensure we admit suitable candidates the programme has a selection procedure that allows us to assess candidates on a more extensive basis.”(Ryerson UMEP, 2003)

The challenge of recognition and visibility for midwifery within the Department of Health Sciences, Faculty of Medicine, Faculty of Community Services and among the health professions in general is daunting. Symbology and visual imagery used within the UMEP texts provides evidence as to the attempts made to define midwifery as distinct from other programs and specifically from biomedicine within the university. The McMaster University crest is the symbol used to visually signify this program. In this instance the midwifery program chose not to develop a separate symbol for the midwifery program (See Appendix I). The symbols included in this crest itself, a book and a phoenix, represent a dominating knowledge form. The definition of a phoenix varies from, “A person or thing of unsurpassed excellence or beauty; a paragon”; a sacred symbol of the Egyptian religion signifying perseverance, representing the story of a mythical bird having lived in the desert 500 hundred years is consumed by fire, later to rise and renew itself from its ashes (Houghlin Mifflin Corp. Dictionary, 2005). This symbol is also referred to as representing death and resurrection as in the eternal life of the Jesus character in Christianity. The symbol was used on the shields of Christian soldiers to symbolize eternal life in Christ and their compliance with the Christian doctrine (Christianity Today, 2005). The phoenix is described as having a snake’s neck, a swallow’s chin and a fish’s tale (Mythical Realm, 2005). This description allows one to comprehend the reason it has been adapted for use in health sciences, as the snake or serpents, consistently used in a caduceus symbol intertwined together to represent healing power and life and death, has a been a consistent symbol of biomedicine . Therefore, the use of the phoenix, depicted with the neck of a snake, as a symbol for health sciences and biomedicine is consistent with this theme. The phoenix symbol paired with the book

symbol in this instance powerfully reinforces the endless dominance of a specific truth, a specific knowledge through time. The book reinforces the renewal and perseverance of biomedical knowledge through education of future practitioners of biomedical science represented in this instance by the phoenix.

There are some significant visual elements of the UMEPs which reveal a continued devotion to the historical holistic roots of midwifery knowledge as part of the culture of midwifery practice. The visually symbolic representations used to depict the values of the Laurentian UMEP are well chosen to represent a holistic health philosophy. This text includes two photos of old world sculptures which can be described as symbols of fertility and female power. (See Appendix I) These photos represent the beautiful, nurturing aspect of the mother and midwife suggesting the possibility for a symbiotic mother/child/midwife relationship. The round belly and voluptuous aspect of the female form emphasized in these sculpture photos is representative of unity and holism. This signifies a powerful state of health, completeness, and well-being in the life process of pregnancy, childbirth and postpartum.

The visual symbolic representations chosen for these UMEP texts represents a clear and vivid reinforcement of a particular paradigm with associated values and authority.

The symbolic representations present in the Ryerson UMEP text are photographic images, some of a midwife with her hands on a pregnant woman's belly in black and white as well as several other colour photographs of babies, depicting hands holding baby feet and a mother embracing a baby (See Appendix I). These photographic depictions are used as symbolic iconography for this text. Several of the photographs which include the babies are adorned with the catchphrase, "Make a Difference" (Ryerson UMEP, 2004).

An interesting aspect of these photographs is that the photos including both the mother and midwife are very stark and clinical as they appear in black and white. The midwife is also using a stethoscope in the picture as opposed to a pinard. A pinard is a traditional object by means of which midwives listened to the heart and movement sounds of the unborn. The choice to depict a midwife with a stethoscope makes her appear to *be* a physician and not a midwife at all. This picture is evidence of an attempt to illustrate the modern nature of midwifery, the so-called “new” midwifery relying on the modernized and techno-savvy professional. Realistically, this photograph which is used repeatedly, seems cold and clinical as the faces of the subjects are excluded. This has the effect of denying personhood to the subjects, in the guise, possibly, of confidentiality. On the other hand, the pictures which include the baby and midwife and/or mother are very warm, colourful and inviting and some include faces. Several of these photos also include the “Make a Difference” caption, previously mentioned.

The UBC UMEP text includes one picture of the program director. There is an omission of visual representation of the student body, faculty and so forth, which also then omits the potential for supporting diversity in recruitment through this means. Holistic symbology is included as an historically significant birth symbol is used to represent the UMEP. (See Appendix D) This symbol is defined as,

“...an adaptation of the birth symbol found on embroidery, cloth, rugs and pottery around the world. Max Allen, a collector of birth symbol textiles, says he has counted 23 different structural techniques for the symbol. (Birth 19:1, 1992). Various forms of the symbol can be found on the covers of the journal *Birth: Issues in Perinatal Care*. Blackwell Scientific Publications” (UBC UMEP, 2003, para.).

This symbol is reflective of a holistic midwifery philosophy. The historical symbol used here is reminiscent of the symbols used by the Anatolian civilization of Catal Huyuk (6000, B.C). The symbol chosen here is also similar to patterns found on Narino gold ear ornaments from the Ecuador era 850-1350 A.D. The combination of figures used in this symbol is representative of the Great Goddess religion of pagan worshippers, pre-witchunts and pre-patriarchal modernization (Allen,1981). In this respect, the text of the UBC UMEP signals its support of feminist and holistic health elements of midwifery.

There are several elements within the UMEP text of UBC which support a holistic philosophy of midwifery. For instance there is an emphasis on *respect* in this text. These descriptions of midwifery care including values such as respect contradict a biomedical philosophy of care. For example, it is stated in the text, “midwifery care requires that midwives work in a relationship with a woman and her family using evidence based approaches as well as informed choice and decision-making as a foundation for mutual trust and respect” (UBC UMEP, 2003).

In terms of feminist and holistic philosophical values, this text claims to be true to a holistic practice. Yet this claim is stated in a self- evident manner which seems to suggest that the administrators and creators of this program had little or no control over the content and knowledge involved in the midwifery philosophy and practice being taught within this program. It is stated here, “midwifery is holistic by nature, combining an understanding of the emotional, cultural, spiritual, psychological and physical ramifications of a woman’s reproductive health experience” (UBC UMEP, 2003). Feminist theory is included in a list of the knowledge perspectives considered necessary to understand the magnitude of the birth experience. For example, “understanding the

magnitude of this experience calls on knowledge from a variety of perspectives including sociological, psychological, anthropological, political and feminist approaches and theory” (UBC UMEP, 2003).

Within the text of the UMEPs in this study, thematic indicators of the dominant discipline emphasizing scientific rationality and biomedicine are also evident. Curriculum descriptions within particular UMEP texts attempt to transcend beyond the borders of the disciplines and are structured so as to support a set of values which incorporate a biomedical paradigm as well as a holistic paradigm. For example, within the UBC UMEP text is argued that the curriculum of this program consists of three specific elements; “human growth and development; pregnancy and birth transitions; and effective care” (UBC UMEP, 2003). Effective care in this context is defined as midwifery care including an emphasis on the family and community (UBC UMEP, 2003).

In terms of curriculum descriptions, it appears to be the priority of this text to combine holistic and biomedical knowledge forms under the umbrella of this midwifery curriculum. As it is stated, “the curriculum combines broad-based knowledge and understanding in the humanities and social and bio-medical sciences” (UBC UMEP, 2003). It is clear that the humanities will be utilized to help aid in understanding the magnitude of the birth experience for women, yet at the same time there isn’t a clear reference as to the usefulness of the biomedical sciences and where specifically this knowledge will assist midwives in performing their work.

In another context UMEP content is more closely aligned with biomedicine. Within the text of the Ryerson UMEP, an ‘active labour management’ theme emerges. The

‘active labour management’ practice is one of the first steps that was taken to clearly distinguish the industrialization era birthing ideology developed and fostered by obstetricians from that of all other practitioners in the area of birthing care (Adams, 1994). ‘Active labour management’ is a maternity care procedure undertaken by obstetricians in a hospital setting involving a specific discourse, practices, technology and philosophy which is reflective of a biomedical management model. ‘Active labour management’ as a specific indicator of the biomedical paradigm is reflective of both the dominance of capitalist-patriarchy and of biomedical values. It is particularly difficult to maintain a language describing midwifery in the UMEP setting which is independent of the influence of biomedicine. Biomedicine has become a naturalized discourse wherein statements made within the medical community are taken for granted as facts (Cameron, 1985). As such biomedicine has established itself as indisputable and self-legitimizing. The Ryerson UMEP uses language which echoes the discourse of biomedicine. Specific terms in statements include “diagnosis” and “management”, while referring to a birth event which is otherwise “normal” (Ryerson UMEP, 2004). The Ryerson UMEP text also omits mentioning support persons in maternity care and focuses specifically on the “mother and neonate” (Ryerson UMEP, 2004). The experience of ‘normal’ childbirth seems contradictory to the ‘diagnosis’ and ‘management’ this text speaks of. The definition of the practice of midwifery which is endorsed and advertised in the program content is also of questionable language in terms of a holistic philosophy. The following statement from the *Ontario Midwifery Act*, 1991, is included to express a central definition of midwifery practice commonly held within the Ontario UMEPs,

“The practice of midwifery is the assessment and monitoring of women during pregnancy, labour and the post-partum period and

of their newborn babies, the provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries.” *Ontario Midwifery Act, 1991* (Ryerson UMEP, 2003).

Specific discourse within the content of the Ryerson UMEP text tends to signify a move away from supporting women in childbirth and toward supporting the system that has been created (Mason, 1990, and Katz Rothman, 1982). In terms of the course content included in the UMEP text, system language such as “management”, “diagnosis”, “intrinsic control mechanisms and extrinsic methods of regulation of reproduction”, “medical conditions”, “alterations from normal mechanisms” and so forth is recognizable of this type of support (Ryerson University, 2004).

Katz Rothman (1982) argues that this type of system language is part of the whole ideology of patriarchal positivism/capitalism which encourages the perception of women’s bodies as pathological. The fact that this text includes the term ‘mechanisms’ while describing women’s body function is problematic in and of itself. This discourse at times denotes a “body as machine” ideology which has been associated with patriarchal positivism/capitalism and is particularly effective in disempowering women by patronization and procedure during pregnancy, labour and postpartum. Adams (1994) reveals how theorists have analyzed the use of this “body as machine” ideology, most famously Foucault, who argued that, the ‘body as machine’ ideology upon which much of scientific medicine is premised is a militaristic attempt at reductionism, power and control.

The description provided in the McMaster University calendar concerning the value and content of a health sciences education, including midwifery, provides the first indicator as to a biomedical thematic tendency in this UMEP text. This text supports the

assumption that a negative impact or illness will occur prior to intervention by a health sciences professional (including midwives). This emphasis on health sciences as the focal point of midwifery education exists in the text literature as well as in the symbolic significance of conferring a BHSc degree upon midwifery graduates and the choice not to differentiate from the crest of the health sciences department as a symbol for the midwifery education program. Evidence of this emphasis on health sciences specifically is present in the calendar description as well as in the course literature.

The choice to award a BHSc. degree, as opposed to a Bachelor of Midwifery degree, is a distinguishing choice in this context. This text has a particular description of Health Sciences that is important for understanding how a health sciences degree from this university may have a different social, cultural and professional designation than a Bachelor of Midwifery degree. In reference to health sciences, it is stated that, “the concept of Health Sciences education is based on the view that health is a broad subject encompassing both the problems of ill health and the impact of biology, environment and lifestyle on health” (McMaster UMEP, 2003). This statement is clearly focused on a pathology oriented model of health care which assumes negative impacts on health and designates all health science professionals as interveners to be consulted after the said negative impact has taken place. This description is not particularly useful to a holistic ideology nor is it empowering for pregnant and/or birthing women as it assumes there is always a state of ill health and a need for interventive techniques to attempt to control all of the environmental and biological factors which may or may not influence ones state of health. The course literature for Level Two of the McMaster UMEP states that students are required to complete nine units from the Faculties of Health Sciences, Humanities,

and Social Sciences as well as the Midwifery Care I intensive, Midwifery Care I tutorials/placement, Pharmacotherapy, Reproductive Physiology, and an elective.

Efficiency discussions have implications not only for the professional status of midwives as predominantly female professionals, but also in terms of the context of services valued and employed by midwives. The comparison of midwifery services with obstetric services in UMEP texts is more conducive to a maintenance of holistic philosophy and practice when based on considerations of quality of care, continuity of care, response to care and care outcomes as opposed to comparisons based on economic performance and cost-cutting capabilities. Midwifery is more likely to maintain a differentiation in philosophy and practice from obstetric medicine and the dominant medical paradigm by ensuring language of measuring value of services and discourse are more appropriate to a holistic philosophy of care including terms reflective of values such as quality, attention to clients (which includes continuity of care and more lengthy appointments), relationships developed, emotional response to care, attitude toward opting for future midwifery care (client satisfaction) and so forth in comparison discussions. The emphasis in comparisons reflects holistic values when based on considerations of quality.

There are many significant factors which are able to be utilized for the purpose of promoting midwifery in comparisons between obstetric and midwifery care. The data of the UMEP texts reveals certain attempts to promote midwifery care based on a comparison of midwifery care and care by *other providers* (the only other legal providers being obstetricians and physicians) on the elements of 'efficiency' and 'safety'. The discourse which is chosen to make comparisons on this basis is limited to the language of

the dominant obstetric profession. One text includes a declaration that midwifery care equals the standards of other (ie. OB) care providers in terms of “efficiency” and “safety”. The text states that, “international evidence overwhelmingly supports the fact that midwifery care is as safe and efficient as care by other providers” (Ryerson UMEP, 2003). Midwives are also defined in this text as “appropriate providers of low-risk maternity care” (Ryerson UMEP, 2003).

Risk and safety discourse has long been used by obstetricians to reinforce their monopoly over childbirth as well as having the effect of disempowering women in childbirth. Risk and safety discourse in content applicable to maternity care has been identified as particularly problematic. Risk tends to be established on the basis of danger to the baby rather than on the assessment of future or present health, lifestyle or autonomy of the mother, most often justifying caesarean section surgery (Murphy-Lawless, 1998). Caesarean section surgery, from a result-oriented perspective, is the ultimate means of an efficient birth. The surgery can be scheduled for a specific time and speeds up the birth event which could otherwise take up to 72 hours.

Within the Ryerson UMEP text exists limited discussions of midwives providing high quality care. Limited discussions of quality are included within a product-oriented headline titled, “Healthy Outcomes” in the following statement, “Colleagues and clients provide ongoing, formal feedback that ensures midwives are providing high quality responsive care” (Ryerson, 2003) and “Midwives play an important role in the health care system as specialists in normal child birth, offering continuous high quality care to healthy pregnant women and their newborns” (Ryerson, 2003). The previous statements refer to the surveillance expectations of the College of Midwives and the expectation that

midwives are ideal for the specific role in the care of healthy, normal pregnancy, labour, delivery and postpartum events.

Definitions of risk and normalcy remain integral to defining scope of practice for midwives and obstetricians. For example, by performing caesarean section surgeries on primipara or first-time mothers in particular, obstetricians are able to corner the market on those women clients for all of their subsequent childbirth experiences. Once a woman has a caesarean section surgery she is more likely to be considered a high risk candidate for vaginal birth, therefore slotted into the category of VBAC (vaginal birth after caesarean section), which midwives are less likely to be providing. Defining vaginal birth after caesarean section as requiring midwives to have ‘discussion’ and/or ‘consultation’ with a physician maintains a competitive edge for medicalized maternity care (CMBC, 1997). Providing that the number of caesarean section surgeries remains high the proportion of first-time mothers who receive caesarean surgeries will maintain a significant client base for obstetricians. According to a 2004 Canadian CIHI report, Canadian caesarean section rates reached an unprecedented high of 22.5% of all in-hospital deliveries in 2001-2002. In the patriarchal- capitalist university structure within which biomedical science functions, efficiency is idealized by measurable time standards as well as the use of technology and mechanisms which speed up the process of childbirth (Simonds, 2002). This thematic reference does not seem conducive to an holistic ideal of midwifery which strives to empower and respect women’s power to birth as opposed to disempowering women through the use of unattainable efficiency standards which tends to lead to progressive technological intervention.

In this text, the language of patriarchal capitalism, in terms of “cost-cutting” and “efficient” production is also used as a sales tactic. The question this begs is to whom is this sales tactic directed? If it is indeed potential applicants, one must assume that these applicants are expected to share in a patriarchal capitalist perception of how maternity care should be performed. This use of economic efficiency language makes midwifery a marketable consumer service for both government officials and those of like-minded capitalist ideals.

A comparison of value between midwife and obstetric services based on economic performance has the potential to negatively impact the new professional and predominantly female workers, midwives, who will want to avoid being labeled as cheap labourers. This label has the potential to negatively impact the status of the midwifery profession as midwifery services appear as less comprehensive care because the professionals are paid less. The economic value and prestige of technology as well as greater cost of the services of man-midwives, later obstetricians, initially allowed them to declare their services superior to those of the female midwife partially on the basis of economic prestige.

The gendered characteristics of women’s health occupations is clearly recognized within the UMEP text description of qualities which define this female dominated occupation. Caregiving is the skill which is emphasized in the application process for potential students as particularly valuable. Volunteer work is mentioned as a good asset to have as a potential applicant. Volunteer work emphasizing the role of caregiving is considered especially valuable. The FAQ section of the Education Program text includes the following question: “I’ve never attended a birth: does this reduce my chances of

getting into the program?”, to which the response is, “Having attended a birth is NOT a requirement for admission to the programme; however, any type of volunteer work or experience may be beneficial to you in understanding the role of a caregiver (McMaster UMEP, 2003). While caregiving is an important skill to have in order to be successful in this occupation, it is also important to recognize that caregiving is a gendered concept in that it has been a social tendency to believe that woman’s natural capacity is caregiving. This skill in particular has not garnered the economic value of the skill of surgery for example. Other valuable skills such as feminist advocacy work would not obviously impede on a prospective students capacity for caregiving and would at the same time, avoid reinforcing stereotypical characteristics of prescribed male and female gender roles.

At the same time, this text attempts to incorporate the patriarchal positivist/capitalist ideals which seem to be beneficial to the promotion of a *new*, modern midwifery moving toward adopting obstetric/gynecology standards of efficiency and safety as a measurement of the quality of care. UMEP texts in certain areas describe a midwifery education that has been dissected from its historical foundations, is clinical in its approach and has been adapted to fit with the cost-efficiency agenda of government. This is not incidental, but rather a conscious choice has been made to construct midwifery in this manner. There were and continue to be stakeholders, agenda setters, public relations interpreters and so forth who have an interest in shaping the midwifery professional identity in a particular way.

Nestel (2000) argues that there was a significant and conscious transformation of the professional midwife identity during the process of professionalization. Midwives were

encouraged and more accepted if dressed in a corporate style rather than hippie style. Visual and physical elitism and a reverence for a “corporate culture image” requiring white midwife mothers to put their work before their children and families became part of the new professional midwife identity (Nestel, 2000).

The list of required skills and occupational challenges provided is also evidence of a program design which screens out those who are less affluent as well as those less familiar with traditional science. The occupational challenges are listed as: clinical placements which take up ½ of the program time, to be on-call and ready to work long and unpredictable hours, no-part-time job possible during the program, ability to relocate, transportation costs, and the ability to travel to more than one site per day (McMaster UMEP, 2003). Some of the choices made in terms of how to structure a UMEP program clearly illustrate that preparing and molding students for professional practice is the priority, as opposed to advocacy, for example. In terms of the tone taken in this text, the academic requirements of the university and specific economic, social and intellectual demands of this program are the emphasis. The tone of this text is orientated to the academic outcome. In particular, the choice to have students be on-call during the program is a significant priority in preparation for the formation of a professional midwife identity. During the professionalization process in B.C. it was recognized that autonomous midwifery was associated with “a hippie fringe element” (Rice, 1997). Certainly, the College of Midwifery of British Columbia and the Midwives Association of British Columbia have made some efforts to contradict this identity, facing the difficult task of creating an identity which is separate from nurse-midwives in B.C., preserving traditional midwifery values such as avoiding unnecessary technology and embracing

alternative medicine. The values which are reinforced in the UMEP setting at UBC, are specifically focused so as to distinguish the professional midwife, the ‘new’ midwife, from former conceptions of ‘hippie’ or ‘lay’ midwives. It is stated within this text that, “Students must be able to integrate knowledge, skills, and professional behavior learned in the academic component of the program with the skills and proficiencies required of the clinical component” (UBC UMEP, 2003). This testament reinforces the idea of modeling professional behavior in midwifery practice. Some behavior associated with the ‘new’ professional midwife is stereotypically masculine professional behavior, replicating the practices of obstetricians, while making this program seem inaccessible to those having lifestyles previously associated with midwifery. For example, “all clinical courses require students to be on-call and available for the duration of the course. Off-call time will be determined for each course” (UBC UMEP, 2003).

This requirement of 24 hour availability not only reinforces specific time standards which fit a biomedical agenda but also gives some insight as to who is considered a desirable candidate for this program. Obviously a student who is financially affluent, with limited commitments and/or an extensive support network would be more attracted to the full-time UMEPs. The commitment and financial aspects of the UMEPs are presented with the effect of attracting and recruiting a specific type of student. The favoured identity seems to be an applicant who is single, financially affluent and willing and able to be marketed. The ideal applicant for this program is one who is compliant with capitalist efficiency standards and the cost-saving measures of government.

Issues of Accessibility and Cultural Diversity for Students and Clients

University elitism is a determinant of the economic and social demography of student applicants and ultimately clients of midwifery. Respect for cultural diversity is one component which sets holistic midwifery apart from obstetrics. A positive approach to cultural diversity within the midwifery profession provides a unique opportunity to broaden the client base and ultimately make midwifery services more competitive.

The ideal holistic UMEP and practice would maximize inclusiveness and diversity for both student and client populations. Accessibility issues will determine the ability to diversify the midwifery profession itself as well as limiting and or expanding urban, rural, ethnically and linguistically diversified and international practice opportunities.

Entrance requirements are one method of limiting accessibility to the UMEPs, thus altering the composition of potential midwives with authority to practice as graduates from recognized university programs in Canada. Accompanying issues are the economic requirements of the program, the location of the education program and the openness of the program to diverse ethnic and cultural backgrounds.

Accessibility to the UMEPs in Ontario in particular is structured to appeal to three different types of geographic groups. For example, the Laurentian UMEP is geared toward northern applicants, while the Ryerson component appeals to urban applicants and the McMaster program to central/out of province applicants. The rural/ urban distribution accomplished by the Ryerson, McMaster, Laurentian consortium actually is evidence of a method of inclusion, targeting specific geographic regions in Ontario. This method attempts to meet the needs of a culturally and socio-economically diverse population of women students and maternity care clients in Ontario. The Laurentian UMEP in

particular example is described as, “flexible and culturally sensitive” (Laurentian UMEP, 2003).

However, there are some economic components of the UMEPs which tend to limit accessibility to less affluent applicants. It is necessary to own a vehicle to attend the Laurentian component of the consortium to accommodate the rural landscape of practicum and university attendance. The program administrators recommend that individual students have reliable vehicles. It is stated that, “students are responsible for their own transportation during all courses and clinical placements. Oftentimes, public transportation is insufficient and it is therefore recommended that students have access to a vehicle” (Laurentian UMEP, 2003).

An ideal student for recruitment is one with very little economic burden, plenty of time to commit, and who does not need to ‘put down roots’ in any particular area as relocation is necessary at some junctures of the program. This text warns of the, ‘long hours, relocation, transportation and cost’ of the program (UBC UMEP, 2003). There are six specific references which act as a warning of the financial burden and time commitments allegedly required of this program. The *Costs other than Sessional Fee* section cautions of “living and travel expenses” (UBC UMEP, 2003). This message is reinforced five other times throughout this text; cautioning ‘extra costs’, ‘travel and living expenses being the responsibility of the student, in terms of clinical placements’, *lifestyle considerations* including two separate references concerning the considerations of the costs and challenges of the program, and the *FAQ* section also reinforces the financial burden of the program by warning of the impossibility of keeping a part-time

job (UBC UMEP, 2003). The language used in this context sends a discouraging message.

The UMEP programs in this study are attractive to financially affluent persons with very few, if any, family or caregiving responsibilities. There certainly is very little recognition of the reality of women's everyday lives where women are far more likely to have caregiving responsibilities which would create serious challenges to pursuing this type of education. These caregiving responsibilities which can create challenges are marginalized, socially devalued and often unacknowledged work (Luxton & Corman, 2001). There is recognition in this text that it would be impossible to keep a part-time job (UBC UMEP, 2003). There is a lack of recognition in direct terms however, that caregiving and unpaid domestic labour are forms of work which may create challenges, particularly for women, to participating in this program. The commitment aspect of this program is far more appealing to single women or men than to the traditional and historical demographic of midwifery apprenticeship and education, older women with children of their own (Barrington, 1985; Mason, 1990).

There is a dichotomous message in terms of access to university education for the profession of midwifery between the ideals of the College of Midwives of B.C. (CMBC) and UBC. The CMBC has a financial component geared to create equity in accessibility for students. The CMBC has a Midwifery Education Bursary which has been established in memory of Jean Cooper for students, "who are in need of financial assistance" (CMBC., 2003) . This effort to address some of the financial challenges faced by midwifery students is more equitable and supportive than the discouraging approach taken by the university.

The requirements and challenges described above clearly discriminate against less affluent potential applicants creating unnecessary challenges for women, who are more often than not, less affluent. The use of particular design features creates the appearance of elitism as well as compliance with market competition features of patriarchal capitalism. The tendency for universities to be operated as corporations creates a tension of financial challenges for those attempting to access UMEPs. Clearly the capitalist ideology of a corporation has a tendency to exclude particular demographic groups, specifically women as a group of persons who are financially less affluent. There is some recognition of the need for bursaries and Ryerson offers a part-time enrollment option in an urban setting as part of the consortium which appeals to less affluent students.

The selection procedure for potential applicants to this program does not require a personal letter component which makes this procedure slightly more standardized. UMEPs do however consistently require a personal interview in order to be accepted into the program. The travel costs required to attend such an interview is yet another barrier to the less affluent in this education system. Another aspect of the selection procedure itself which has the potential to limit the diversity of the applicant pool is the type of extra-curricular activity considered valuable in this context. Volunteer work in the area of caregiving is seen as particularly useful in terms of admission to this program, while other less feminine forms of volunteer work which may provide equal information as to midwifery client services including advocacy work for midwifery or feminist associations is not considered as relevant (McMaster UMEP, 2003). This component allows particularly oppressive conceptions of male and female gender roles and masculine and feminine skill characteristics to enter into the considerations of an applicants'

applicability for the midwifery profession. It could be argued that volunteer work in an advocacy environment would provide equal preparedness, yet not equal in terms of the feminine/caregiving role this text defines as compatible with success in university midwifery education.

Additionally, a substantial thematic element with a clear emphasis on social inclusion and diversity can be discerned within the UMEPs studied. There is evidence in the Ryerson UMEP text that administrators of this program recognized that social inequality makes it difficult for all women to access education. Therefore, the structure of this program as well as specific principles outlined in the university education program text reveal that inclusion is an important priority. There is an emphasis on flexibility in terms of making the program affordable for *all* students. The Ryerson UMEP offers bursaries specifically for midwifery students, which is not as elitist as other UMEPs. There is also recognition of the need to have a part-time program in order to accommodate women and/or men students who may have family commitments and financial constraints.

The Ryerson UMEP text emphasizes a commitment to flexibility and inclusiveness suggesting a commitment to diversifying the student population of the program. This mission statement and the fact that the midwifery program at Ryerson has aligned itself with the Faculty of Community Services rather than the Department of Health Sciences illustrates a truly empirical/ holistic health focus of this program. The empirical /holistic health aspect of the Ryerson program includes three distinct features: there is an emphasis on women having choice and control over their own health care decisions specifically using the term “inclusiveness” in this principle (Ryerson UMEP, 2003), a significant feminist presence evidenced in text and the program itself is located

within the Faculty of Community Services at Ryerson rather than within a Health Sciences faculty. For example, “This innovative program reflects an emphasis on health promotion and supports women’s participation in their health care” (Ryerson UMEP, 2003). There is an emphasis on “public participation in the program” that allows for advocacy group and feminist involvement in the direction of the program (Ryerson University Midwifery Education Program, 2003). The only opportunity for public participation evident in the UMEP according to this text however, is one of twenty spaces on the *Advisory Committee*, reserved for a single *Consumer Representative*.

The Ryerson text also emphasizes a program which is structured so as to be “flexible” (Ryerson UMEP, 2003). This factor ultimately allows greater inclusiveness and diversity within the ranks of students. Theoretically, diversity of student base will also positively affect the diversification of the professional and client base as these students begin to practice.

The Ryerson UMEP text does utilize terms which are consistent with an *holistic* health paradigm such as “well-being”(Ryerson UMEP, 2003). The structural elements of this program are conducive to encouraging students to maintain, develop and/or adopt an *Empirical/holistic* ideology of birth. The fact that this program is part-time, offers bursaries for those in financial need specifically within this program and emphasizes support networks, programs and an advocacy group called the Association for Ryerson Midwifery Students (ARMS) is further evidence of a commitment to diversity (Ryerson, 2004). This text also makes the effort to acknowledge the work of feminist activists in making regulation and university midwifery education possible, tracing this now historical process in a “Why Ryerson?” section (Ryerson, 2004).

Attempts to diversify the midwifery professional population is expressed in various ways across the UMEPs. The values relevant to inclusion/exclusion, expressed in the Laurentian UMEP text are very sensitive to the First Nations cultural community in northern Ontario. Students are encouraged and provided with knowledge as to, “the social and cultural meanings of pregnancy and birth to women and their families, of particular importance are the values and preferences of native peoples and the many cultural communities within Ontario” (Laurentian UMEP, 2003). There is also a component of the application process which uses *Native Applicant* status and/or *Northern Ontario* applicant status as a specific criteria for admission to the Laurentian University midwifery education program. This illustrates that those who designed and implemented this program recognize the challenges faced specifically by these population groups and have made a commitment to diversifying, to this extent, the professional midwife population.

The *personal profile* aspect of the paper application for this program reveals an even deeper commitment on the part of the designers of this program to include applicants from Northern and Francophone cultural communities. The following statement certainly reveals the type of applicant who appears to be most desirable to the program designers, “keep in mind that Laurentian university is a bilingual (English and French), tri-cultural (Anglophone, Francophone, and First Nations) university. We have a strong interest in preparing practitioners for northern, rural and remote communities” (Laurentian UMEP, 2003). The subjects which an applicant is directed to address in the personal profile are: 1. ‘the personal attributes and qualities’ which make one “suited” to pursuing midwifery studies at Laurentian. 2. past/ current experiences 3. demands of

student life/coping strategies 4. advantages/challenges, of being a midwife/student in a northern, rural or remote community' (Laurentian UMEP, 2003).

The potential to avoid profiling in favour of appealing to a diverse population is an apparent feature of this text. In terms of appealing to diverse populations of women the FAQ section of this text provides evidence as to how attractive this program would be to a “diverse” group of potential women students. One included FAQ is posed as: “is there any particular “profile” that is more likely to be selected?” This question receives the answer: “Midwifery students are a very diverse group. What they have in common is a desire to be midwives. After that-well, they differ in age, in life experience, in academic background, in geographic location, culture, religion, etc. etc. Applicants who are selected generally describe themselves clearly and relate their interests, strength and experiences to being a midwifery student” (Laurentian UMEP, 2003, para.). This is a very positive response that seeks to achieve a sensitivity to the needs of a diverse population of women.

Emphasis on diversity directed at potential applicants is evidenced in the inclusion of an Aboriginal special applicant status option. This text defines Aboriginal as “Indian, Inuit, Metis, as recognized in the Constitution Act, 1982” (McMaster UMEP, 2003). The option to apply in a special applicant status requires a letter of recommendation from one’s First Nation, Band Council, Tribal Council, Treaty, Community or organizational affiliation (McMaster UMEP, 2003).

Glaring omissions which are obvious in this study include a lack of significant reference or discussion of spirituality, diversity in terms of age, sexual orientation or race in respect to either clients or students, and an avoidance of overtly political topics

such as advocacy and empowerment. Visual demographics provide evidence as to omissions in the diversity component of the UMEPs which would otherwise encourage culturally and ethnically diverse groups of students to envision themselves in the program. One of the non-quantifiable measurements included in this analysis is a discussion of the diversity that is visibly apparent in this text. Considering that only 11 percent or 2 of 18 pictures used in this text to represent those involved in the program include photographic images of visible minorities, this text is not encouragingly diverse. Despite the fact that the written text of this program claims to be committed to diversity and inclusiveness, this is not illustrated in the visual demographics. There is also a lack of discussion within the textual data of diversity and access issues for applicants who could face barriers due to their gender or sexual orientation. This fact may have an effect on the ability of students from diverse demographic backgrounds to envision themselves in this program. Despite the diversity-positive language used in the FAQ section, the designers of the Laurentian UMEP chose to also include a photograph of the student body of the midwifery program at Laurentian as a visual textual representation. This photo includes a very homogenous, young and Caucasian, demographic group of students and does not include a date or any information as to how this photo would encourage diversity in terms of student applicants. It is important to recognize that as humans we are not only influenced by the force and perspicacious nature of the words of a text but we are also moved by the images provided as demonstrative and promotional devices. As such, it is necessary to ensure textual messages and visual images included in text have a compatible impact and intent.

There is some evidence in the curriculum content to suggest that students will experience a diversity component once in the education program. Some of the texts listed a Social and Cultural Dimension of Health Course have an obvious holistic health emphasis including Hall J. (2001) *Midwifery, Mind and Spirit* and Schott J. & Butterworth-Heinemann A.H. (1996) *Religion & Childbearing in a Multiracial Society*. The course description for Health Sci 1C06- Social and Cultural Dimensions of Health provides additional support for diversity in the program. This component will have a positive impact on students perceptions of potential clients and their understandings of cross-cultural and diverse interpretations of the meanings devoted to and practices of maternity care. This course is described as focusing on,

“The understanding of individuals, social and cultural groups in relation to health and health care. Special emphasis will be placed on understanding the social and cultural meanings of pregnancy and birth to women and their families, in particular cultural communities within Ontario” (McMaster UMEP, 2003).

The required text list is similarly focused on diversity, including texts such as: Davis-Floyd R.E. (1997), *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*; Schott J. & A. Henley (1996). *Religion and Childbearing in a Multi-racial Society*; Schroff F. (1997). *The New Midwifery: Reflections on Renaissance and Regulation* (McMaster UMEP, 2003).

Although the curriculum content does not diversify the population of students and clients, additional mechanisms to recruit specific marginalized populations are an attempt in this area. The support systems and specific designations made for Native, Northern and French cultural groups of women applicants in Ontario are also evidence as to the specific challenges these women face in accessing education. The choice to make this

designation is particularly supportive of community advocacy and a feminist belief in opening up the professions to women of marginalized populations. The approach taken in the UBC UMEP text emphasizes diversity which fits very well with a holistic philosophy of midwifery. As well, this emphasis is a sign that someone has recognized that universities are not always the most open or accessible spaces for all groups of persons. It is also a recognition that midwifery as a health care option should be accessible to a diverse population. This text values this ideal to the extent that, “students will learn to see childbirth from a number of different cultural perspectives” (UBC UMEP, 2003).

While on the other hand this same UMP program at UBC over-emphasizes the need for English language proficiency skills. The UBC UMEP in particular places an emphasis on “high level communication skills”, for the stated purpose of communicating “with clients, with family members, with preceptors, with reporting to other health care professionals including physicians and nurses and in presentations or in-services to health care agencies and personnel” (UBC UMEP, 2003). This reinforcement of English language proficiency is particularly redundant highlighting an elitist component of this test. The admission process includes an English language proficiency test yet the program reinforces this requirement further within discussions of professional requirements (UBC UMEP).

One of the most striking aspects of this text in terms of valuing a holistic philosophy, is that the selection of candidates for this program is made by consensus (UBC UMEP, 2003). This is particularly interesting as consensus decision making has been an important part of the feminist philosophy and Aboriginal philosophy that contradicts the

adversarial style of those involved in biomedicine. Davis-Floyd (2004) argues that it is partially consensus –decision making which allows American midwives to maintain their counter-cultural space in the market as they modify in their own way how American midwifery is standardized and commodified for the consumer. In this sense consensus decision making by governing bodies within the midwifery regulation structure can be viewed as a successful maintenance of pre-professionalization ‘counter-cultural’ or holistic ideals.

There are certainly other changes post-professionalization vis-à-vis the market that Davis Floyd (2004) discusses which emphasize individual choice as opposed to more holistic ideas such as community or family. She argues that the commodification or selling of midwifery in the market can be more than just “selling out to capitalism”, but rather “facilitating the heterogenization of individual choice”, by offering consumers another choice (Davis-Floyd, p.245). On the other hand, there fails to be a clear consensus through this research on how choices for consumers have and continue to be constrained in the market by patriarchal capitalism, medical dominance, sexism, racism, barriers to education, poverty and so forth.

Emphasis on diversity, cultural competency, accountability, international practice and emergent crisis related to reproductive health, including HIV/AIDS, are relevant to the overall reputation of this profession. Women as clients in a holistic midwifery system would ideally have the ability to choose a culturally appropriate care provider, having access to online information about midwifery education and regulation which is reflective of diversity. Universities have a responsibility to ensure information is accurate and reflective of holistic ideals for diversity and inclusiveness. Clients as well as future

midwifery students and professionals are likely to access this information while considering choosing a midwife assisted birth and/or when considering pursuing midwifery training in Canada. The content of available program information online and in print will have the most impact on a potential applicant's determination to pursue studies in a specific UMEP.

Funding

Funding is evident in recruitment attempts within this text. The intended audience or ideal applicant appealed to by the UMEP text seems to be younger students, age 18-25, without dependents. As previously stated, there is little emphasis on requirements to have had experience attending births. Those who are currently graduating from high school or an undergraduate program seem to be particularly attractive candidates. Evidence supporting this claim is the fact that there is an extreme overemphasis on personal independence, "self-directed learning independence" as well as mobility and financial affluence which are not always possible when one has dependents (McMaster UMEP, 2003).

Economic challenges to participation in UMEP education as an exclusionary strategy is identified in particular areas within the UMEPs. An emphasis within text of the overwhelmingly challenging economic barriers existing to potential and current students serves as a reflection of the exclusionary and/or stratified nature of the patriarchal capitalist system. Within this text is an emphasis on lifestyle considerations in terms of car ownership, computer access, and the general financial burdens of this program. There is also a clear emphasis on "careful financial planning" (McMaster UMEP, 2003). These are considerations which are possible only for those women who are affluent.

There are few, if any, support systems put in place or mentioned in this text to counteract the negative impact of the economic barriers of this education program. In terms of finances, one specific section on financial assistance as well as areas warning of the exorbitant costs of this education program are also included. The bulk of these sections exist within the calendar description for the program as opposed to within the program literature itself. The financial assistance stated to be available is also limited to federal and provincial government funding through the Ontario Student Assistance (OSAP) Program.

Lifestyle Considerations for a Midwifery Student seems to be a consistently tricky section of UMEP texts across the university spectrum, as of course the program administrators want to be as honest as possible about the challenges of this program while at the same time some of the information is stated so as to be discouraging or even prohibitory. Evidence of the desire of designers to be honest is clear in the following statement, “in order to assist you with your decision to apply to the Midwifery Education Program; we have outlined some of the challenges and realities of being a student within the programme” (McMaster UMEP, 2003). The travel costs, time management challenges, computer use requirements, communication requirements, transportation ownership, vehicle maintenance requirements, as well as relocation costs are outlined. The effect of this description of the costs and challenges of this program is that it has the potential to screen out applicants who are not economically affluent. This description is prohibitory as opposed to supportive and there is a lack of information as to the resources available to those who may not meet the economic requirement for participation in this program.

Funding and allocation of financial resources is an aspect of all of the elements discussed here, yet it is key to broadening access to this profession to under-represented and marginalized groups through scholarship and bursary funds. As well within the structural dynamic of the university funding allows for a greater capacity to develop research, international practice and knowledge exchange networks, provided that advanced degree programs (PhD and MMw) are a part of the structure thus heightening the capacity within the midwifery profession for national as well as international evidence-based practice. Funding support also has the potential to alleviate financial barriers for potential applicants and students who have limited financial resources. The structure of the university and priority setting by dominant funding agencies including the federal government limits funding to disciplines with advanced professional accreditation.

Generous and dedicated funding is also important to build capacity to appeal to a diverse population of applicants, finding research with respect for cultural diversity, in diverse contexts both nationally and internationally. The amount of and sources of funding in support of research to inform midwifery practice are also reflections on the value of this professional service in the larger health care system scheme. Substantial funding allows for greater prestige and accountability within and between this health care profession and other professions within this system. Without adequate funding the occupation becomes increasingly dependent on dominant biomedical disciplines for best practice research and increasingly dependent on women as a cheap alternative source of labour in order to offer choice and options in the reproductive care division of the health care system.

Chapter 6- Implications for Future Research and Development

Conclusion

This study has provided some perspective on the complexities of incorporating a holistic midwifery philosophy into the pre-existing capitalist-patriarchal structure of the university. This incorporation is occurring in the larger context of health care system restructuring in which there is shifting of responsibility for care as the government attempts to save money, use resources more efficiently, capitalize on the paid and unpaid labour capacity of women and streamline services wherever possible. This can work in favour of midwifery, but it also has its limitations in terms of professional prestige, earnings potential, labour mobility as well as the allocation of university resources to midwifery programs. The priorities of the government funded health care system, resultant of an efficiency agenda and restructuring trends has meant shifting the responsibility for health and health care to an increasingly privatized setting implicating women as appropriate providers of cheap and unpaid care. In this context, the labour capacity of women has been identified as an efficient means of streamlining resources in health care.

The university system is implicated in a struggle for the survival of an historically marginalized and holistic midwifery knowledge as traditionally male dominated professions in the health care field have dominated the disciplines in terms of prestige, visibility and paradigmatic priority. Holistic midwifery has been challenged in terms of the university resources allocated to UMEPs, the challenge of coexistence of holism and biomedicine, challenges of diversifying client and student populations, advancement potential for students, expected remuneration in practical settings, proximity to established disciplines and faculty sharing with dominant disciplines within the institution.

The findings from this study suggest implications for further research key to the future development of university and community midwifery in Canada. I will suggest what implications this research has for the future development of university midwifery education in Canada, for advocacy groups, women who may be midwives, interested students, potential or current clients of midwifery services.

This research has the possibility to inform those involved in curriculum design and professional university midwifery education structure design as to the specific barriers and challenges affecting women when ideological struggles for ascension occur under patriarchal capitalism within the university system as a structure of regulation. The interplay between empirical/holistic health and biomedical patriarchal capitalist conceptions of care concerning pregnant and birthing women is consumed within midwifery professionalization. Out of a textual and content analysis of the prevalent themes consistent within university midwifery education in Canada, particularly relevant to women as potential applicants, professionals and clients, I would recommend that future education design committee members take into consideration the economic, cultural, material and ideological barriers and challenges facing women as the predominant applicants, professionals and clients for this profession.

One of the reasons that this study is important and relevant to consumer groups and midwifery advocates in provinces who have yet to make choices as to the education structure they desire is evident in the text of the McMaster university midwifery education program. It is stated that, “The educational programme is an integral part of the evolution of the profession of midwifery in Ontario and Canada. The programme helps create future leaders and teachers” (McMaster University Midwifery Education

Program, 2003). Students influenced by a particular institutional philosophy and structure of midwifery education will assume control of this establishing profession. The practices and choices of recent graduates and regulated professionals will establish midwifery knowledge and practice in the eyes of the public, clients, and professional partners. For this reason it is vital to determine the impact of the university midwifery education system on these professionals and potential professionals and ultimately its impact on midwifery knowledge and practice. There is an array of choices as to how to structure each specific university midwifery education program. Specific decisions have been made as to the education design, impacting the future of the midwifery profession itself. Therefore it is particularly relevant to those involved in advocating and making choices as to the future design of midwifery education in the not yet legislated provinces.

It is important to think about what may seem inconsequential, yet glaringly apparent to a potential applicant or client, including the type of language used to describe this program, the photos included in the text, as well as the audience one is aiming for when designing the content of the program description text. All of this information will have a profound impact on the type of applicant who applies to this program and the conceptions that the public and potential applicants have of midwifery and university midwifery education.

The factors contributing to the ability for women to access university midwifery education in Canada as well as the factors contributing to the ideology enculturated upon women as students are relevant features of the choice to incorporate midwifery education into the capitalist patriarchal university and health care systems. It is these factors which will ultimately impact women as potential students, women as students, women as

professionals and women as clients. Women as potential students will be impacted by the recruitment features of the university midwifery education program design and apparent preferences for types of candidates, admission procedure, ideological connection and material and economic considerations. Women as students and professionals will be impacted by the philosophical approach of the education program, the values of the program, as well as the sensitivity of the university to cultural, economic, gender, and political constraints. Women as clients in particular will be impacted through the type of care they will receive as university graduated midwives impact the cultural and practical knowledge base of this recently formed profession.

A repetitive emphasis on the economic challenges of university midwifery education programs and the list of required assets and skills makes these programs appear to be impossible to access for those of lower class status. This particular design feature illustrates a clear ignorance of the economic demands on women and the economic factors affecting women's lives. Although the program texts in question emphasize women of particular communities working within those same communities, there is a lack of similar emphasis on lower class, or less affluent women working in their own communities with similar lower class or less affluent women.

There is also evidence of professional elitism consistent within these texts as inter-professional collaboration or perhaps what could be termed, 'inter-professional accommodation' of the egos of non-midwife health care providers is emphasized. This emphasis has the likely intention of neutralizing conflict between midwifery and non-midwifery health disciplines in practice. However, accompanying this emphasis is a necessary discussion on the practical application of inter-professional collaboration as

well as the conflicts that will likely arise for clients and midwives working within a potentially rigid and conventional patriarchal health care system and university environment.

The question must be addressed as to how much collaboration or ‘accommodation’ is possible before women-centred values begin to be eroded? In this particular instance an emphasis on professional collaboration can be seen as prioritizing the needs of the midwifery system over the needs of midwifery clients and the needs of midwifery professionals. Inter-professional collaboration may be implicated in particularly unsavoury interactions between feminism and midwifery education in terms of the methodological challenges that have been faced in this project. The refusal of faculty and administrators to share program information, in the form of syllabi, as well as some particularly blatant criticism of feminist scholarship in the methodological process for this research tends to suggest that faculty who are committed to and knowledgeable of reductionist, deconstructive obstetric science, but cannot envision the spiritual, political and social ramifications of obstetric practices on a woman’s body, may do more harm than good in their enculturation of students. Therefore, an openness to diversity in student recruitment as well as an openness to feminist scholarship, which is not currently consistent throughout university midwifery education, may perhaps be positive potential features of an adjusted or developing university midwifery education program.

Whether intentional or not, access and visual features of the university midwifery education programs analyzed in this project depict an ideal candidate for university midwifery education dramatically differently from the demographics of midwives practicing previous to regulation of midwifery in Canada. A qualitative content and

textual analysis of the online midwifery and university education content directed at potential applicants and the public reveals that the preferred characteristics for an ideal candidate are: younger, financially affluent, and free of family commitments and /or well supported in those commitments. Evidence for these characteristics has been found in each of the university texts analyzed. In summary the education requirements set at high school completion suggest a younger candidate, while the physical requirements and time commitments outlined in particular instances as well as the technological competency which is assumed also fit with the characteristics of a younger applicant demographic. The financial challenges of these programs are also reiterated and reinforced to the point of deterrence. Therefore, younger students, free of the economic, emotional and time challenges of family commitments or well supported by family partners are the most promising candidates. The university midwifery education programs analyzed here in general have a tendency to favour more affluent applicants with an overemphasis on the economic challenges and asset requirements of these programs, including vehicles, computers and relocation funds, while outright banning students from part-time employment.

The only potential exception to this tendency for economic elitism and ageism is perhaps the part-time option at Ryerson which has the ability to allow students more economic flexibility in terms of lower tuition costs, part-time employment, lower child care costs and so forth. These costs are also defrayed somewhat by the bursary scheme for midwifery students, particularly at Ryerson. However, there is one bursary designated for UBC midwifery students through the College of Midwives of B.C., while

information regarding this funding availability was not at the time of data collection linked to the university program text.

In light of this evidence I would suggest creating dynamic and revolutionary methods of economic and financial support for women students attempting to access university midwifery education. One support system which could be implemented to counteract the financial challenges and access issues faced by particular demographic groups would be providing a stipend for clinical placements, similar to trade programs. In order to better support women students and to determine the reproductive care needs of communities of women, consultations should be conducted with women's community groups, including single mothers, African Canadian women, First Nations and Aboriginal women, Francophone women, and immigrant women, at the every least in order to determine the feasibility and/or desirability for an entrance component to the professional university education program specifically for women students facing additional barriers to professional education.

University midwifery education should be assessed with a specific focus on, but not limited to, gender, race and class as additional challenges to women successfully accessing professional midwifery education. Not only do these barriers represent challenges to accessing education for specific communities of women but also represent the barriers existing in particular communities for women who could benefit from accessing midwifery services which are culturally sensitive, culturally reflective and provided by representative women within those communities.

These particular findings suggest that it would be prudent for groups considering implementing university midwifery education in the not-yet- regulated or legislated

provinces to consider the oppressive economic and social features of patriarchal capitalism which have the potential to limit women's access to and success in university midwifery education. University education design has been proven to impact the cultural values, pay scales, status, demographics and practices of women as midwifery professionals which can potentially impact the choices of and care received by women as clients.

In order to contradict oppressive features of patriarchal capitalism including efficiency standards, cost-saving measures, biomedical hegemony, patriarchal and/or exclusivist language, exclusion from access to university education, and so forth (all of which have the potential to negatively impact a holistic midwifery philosophy and practice through the university system), it would be empowering to design or adjust university midwifery education to meet the needs of a diverse population of women. Women, as the most likely demographic group to both attempt to access services from this professional field as well as to attempt to access education in this professional field, face specific challenges to success and empowerment which can be overcome by designing support systems, cultural and social demographic sensitivity schemes, utilizing women-centred and feminist language in program literature as well as an explicit openness to diversity.

This analysis has shown that the support systems necessary as core features of a university midwifery education program are financial supports in order to avoid exclusion on the basis of class, gender, sexual identity, age, ability and race. Working as a midwife and accessing midwifery services remains a socially radical choice. This choice has been mediated by at least a century of obstetric, hospital-oriented birthing practice, legitimization of unnecessary use of technology and associated interventions

and propaganda depicting the medicalized maternity care as the only safe maternity care. This phenomenon remains particularly evident in the not-yet legislated or regulated provinces. The length of time between the regulation of midwifery in Ontario, in 1993, and the failure to establish regulated midwifery across the country is evidence of the regionalized power of medical authorities and obstetric practitioners as well as evidence of an unchallenged patriarchal capitalist and socially conservative polity.

Not only are support systems relevant to counteracting the potentially negative impact of patriarchal capitalism and biomedicine on midwifery within the university and health care systems, language usage also send a vivid message as to the goals, values and affiliations of university midwifery education program. The use of patriarchal positivist and biomedical language has the potential to alienate potential applicants whose belief systems or orientation tends to have more in common with an historically established holistic and empirical midwifery philosophy and practice. Preservation of this historically established and accepted practice of a holistic and empowering midwifery philosophy and practice in Canada is vital to counteracting the potentially negative impact of a patriarchal capitalist and biomedical university and health care system on women's birthing care. The potential negative effects of this system, which are complicit with the values of biomedicine and patriarchal capitalism, are visible in the narratives of women who have experienced medicalized childbirth as well as in the research of feminists who have contradicted truth claims made by practitioners and supporters of obstetric science. Women have been brutalized, demeaned and disempowered in their interactions and bodily experiences within the obstetric field of the health care system in Canada.

A midwifery system engaging in holistic and empowering practice has the potential to counteract the negative impact that Obstetric practice has had on women, children and families for over a century in Canada. It is necessary however, to clearly recognize the tools with which obstetric science has come to occupy its current position in order to avoid similar pitfalls. Aims at achieving efficiency and precision production are precisely the type of elements in language, education and practice which are demonstrative of a crisis in obstetric science.

Subversive Strategies and Future Research Potential

One of the most fascinating discoveries in the methodological research process in this study has been a discovery of the course texts considered necessary and relevant to the education and practice of midwifery. This is fascinating as this data provides a great possibility for future research. The discovery of what is considered valid knowledge, whose theories are considered part of the philosophical approach to midwifery in Canada, whether social historical midwifery traditions are considered relevant for study or not and how the use of texts differs across the spectrum of universities are thriving questions to be answered in a potential future research study. The implications of such a study may inform interested organizations as to whom is writing midwifery education texts, and the potential need or possibility for midwives performing their own research which informs university midwifery education and practice in Canada. A needs assessment in terms of creating Masters degree, and PhD programs for midwifery is a potential outcome of this future research possibility. The determination of an apparent need for a Canadian midwife contribution of knowledge and study in terms of the texts available is relevant and likely in this context. The specific texts currently being used in various courses at

McMaster and UBC university midwifery education programs range from feminist publications such as, Davis-Floyd, R. Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives, Schott. Religion and Childbearing in a Multiracial Society., Schroff, F. The New Midwifery: Reflections on Renaissance and Regulation., Johnson, J. Taylor W. Skills for Midwifery Practice., Morrison D., Being Pregnant., Mander. Failure to Progress: the contraction of the Midwifery Profession., and Palmer GH. The Politics of Breastfeeding. Bennet V.R. & Brown, L.K. Myles Textbook For Midwives 14th Ed. , to biomedical obstetric science publications including, Cunningham, F.G. Williams Obstetrics., Enkin, Marn, Kierse, Renfrew, Nielson. Guide to Effective Care in Pregnancy and Childbirth, and Thomas, C. Taber's Cyclopedic Medical Dictionary.

However, as the only *complete* text list is for McMaster University and UBC midwifery course offerings, it would be unfair to make cross-comparisons using this information in the present analysis. It would be interesting to proceed with a feminist linguistic analysis of all course texts listed and courseware for all of the university midwifery education programs in Canada, provided careful negotiation and cooperation from faculty made complete course text lists available for all UMEPs.

A comparison of the development process and content of Aboriginal Midwifery Education Programs and pre-existing University Midwifery Education Programs in Canada would also be an opportunity for research which could extend from this paper. The choices which have been made specific to education design and structure for the purpose of providing culturally appropriate birthing care in Aboriginal Communities compared with the choices made outside of Aboriginal communities in the non-designated University Midwifery Education models, would enable a discussion of the

opportunity for comprehensive birthing care in Canada, the advantages and disadvantages of particular education models and pedagogy, as well the limitations and/or opportunities of each model for national/ international practice.

In conclusion, UMEPs can and should develop to better reflect holistic intentions, values of diversity and sensitivity to the material reality of the lives of women as the most likely potential applicants and future midwifery professionals and/or clients. The profit-oriented and efficiency based structure of the university is not conducive to openness, inclusive or holistic program design. The hierarchical department structure provides the means to obscure and undermine the development and progress of the profession of midwifery within the university. The male-dominated professions dominate through greater funding opportunities, numbers, degree opportunities, future earnings potential and employment mobility.

The admissions process for UMEPs in Canada is hierarchical and perpetuates gender, race and class disparities in the professions as well as failing to address accessibility to midwifery as a maternity care option in marginalized communities. The setup for professional practice that is existent in the UMEPs reinforces a tiered system of health care and professional membership and legitimizes this model of education through the university as an institution. The implications of the UMEP model for the development and survival of the midwifery profession is of key importance. This model has become the standard and will dictate the demographic composition and practices of future midwifery professionals.

Holistic midwifery education and practice is a key solution to the problems identified with medicalization of childbirth. In order to enable this solution, the findings of this

study suggest that UMEPs need to be developed using a gender and diversity perspective which is sensitive to the cultural, geographic, and socioeconomic context of the communities surrounding the program. I would recommend that future education design committees take into consideration the economic, cultural, material and ideological barriers and challenges facing women as the predominant applicants, professionals and clients of midwifery.

The university has placed pressure on the holistic components of midwifery knowledge within the UMEPs to conform to efficiency standards, biomedical science degree components, masculine professional characteristics, and shared faculty and curriculum components of dominant health sciences disciplines. The counter strategies within the UMEPs to assert independence of women's holistic midwifery education and value for women professionals are evidenced in the stated intentions to establish advanced professional degrees for midwifery, independent funding, continuity of care, and community inclusion in both education and practice components. The priority of the Ontario consortium to include education and practice components for indigenous, rural, northern and urban communities is a reflection of holistic intentions for inclusion. The consortium structure provides some opportunity to ensure cultural diversity and inclusion in recruitment strategies, yet cultural competency and accountability in UMEPs overall remains a question for further study. Incorporating the traditional practices of pre-legislation holistic midwifery into UMEP models is key to establishing options in maternity care as a response to the negative features of medicalization and the obstetric monopoly on maternity care. In the context of the future development of existing and

new UMEPs the integration of traditional holistic midwifery knowledge into UMEPs is central to providing a legitimate alternative to obstetric maternity care for women.

McMaster University Crest

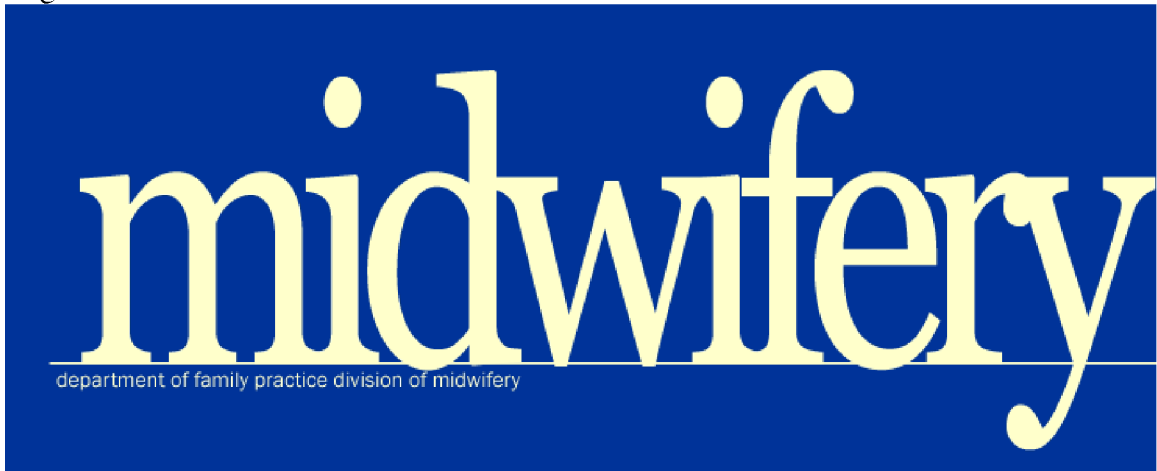


Laurentian UMEP Photo Collection





UBC General
Logo



Ryerson Midwifery



Appendix II

Code Categories:

Advocacy

- empowerment
- equal
- egalitarian
- autonomy (mous)
- advocacy
- enlightenment

Community

- family
- community
- cultural diversity
- group
- solidarity
- we

Economic

- wealth
- money
- car/transportation
- rent
- housing
- financial/ support
- capital

Elite

- on-call
- professional
- specialty (ization)

Empirical Health or Holistic Health

- well-being
- hands-on
- client
- baby
- normal
- spiritual
- mental health
- empirical

Individual

- he
- she
- I

Omissions

- what is definitively left out of the text

Power

- control
- authority
- mastery
- dominate (ion)
- power
- supremacy

Scientific Rationality

- pathology (ogical)
- illness
- disease
- patient
- neonate
- intervention
- abnormal
- sick (ness)
- management
- efficiency

Symbol

- feminist
- biomedicine

Examples:



SEATTLE
MIDWIFERY
SCHOOL
EDUCATION
ADVOCACY
EMPOWERMENT



caduceus 1 medical symbol

Technology

- tools
- measurement
- testing
- “body as machine”
- “body processes”
- EFM- electronic fetal monitoring
- IV
- episiotomy (KWIC)
- C-section, VBAC (KWIC)

Tone

- education/ academic
- professional
- empowerment
- advocacy

Visual (character demographics)

- age
- ethnic background

Content Analysis Coding Manual-Thematic Areas

Notation Method 1; P for positive N for Negative

Feminist Political Consciousness

Community: This category is designed to measure the level of commitment to community in midwifery education. The theme community encompasses an emphasis on *family, support persons, relationships, partnerships* and so forth. Using phrases such as *we* and *relationship* or midwives providing *choices* in terms of a *partnership* or *friendship* denotes the presence of this theme. A political commitment to preserving community relationships also means expanding beyond the authoritative relationship that Physicians favour developing with their clients. This theme thus also includes associated terms such as *equality, empowerment* and *enabling*.

Example: “it is important for the woman in labour to have her ‘*support persons*’ with her” or “*we value the involvement of the whole ‘family’*”

Guiding terms: *family; community; group; solidarity; we; support persons; relationship* etc.

Empirical Health or Holistic Health: This theme can be identified by the normalcy of the discourse used as well as the presence of the philosophy that birth is a normal physiologic process that encompasses the mind, body and spirit. This philosophy includes the belief that women have the strength within themselves to have a meaningful, powerful and positive birthing experience. This philosophy also includes a desire to reduce the amount of intervention and technology used in childbirth, therefore allowing women to have a birthing experience with less intervention and less birth trauma.

Example: “Pregnancy is a healthy time in a woman’s life and is a normal part of the life-cycle.”

Word Associations: *well-being; hands-on; client; baby; normal; spiritual; mental health; empirical; emotional health; holistic; natural; cultural; healthy; life-cycle, birthing babies, catching babies, whole person, etc.*

Patriarchal Capitalism/Exclusion: Exclusionary strategies are a means of social stratification by which masculinist values of individualism and competition are reinforced. Exclusionary strategies work by systematically, ideologically and directly excluding women from access to a social institution. Exclusionary strategies can come in the form of making requirements which make it overly difficult or unwelcome for single mothers, black women, aboriginal women, muslim women or lesbian women, for example to enter into an education program and profession. The categories *Elite, Economic* and *Individual* will measure the presence of this theme.

Economic: Economic exclusion is measure by a focus on overemphasis on the amount of capital or financial support needed to be successful in this program.

Guiding Terms: the presence of this theme will be signified by such terms as *wealth, money; car/transportation; rent; housing; financial/support; capital; remuneration* and so forth.

Elite: Elitism is measured in terms of the experience, education or class background desired of the applicants to this program as well as social status. For example, single parent are likely considered to be low status applicants, therefore requirements will likely make this lifestyle inconsistent with success in this program.

Guiding terms: The theme elitism can be identified by a demand for midwifery students to be *on-call 24 hours, rational* as opposed to *spiritual*, dressed in *corporate style* as opposed to *hippie style*, a reverence for a “corporate culture image” requiring *white midwife* mothers to put their work before their children and families as *specialists*.

Individual: This category is included in order to make a comparison to the family/ community emphasis of the data as well as to document the degree of importance placed on individualism as part of patriarchal-capitalism.

Example: If a woman wants to have a midwife assisted birth she will have to fit certain criteria. (As opposed to “we will discuss the approach to birth that would be best for her family.)

Word Associations: *he; she; I; individual; each woman.*

Power: Power is included as a theme in this content analysis in order to recognize the prevalence of a patriarchal paradigm as well as again determining the relevance of biomedicine in the way that the midwifery program is presented. Biomedicine is premised on the idea of control through rationality and separation. (Denzin et al, 2000) This situation is idealized in the physician-patient relationship which is one of differentiated power and control. Guiding terms to identify the presence of this theme are *control, mastery, authority, domination, power, supremacy.*

Example: “The midwife should be in control of the birthing situation at all times.”

Biomedicine/ Science

Scientific Rationality : A discourse of *pathology* signifies the presence of a biomedical paradigm which relies on the principles of scientific rationality. The use of language such as *sick, disease, illness, condition, unwell, 'body as machine', symptomatic* and so forth, will point to the presence of this theme. Another concept which comes under this theme is the idea of system language and childbirth as needing *scientific management*. The guiding terms *illness, neonate, disease, intervention, abnormal, sick (ness), management, timing (hours etc), measurement, efficiency and patient* all fit within this discourse.

Example: “The midwife should expect the worst because pathology is more common than not.” Or “Pregnancy is a complicated medical condition.”

Medical Technology: Technology which has been developed to promote efficiency as opposed to making birth a more empowering experience for women will be noted by this theme. Technologies, techniques and ideologies which are associated with a biomedical model of care are *instruments, testing, “body as machine”, “body processes”, mandatory IVs, mandatory episiotomy, C-section (mandatory C-section for VBAC), induction, pitocin, amniotomy, forceps, anesthesia,* and so forth.

Example: “Intra-venous fluids are very helpful and are mandatory protocol.”

Diversity: It is important to examine the diversity of this program, as diversification is contrary to the social stratification efforts of patriarchal-capitalism. Diversity will be measured by the category Visual Demographics.

Visual Demographics: The visual demographics of the pictures provided to the audience of this text will be examined in order to record the racial and/or ethnic background, age, sexual orientation and physical abilities of the students.

Determinants

Symbol: All symbols within the text will be recorded and their meaning and history will be investigated. These symbols will be analyzed on the basis of their association with a particular history. Symbols, may have been taken from biomedical sources, medieval midwifery sources or feminist sources. This information will be noted.

Omissions: What is definitively left out of this text? For example is there a noticeable omission of references to diversity and/or spirituality or VBAC? Any of the word associations that are not mentioned will be added to this category.

Tone: The tone of the overall text for each university will also be recorded. The text will be coded according to the following: educational/academic; political; feminist; or scientific. The criteria for coding this category is based on an overall emphasis and general impression. The tone of the entire text for the program information of each university will be determined.

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