OBSTRUCTED LABOUR:
RACE AND GENDER IN THE RE-EMERGENCE OF MIDWIFERY IN ONTARIO

by

Sheryl Nestel

A thesis submitted in conformity with the requirements
for the degree of Doctor of Philosophy
Department of Sociology and Equity Studies in Education
Ontario Institute for Studies in Education of the
University of Toronto

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Obstructed labour: Race and gender in the re-emergence of midwifery in Ontario

Doctor of Philosophy, 2000 - Sheryl Nestel, Department of Sociology and Equity Studies, Ontario Institute for Studies in Education of the University of Toronto

Abstract

Responding to the admonition of numerous scholars that contemporary social and political formations in the West must be viewed in relation to histories of colonialism and contemporary relations of neo-colonialism, this study undertakes a contrapuntal reading of the production of white First World women as acting political subjects through their material and discursive relationship to Third World women and immigrant women of colour. Focused on a very specific feminist initiative - the movement to revive the practice of midwifery in Ontario, Canada - this research untangles the paradox represented by the conspicuous under-representation, relative to their numbers in the Ontario population, of immigrant midwives of colour in the ranks of the province's newly-legalized midwifery profession. Moving from an examination of (global) macroprocesses of power, to an explication of institutional forms of racist exclusion and concluding with an examination of microexpressions of racism, unequal relations between women are shown to underlie the successful challenge to patriarchal medical authority mounted by provincial midwifery activists.

Through the examination of substantial empirical evidence, including state documents, movement publications, and data derived from forty-seven interviews with practising and non-practising midwives, this research traces how racist
exclusion operated to construct the Ontario midwifery movement and the bureaucratic structures which superceded it, as normatively white spaces. The (re)production of racially exclusive spaces can be seen to result from both deliberate choices and seemingly-benign inertias, neither of which are necessarily linked to an intention to enact racism. Rather, it is argued, racist exclusion must be understood as unavoidable when race-blind epistemologies guide actions. The epistemological stance within which the Ontario midwifery initiative was locked dictated that women were oppressed in similar ways and that race and other critical dimensions of social identity only complicated a foundational gender oppression. Such a stance does not require that hierarchical relations among women be taken into account. This research illustrates that the failure to inquire after the differential impact of feminist political strategies on women positioned unequally in the social field dooms those seeking to address the "universal needs of women" to reproducing global and local structures of domination and subordination.
Acknowledgements

I am indebted to many people for their support. My community of friends at OISE/UT, many of them activist/scholars of dedication and accomplishment, provided a rich and supportive environment in which to be a student. Thanks especially to Yvonne Bobb-Smith, Jane Ku, Eve Haque, Nuzhat Amin, Janice Hladki, Teresa Macias, Ruth Groff, and Victoria Littman. Zoe Newman and Doreen Fumia have always been there to listen, read, critique and celebrate, all in good measure. Esther Geva has provided sound academic advice, encouragement and Shabbat dinner. Friends outside of academia have offered unerring support, happy distraction and intelligent feedback. Thanks especially to Rhonda Chorney, Frumie Diamond, Cheryl Gaster, Isabella Meltz, Anona Zimerman, Jaye Rosen and Rabbi Liz Bolton. Thanks also to Claire Pizer for helping me live through this.

Thanks to Ivy Bourgeault for writing the thesis that provided a road map to the re-emergence of midwifery and for many hours of good talk. Christine Sternberg, RM has been a sounding board, a critical reader and walking proof that resistance is always possible. Sara Booth has been a mainstay throughout this project, urging me on through moments of painful uncertainty.

Every student should be entitled to a committee like the one that guided me. Kari Dehli has maintained a constant interest in my work and urged me to take it in new directions. Ruth Roach Pierson is a scholar to be emulated, a steady ally and a joyful presence. She has mentored me and nurtured me in innumerable ways and I treasure our friendship. My supervisor, Sherene Razack, is a woman of extraordinary generosity, acute intelligence and keen observation. All of us who work and celebrate with her derive enormous benefit from her finely honed sense of justice and from her ability recognize what is really important in life. In the eight years that I have known and worked with her she has never let me down. If there are any glittering moments in this thesis, it is her light that they are reflecting.
My dear friends Donna Jeffery, Barbara Heron and Carol Schick have provided emotional and intellectual sustenance with unstinting dedication; I am privileged to receive the bounty of their friendship. My husband Sydney Nestel has remained unflappable throughout these years of trying to balance work, graduate education and family. He is my best critic and most steadfast support and I thank him with all my heart.

And finally, Brenda Hyatali, a woman of extraordinary courage, optimism and kindness made the conceptualization and completion of this thesis possible and I dedicate it to her.
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Chapter One

Introduction

The invented text is produced by a subject constituted in and through the same contingent social practices of those for whom the critique is performed. Hence, it exists as a fragment in its own right. The goal, in this process is not to produce a master text encompassing all known and possible conditions of its making. Rather, the goal is to pull together those fragments whose intersection in real lives has meaning for social actors -- meaning that confines them as either subjects empowered to become citizens or social actors with a potential to enact new relations of power. As such, the invented text functions to enable historicized subjects to alter the conditions of their lived experience.

Raymie E. McKerrow (1993)
"Critical Rhetoric and the Possibility of the Subject."

White women can no longer see ourselves as innocent of the domination of others due to our oppression by men. If for no other reason, this realization should make race a matter of urgency for all those interested in gendering.

Jane Flax (1993)
Disputed Subjects

Key research questions

This research is concerned with the ways that white feminist projects reproduce racism at the intersections of global and local relations of power. Focused on a very specific feminist initiative - the movement to revive the practice of midwifery in Ontario, Canada - this study pivots on several key questions: (1) How have legacies of colonialism, including an increasingly globalized economy, structured the conditions under which white women in the West have begun to transform their relationship to patriarchal forms of social organization? (2) How are feminist projects which make claims on the state regulated in ways that reproduce racial dominance through legal and institutional
means?, and (3) How are practices of racist exclusion effected in such projects through the privileging of white cultural competencies and through everyday acts and utterances which go unrecognized by members of dominant groups as racialized forms of power?

The research context

Many births throughout the world are attended by midwives trained in a variety of ways which range from traditional apprenticeship models to those grounded in Western medical and obstetrical knowledge, to models which borrow liberally or judiciously from each of these. In North America, however, physicians have maintained a century-old monopoly over the provision of care to pregnant and birthing women. The medical model within which physician care has been offered has historically regarded human parturition as an inherently risky and habitually pathological process. While childbirth reform activists have long argued that many standard obstetrical procedures are both inhumane and clinically ineffectual, such practices have been slow to disappear (Enkin, Keirse, & Chalmers, 1995; Kaczorowski, Levitt, Hanvey, Avard, & Chance, 1998). One response to the medicalization of childbirth in North America has been the revival over the last thirty years of the practice of community-based midwifery which is characterized by the provision of services to birthing women outside of conventional medical institutions. While the practice of “lay midwifery”¹ was, with

¹ The terminology surrounding the classification of midwives is complex, and shifts depending on geographical and temporal location. The use of the term "lay" midwife here is meant to invoke the context during which that term was current. It is meant to identify midwives who may have been trained in formal training programs and through empirical means, but who are not affiliated with nurse-midwifery or direct-entry midwifery training in medical institutions. Its use has, however, for some time been considered to be disrespectful of the considerable expertise of those midwifery practitioners educated outside of medical institutions and it has come to be replaced by the designation "direct-entry" midwife, a term I employ throughout much of this thesis. Direct-entry midwifery in Canada and the U.S. largely refers to midwives who are institutionally-educated but who have not been required to undergo prior nursing training. For a discussion of the different usages of classificatory terms for midwives see Rooks, J.P. (1997). Midwifery and childbirth in America. Philadelphia: Temple University Press, p. 8.
a few exceptions, largely eradicated in Canada early in the 20th century, in the 1970s it began to be embraced by some middle-class white women (Fynes, 1994). These empirically-trained midwives acquired the skills necessary to the provision of reproductive care within a framework which promoted informed choice in the birthing process, appropriate use of technology, and the recognition of birth as a psycho-social as well as a physiological event. Central to this form of midwifery has been the belief that while choice of birthplace is a fundamental right, a woman's home is the birthing venue most likely to provide the optimum conditions for the achievement of humanized childbirth. Decidedly white and middle class, the midwifery movement in Ontario grew from these roots while incorporating aspects of feminist and traditional women's health movements, counterculture lifestyle practices, and long-standing efforts by white, British-trained midwives to have their skills recognised within the health care system. By the mid-1980s, midwifery shifted from a loosely-organized social movement to a tightly-orchestrated political project which systematically pursued state regulation and funding for the revitalized profession.

The first Canadian legislation establishing midwifery as a state-regulated and state-funded health profession was passed into law in Ontario on December 31, 1993. Hailed as a "victory for women" (Martin, D., 1992, p. 417), the enactment of midwifery legislation in Ontario has been viewed as a triumph of grassroots feminist organizing and as part of the ongoing struggle for gender equity and female reproductive autonomy. There can be no doubt that the midwifery model of practice as developed in Ontario has much to recommend it over a medical model of maternity care that has been documented as consistently overly-interventive and frequently misogynistic (Davis-Floyd, 1992; Rothman, 1991; Martin, E., 1992; Oakley, 1984; Scully, 1994). However, the benefits resulting from the legalization of midwifery have been very unevenly distributed. Indeed, the Ontario midwifery movement is indistinguishable from many other Western feminist projects of the last three decades which have claimed to seek gains for all women but which have, in fact, produced economic and socio-political rewards primarily for white women.

The role of law in creating racialized subjects has been crucial in this process. While the legislation itself distinguishes between, and creates the categories of, legal and illegal midwives, the relatively unmarked character of these classifications has been transformed in the process through which the Midwifery Act has been implemented. Those empowered by law to develop the disciplinary framework of the profession made decisions early on which served to attach racialized bodies to the "illegal" category. In the province of Ontario, immigrant midwives of colour who possess considerable professional skills, competencies

3 Medical misogyny must certainly be understood to have significant racial dimensions and I do not wish to imply otherwise. What I am attempting to characterize here is how childbirth reform has been couched primarily in gender terms. For a rare exception see Waite, G. (1993). Childbirth, lay institution building, and health policy: The Traditional Childbearing Group, Inc. of Boston in a historical context. In B. Blair & S. E. Cayleff, (Eds.), Wings of gauze: Women of color and the experience of health and illness. Detroit, MI: Wayne State University Press.

4 The term "women of colour" in its various forms is a problematic, but indispensable one. While this phrase represents an act of self-definition and resistance to racist terminology by groups which have been subjected to racialized definitions and
and credentials have found themselves largely excluded from access to the newly legalized midwifery profession. While in the period immediately following legalization, racialized minority women represented nearly half of the hundreds of women who had inquired about having their prior midwifery training recognized in the province, it appears that they currently comprise just 10% of registered midwives in the province. In this thesis, I will attempt to demonstrate that the devaluing of non-European experience, credentials and training, the deployment of inferiorizing discourses surrounding "immigrant women," a tenacious adherence to forms of feminist politics which privilege the skills and interests of white women, and numerous acts of "everyday racism" (Essed, 1991) have converged to create a predominantly white midwifery profession in a geographic space whose multiracial character is one of its most frequently invoked social signifiers.

In Ontario, a place significantly shaped in the last three decades by postcolonial migrations, these racially exclusionary dynamics reflect not only histories of colonialism, but contemporary relations of domination where the local and the global are so thoroughly intertwined that their ontological positioning as oppositional categories can no longer be defended (Said, 1993; Stoler, 1995).

exclusions, it nonetheless fails to capture the multiple subject positions occupied by these women, eliding axes of difference along which women who share racialized status are positioned. In some senses the term represents the inadequacy of modernist language in representing multiply constituted identities, a condition which Ali Rattansi (1994) has called "a perennial excess of things over words" (p. 59).

5The College of Midwives of Ontario has not collected statistics on the ethnic/racial group identification of its members. Consequently, any claims about the numbers of racialized minority women who are registered midwives represent estimates. In June, 2000, I asked four individuals who are intimately involved with midwifery in Ontario to review the most recent lists of registered midwives issued by both the Association of Ontario Midwives and the College of Midwives of Ontario. These women were able to identify 17 women of colour and 2 Aboriginal women among approximately 180 midwives listed as registered in the province. Just over 10% of registered midwives in the province were identified by the four informants as women of colour or Aboriginal women. Three of the women of colour identified were known not to be practicing. The estimates indicated that slightly more than half of those identified as women of colour were graduates of the CMO's Prior Learning and Experience Assessment program. While I must emphasize that this is not an official accounting, this estimate is likely highly accurate.
Liberatory movements are not exempt from enmeshment in such neo-colonial processes and the movement to legalize midwifery in Ontario offers a practically paradigmatic example of this. Like many feminist projects of the 19th and 20th centuries, it occupies a "historically imperial location" (Burton, 1994, p. 1), deriving material and discursive benefit from an engagement with Third World women. While midwifery policies and everyday practices in the province have discouraged the entry of immigrant women of colour into the lucrative and prestigious profession, travel to the Third World and access to the bodies of birthing women there have played an indispensable role in the legalization of midwifery by helping white midwives achieve professional knowledge and status. These travels are rendered benign and even benevolent through epistemological claims about women's shared identity, an alchemical process in which "Third World" space and those who occupy it come to constitute a commodity for First World's women's consumption and social advancement.

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6 The use of the term "Third World" continues to demand explication on the parts of those who use it. While acknowledging the assertion of Theo David Goldberg (1993) that "Third World" is one of three "conceptual schemata hegemonic in the production of contemporary racialized knowledge that now define and order popular conceptions of people racially conceived" (p. 155) and that of Ella Shohat and Robert Stam (1994) that First World/Third World struggles take place not only between nations but also within them. I will adopt this term here as a provisional one. As Shohat and Stam argue, "Third World" can signal "both the dumb inertia of neocolonialism and the energizing collectivity of radical critique but with the caveat that the term obscures fundamental issues of race, class, gender and culture" (p. 26).

7 While in the pre-legislation period, white midwives and midwifery aspirants travelled with some frequency to Third World sites seeking midwifery experience, in recent years, First Nations midwives from Ontario have also pursued midwifery training in clinics on the Texas/Mexico border, choosing to circumvent the provincial midwifery education and certification programs. While such a development raises complex and difficult questions about the hierarchical relationships among marginalized First World and Third World women, any explication of this particular set of relations is regrettably beyond the scope of this thesis.
Despite the legalization of the profession in a number of Canadian provinces,\(^8\) midwifery continues to be perceived as an archaic and discredited form of maternity care or as a primitive practice surviving only in "underdeveloped" regions. Indeed, as one recent study shows, the Canadian Medical Association Journal only ceased publishing articles which represented midwives as atavistic relics after midwifery legislation was passed in Ontario (Winkup, 1998). Those seeking legal status and state funding for midwifery in Ontario then were faced with the task of constructing a politically efficacious subjectivity in a socio-political context where physicians regarded midwives with more than a modicum of ambivalence.\(^9\) Such ambivalence was not limited to doctors. Vilified for much of the last century, the midwife has been portrayed as a degenerate and unmistakably racialized figure in both professional medical journals and popular writing (women's magazines, pregnancy advice literature, etc.) where her primitive ministerings were contrasted with the "advances" of medical science. In order for the midwifery project to achieve broad-based political support, the midwife needed to be reconfigured in the public imagination as respectable, i.e., knowledgeable, modern, educated and Canadian/white. Women whose identities endangered this reconfiguration found themselves largely evicted from the grounds of midwifery subjecthood.

The research design

As Beverly Skeggs (1997) notes, "methodology is itself theory" (p. 17), and the design of this project reflects a number of theoretical/methodological commitments. Responding to the admonition of numerous scholars, (Said, 1993;  

\(^8\) Midwifery is currently regulated by legislation in the following provinces: British Columbia, Alberta, Saskatchewan, Manitoba, Quebec and Ontario.

\(^9\) As I will demonstrate in Chapter Four, unlike physicians in the rest of the country, Ontario's doctors did not oppose legalized midwifery, but they did stridently oppose home birth, a practice that midwives considered key to autonomous midwifery practice and one which they refused to abandon under the proposed legislation.
Morrison, 1993; Stoler, 1995) that contemporary social and political formations in
the West must be viewed in relation to histories of colonialism and contemporary
relations of neo-colonialism, this study is structured as a contrapuntal reading of
the production of white women as acting political subjects through their material
and discursive relationship to Third World women/immigrant women of colour.
Moving from an examination of the macroprocesses of power to an explication of
institutional forms of racist exclusion and concluding with an examination of
microexpressions of racism, this thesis attempts to demonstrate how unequal
relations between women underlay the successful challenge to patriarchal
medical authority mounted by midwifery activists in the province.

While I devote many pages of this thesis to theory, I have attempted to
merge my theoretical concerns with my empirical (but not empiricist) impulses
(Scheper-Hughes, 1992, p. 23). In the course of this research, hundreds of
Ontario midwifery movement and government documents and publications linked
to the development of midwifery between 1981 and 1998 have been examined
and analyzed. These documents were supplemented with interviews conducted
with white members of the Task Force on the Implementation of Midwifery (the
first government body established to shape entry to the new profession in the
province), with white members of the Interim Regulatory Council on Midwifery
(the successor body which formulated regulatory policies prior to legalization),
and with officials of the College of Midwives of Ontario. I have interviewed
relatively few white women who participated at the policy-making level in either
midwifery organizations or government-appointed bodies related to the re-
emergence of the profession inasmuch as the ideologies and political positions of
such women have been widely circulated in the documents reviewed. I have
examined these not only to locate the decisions which have effected exclusions,
but also in order to uncover the "discursive repertoires" evident in the texts, as
well as in the collected narratives, which demonstrate the many ways in which
racist exclusion is named, justified and rationalized as something other than
subordination (Wetherell & Potter, 1992, p. 2).
The global and institutional processes alluded to above link inextricably with numerous microprocesses that have functioned to differentiate "respectable" midwives from those practitioners deemed unworthy of inclusion in the new profession. The contrapuntal methodology mentioned above, and which will be explored in greater detail in the next chapter, is a useful tool for showing how the respectability of some midwives has been produced through comparison to a range of undesirable midwifery subjects. These processes have been examined in this thesis through my research with three groups: white midwives who defined themselves as socially, politically or ideologically estranged from the central group of midwives who orchestrated much of the legalization project; students in the provincial Midwifery Education Program who have found themselves being bent towards a normative identity as they are groomed to be "ambassadors of the profession;" and immigrant midwives of colour who have found themselves largely excluded from practice in the province.

While this project has been designed as one which researches "up," focusing its inquiry on "the exercise and mechanisms of white privilege and power" (Maynard, 1994, p. 21), such research could easily circumvent the destabilizing and sometimes violent encounters with white dominance that marginalized people negotiate on a daily basis. If, as Teun van Dijk (1993a) has argued, official norms of anti-discrimination and multiculturalism guarantee that whites do not normally admit to discriminatory practices, then these must be accessed through the accounts of the racialized minority people upon whom such practices have impacted. Counterposing an analysis of racist exclusion with testimonies about the impact of these practices is critical to a contrapuntal reading of the context I have described. Such an intervention is also necessary if a self-referential engagement with naming and defining whiteness is to be avoided. If, as Aida Hurtado and Abigail J. Stewart (1997) have observed, "people of Color are experts about whiteness, which we have learned whites most emphatically are not" (p. 308), then their descriptions and testimonies are
critical to any attempt to describe how white domination works. Consequently, my analysis in this thesis draws heavily upon the narratives of 23 women of colour, including midwifery students, midwifery board members and immigrant midwives. Jane Jacobs (1996) acknowledges the risks of presenting and interpreting the words of "those marked as Other in the imperial imagination," admitting that such "intercultural interpretation" is never innocent and that researchers cannot simply divest themselves of their dominant positioning in a "not-so-fraying imperialist world" (p. 24). However, argues Jacobs, an anti-colonial project which does not take into consideration "how colonialism encounters and is transformed by those it seeks to dominate...might simply work to embellish the core" (p. 24).

**Why critique? Why race?**

In a climate of political backlash against policies and projects aimed at the achievement of social equity\(^{10}\) (and I count the Ontario midwifery movement among these), what is to be achieved by critiquing their aims and practices? I would respond to this by arguing that feminist and other liberatory practices and agendas are formulated and deployed in relation to local contexts of struggle. Their liberatory effects are never guaranteed, but are always contingent on how such movements interface with historical and contemporary relations of domination and subordination (Kaplan & Grewal, 1999). Feminist postmodern theorizing has been exceedingly useful in helping us to understand this contingent positioning by explaining that subjects always occupy social locations which are both multiple and contradictory, that women, for example, can be simultaneously oppressed by gender and privileged by race, class, sexuality, religion or any other of a number of social identities. As Susan Stanford Friedman (1998) has argued, "[I]dentify depends on a point of reference: as that point moves nomadically, so do the contours of identity, particularly as they relate

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to the structures of power" (p. 22). It is critique which allows us to see this relationality by exposing the "historical limits of our knowledge and subjectivities and...the concealed material relations of power that produce them" (Ebert, 1996, p. 12). Understanding upon whose penalty our privilege rests might enable us to construct projects which, rather than effecting change along a solitary axis, might "multiply the sources of resistance in the many relations of domination that circulate through the social field" (Sawicki, 1993, p. 45).

This research foregrounds relations of domination and subordination between white women and women of colour and it does not hesitate to name the perpetuation of white dominance through institutional processes and intersubjective means as "racism." Virginia Dominguez (1995) prudently asks "what the invocation of racism accomplishes contextually given a field of available options that range from its silencing to its naming as a different 'thing'" (p. 326). I would respond that such an invocation is a powerful discursive intervention in modern liberal societies where the irrelevance of race is proclaimed at the same instant that racialized forms of differentiation and exclusion proliferate (Goldberg, 1993). Inasmuch as racism in modernity is produced in and through a variety of designations, opinions, exclusions and rationalizations which appear to have nothing to do with race, we require sophisticated strategies to comprehend its operations. Critical and feminist scholars have not been adequately attentive to these processes and the installation of race as an indispensable category of analysis in such scholarship is long overdue (Higginbotham, 1992; Barbee, 1993).

This thesis provides evidence that critical inquiry must engage with processes of racialization, inasmuch as the reproduction of historical relations of racial dominance frequently remains unacknowledged in contexts where concerns with gender inequity or other forms of injustice appear to be central. Indeed, histories of subordination are reproduced in and through the habits of racial dominance which structure everyday encounters between white people and
racialized minority people. It is one of the central intentions of this thesis to identify such habits in order that racially dominant people can begin to recognize, take responsibility for, and ultimately abandon behaviours that contribute to racial hierarchies. Such a strategy requires both that stories of subordination be loudly amplified and that those of us on the dominant side of the racial equation attempt to apprehend the insurgent responses of subaltern peoples which have been historically inaudible to us (Spivak, 1998). This thesis attempts to accomplish both these goals. Finally, the invocation of racism here is an unabashedly political move. I mobilize its undeniable discursive power and moral challenge in the hope that a more intense scrutiny and a swifter ameliorative process will be brought to bear on the inequities which I have worked to catalogue in these pages.

The inventor of the text

"One learns about method," claims Norman Denzin (1994), "by thinking about how one makes sense of one's own life" (p. 505). In my own case, confrontation with the contradictory aspects of my identity actually impelled me to pursue the research upon which this text is based and to seek a method that could explain the contradictions that seem to buffet me from one kind of social positioning to another. Thinking back, I remember this process as located in two instructive and emotionally charged "moments" in which I am rendered first marginal and then dominant in relation to two different groups. The first moment occurred in 1989 when I attended an annual general meeting of the midwives' professional body, the Association of Ontario Midwives (AOM). The second "moment" took place in 1995 when more than ten immigrant midwives of colour enrolled in a community college course that I taught. Both of these moments have more than a little to do with my Jewish identity and its relationship to the conditions of forced migration and diaspora in the twentieth century.
I, myself, have been a migrant, albeit an extraordinarily privileged and largely voluntary one. My migrations have been prompted not by touristic longings but by a "dream of belonging" (Pollock, 1994, p. 84) linked to the displacements suffered by previous generations of Jews. In 1988, I came to Canada after having emigrated from the U.S. to Israel and living there for 15 years. Moving to Israel had been part of my quest for a less fragmented existence. I had struggled to reclaim a connection to Jewish history and culture which had been jettisoned by my parents who were children of relatively unassimilated Russian Jewish immigrants. Like many second generation American Jews, they had abandoned a ghettoized Jewish existence in the mid-West and had migrated in search of both prosperity and new unmarked American white identities in Southern California (Moore, 1994). Having reclaimed my connections to Jewish identity, I wanted to live in a place where my cultural and political commitments did not need to be explained and where the rhythms of life and timelines of weekly and yearly rituals and celebrations did not always require negotiation with a Christian majority culture. I wanted to pursue a form of radical left politics that did not render me anathema to an American Jewish community which increasingly saw "New Left" Jews as a threat to Jewish self-interest and to the respectability and white racial identity - what Karen Brodkin (1998) has called "a whiteness of our own" (p. 39) - claimed by and conferred upon North American Jews in the years following World War II (Staub, 1999). A peace activist both before and after my emigration to Israel, I eventually gave up hope of a just settlement between Palestinians and Jews. I became tired, as I explained it, of being the "master of a million Arabs" and I left Israel.

In Israel, I had worked as prenatal educator and been involved for many years in a leadership role with the movement for de-medicalized, humanized childbirth. In 1989, after returning to Canada I was in need of work and of a community of activists with which I could pursue my commitment to childbirth reform. A friend suggested that I get involved in the burgeoning midwifery movement. I recall attending the AOM's annual general meeting that year and the
terms of that recollection are decidedly embodied ones. In a recent autobiographical article, Melanie Kaye/Kantrowitz (1996) compressed all the habits and embodiments which produce gendered Jewish difference in relation to bourgeois white femininity in North America into a moment of physical and emotional intelligence. "Before I knew what a shiksa" was," confesses Kaye/Kantrowitz, "I knew I wasn't it" (p. 123). On that day in 1989, I also knew I "wasn't it." I recall watching the speakers and feeling my own sense of expertise and competence gained in another place hopelessly eroded. The women I saw were highly articulate, attractive and poised. But in my view, they were, above all, characterized by their embodiment of a kind of neutral citizenship. Marks of racial or class difference were not to be observed. These women were precisely, as I will argue below, the liberal subjects who could make claims to better the lot of "women" with no complicated involvements with other categories or designations. As privileged as I was as a white-skinned woman, as a native speaker of English, as a North American by birth, and as a middle-class person with access to significant cultural and material resources, it was clear to me that the excesses of my Jewishness - including my physical body, the estrangement from North America brought about by my wanderings, and my commitment to a life which collided not infrequently with Christocentric social organization - placed me outside the centre of this world.

As Caren Kaplan (1998) has argued, white North American Jews frequently experience a cognitive, and not infrequently political, dissonance between our access to privilege and the threat of racism "expressed as antisemitism" (p. 453). For North American Jews in the post-war period, the dissonance produced by multiple and contradictory positioning has frequently been muted through a foregrounding of our claims to subordinate status. We find it difficult, if not impossible, to see the contingency of our successful assimilation and the production of our whiteness on our material and discursive relationships.

11 "Shiksa" is a Yiddish term for a gentile woman.
to racialized others. As "model immigrants," we North American Jews are those who seem to prove liberalism's claim that merit is foremost and race irrelevant in the struggle for social advancement. We embrace this illusion, I believe, because our differentiation from those deemed more paradigmatically human has brought violence upon us again and again. Keeping all this in mind, I want to return to the scene of my own cognitive dissonance - my encounters with immigrant midwives of colour.

In the Summer of 1995, the interdisciplinary childbirth educators training program that I had taught for several years - a collaboration between a suburban college and an urban teaching hospital - received nearly triple its usual number of applications for the coming academic year. Even more unusual was that half of the students applying were women of colour, most of them trained midwives from countries in the South. Childbirth education has been an overwhelmingly white avocation in Ontario (and elsewhere in North America) and the opportunity to develop a more diverse pool of childbirth educators was decidedly welcome in a city where 'visible minority' people comprise nearly half of the population. However, most of the students of colour came to the program with slightly different intentions. Midwifery had been incorporated into the Ontario health care system in 1994 and many of these women had entered the childbirth educators training program as a way of learning about the alternative birth movement and preparing for the complex process of becoming registered as midwives through the newly-formed College of Midwives of Ontario's Prior Learning Assessment program.

Because I moved primarily within white and white Jewish spaces, had I not encountered this group of women, nothing, not even my own minor sense of marginalization, could have interfered with my understanding of the reemergence

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12 There is not adequate space here to demonstrate the degree to which the benefits accruing to Jews through assimilation have been accompanied by exorbitant costs including the constant reformulation of gender and ethnic identities in order to bring them more into line with white Protestant norms (Prell, 1999).
of midwifery in Ontario as a laudatory, woman-centered project. That understanding could only have been challenged through contact with immigrant midwives of colour. Listening to them week after week, and reading the essays they produced for the course, I was struck by the depth of their knowledge about childbearing, their commitment to humanized maternity care practices and their clearly feminist positions on issues related to health care. Their integration into the midwifery profession in Ontario should be relatively smooth, I conjectured. But as time passed, I realized that this was not to be the case. I was dismayed to see how, with only one exception, these women retreated from their dream to practise midwifery in Ontario. I, on the other hand, had not been forced to retreat from what I knew best. Shortly after attending the 1989 AOM meeting, I found a job in my field and had located and become involved with advocacy groups in which I felt comfortable. No one required me to have "Canadian experience." Indeed, I had none. This did not stand in my way. The anomaly represented by these very different outcomes for differently raced immigrants, and the extraordinary ease in integration that my whiteness had purchased could not be denied. How racialized knowledge was produced and utilized through the romanticization of "primitive" childbearing practices had been the topic of my recently completed master's thesis and it was clear to me that issues of race figured powerfully in the midwifery equation as well. I found the need to account for the racialized dimensions of midwifery's re-emergence so compelling that it became my dissertation topic.

In describing these "moments" I have attempted to highlight the filters through which I am poised and positioned to view the topic at hand (Behar, 1996). The subordinate aspects of my positioning allow a more critical perception of white dominance but I am by no means innocent of engaging in its practices nor am I denied most of its privileges. While I can struggle to hear, see and listen better, my dominance creates epistemological limits. There are however, as Trinh (1989) notes, "in between grounds" (p. 41) which can be occupied in a struggle to hear/see/listen in ways that acknowledge how power operates in the
transmission of knowledge. I have attempted to gain access to these spaces by constantly reassessing how historical legacies and everyday practices restrict what will be said and what will be heard when I, as a racially dominant woman, research racially subordinate "Others." As I will demonstrate in Chapter Six, these binary formulations are never secure and those positioned subordinately exercise authority and subvert dominance in innumerable ways.

Under such conditions of production then, what kinds of claims can be made and what can they be expected to achieve? In this thesis, I consciously compose a new tale in which I unravel the strands of Ontario midwifery's heroic story and introduce newly collected threads spun from previously unheard narratives, and disparate statistics, documents and theories, re-weaving them into an alternative telling of the re-emergence of midwifery in the province. This new telling reverses the heroic fable of women's gain to show its underside of racial dominance. While such a reweaving must be considered to be primarily a discursive intervention, discursive shifts are indispensable precursors to the reconfiguration of material relations of power. "As alternative stories become available," explains Jane Flax (1998b), "more subjects are likely to resist" (p. 10). For white women involved in midwifery and other feminist projects, the counternarrative that I have constructed might provide a road map for thinking beyond the dominant positions into which we have been structured. We cannot transcend those positionings, but we can certainly begin to learn how to avoid reproducing dominance from within them and we can and must struggle to reconstruct the institutions which perpetuate our dominance. For those who have already begun from within midwifery to address its history of exclusion, I hope to provide ample empirical evidence with which they can argue that what has been dismissed by those in power as an unfounded or exaggerated claim is, in fact, an inequity which requires redress.

13 In a recent dissertation, Margaret Macdonald (1999) reports that my research has been characterized by midwives in Ontario as "harsh," "inaccurate," and "premature" (p. 14).
What then does this research achieve for immigrant midwives of colour? Unlike white women, the women of colour interviewed required no academic explanatory schema to understand their experiences as deeply embedded in racist processes. Indeed, they instructed me on this point. As I will discuss in Chapter Six, they circulated these observations widely among themselves and responded to them with actions that are not always discernible to the racially dominant. My concern, then, is to see that their words and actions are articulated in ways that midwifery policy makers and others who continue to rely on unearned privilege to pursue a midwifery career can hear so that they might be forced to respond. As Michelle Fine (1994) has argued, race and class are codified as "good science" and I can capitalize on such privileges and the authority of science they confer to circulate credible stories. Using my privilege to circulate these stories is also critical because I am less likely than immigrant midwives of colour to be penalized for their telling. As I discovered when attempting to book interviews and in struggling to negotiate with the women about which of their stories they would allow to be told, immigrant midwives of colour feared the consequences of challenging midwifery authority. Already marginalized in the process of becoming registered in a small and tightly-knit professional community, they were concerned that despite my efforts to disguise their identities, they might be recognized in the text of this thesis and that such recognition would compromise the way they were evaluated, supervised and considered for employment.

There can be no doubt that telling the stories of immigrant midwives of colour captures me inescapably within what Elizabeth Ellsworth (1997) has defined as one of "the double binds of whiteness" in that

I assume yet again the position within knowledge that has been historically reserved for me given my white skin: the position of one who names, who knows, who defines. And yet, if I do not do this work I assume...a privileged position within whiteness which is
(re)secured for me each time I do not do this work: the unmarked, unraced, unspoken norm. (p. 265)

There is no easy way for those doing politically-engaged anti-subordination research to escape the bind that Ellsworth describes. Because we are all always already located in an uneven social field, no textual manipulations or strategies for reciprocity between dominant researcher and subordinate research subject can make disparities of power disappear from even the most diligently constructed texts. Only small displacements of power will be achieved. What is critical in this process is for the researcher to struggle to recognize (and this will only ever be a partial recognition) and foreground the many ways that research subjects themselves exercise power in the research encounter. Despite the best strategies and intentions, power will continue to accrue to the academic researcher, reconferred through the scientific status of the text. However, as Aihwa Ong (1995) argues, the "most crucial point is not that we reap material and social benefits from [the stories of marginalized informants], but that we help to disseminate their views and that we do so without betraying their political interests as narrators of their own lives" (p. 354).

**Collecting the data**

My positioning as a politically engaged researcher and one with a history as a childbirth reform activist and anti-racist educator worked both for and against me as I gathered documents and conducted the interviews with 47\(^{14}\) women that have helped shaped this thesis.\(^{15}\) In the Fall of 1996, the Toronto

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\(^{14}\) Forty-nine women were originally interviewed; two women withdrew from the study.

\(^{15}\) The interviews were conducted between December, 1997 and February, 1999 and lasted between 45 minutes and four hours each. All the interviews were transcribed by me. The 900 pages of interview data were then coded using QSR NUD*IST (Qualitative Solutions and Research, Non-numerical Unstructured Data Indexing Searching and Theorizing) computer software. For a discussion of NUD*IST software in qualitative analysis see Pateman, B. (1998). Computer-aided qualitative data analysis: The value of NUD*IST and other programs. *Nurse Researcher* 5(3), 77-89. Themes were determined
Birth Centre committee was preparing to implement a project, twenty years in the making, for a community-controlled, out-of-hospital childbearing centre based on principles of access, equity and the appropriate use of technology (Sutton, Cheetham, Krieger, & Sternberg, 1993). The project, the result of tens of thousands of hours of volunteer labour, was cut by the newly-elected Progressive Conservative government in Ontario. As a board member, it fell to me and several others to dismantle the organization's massive archives. What came into my hands was a wealth of historical data documenting the re-emergence of midwifery in Ontario, including newsletters, reports, personal correspondence, announcements of events, and minutes of meetings. Having direct access to these documents was important inasmuch as I felt that organizations such as the AOM and the College of Midwives might deny me full access to their archives because of the controversial nature of my research.

My past activism and my work as a childbirth educator also facilitated access to five white midwives whom I define as "non-elite." These women, who knew me or knew of me, agreed eagerly to be interviewed because they viewed my research as a venue for articulating their dissatisfaction with the way midwifery had been integrated into the health care system in Ontario. My work as the co-ordinator of the childbirth educator's program mentioned above was also key in negotiating interviews with white members of midwifery boards, midwifery students and immigrant midwives of colour. Many of my former students had been accepted to the province's Midwifery Education Program and had maintained contact with me and frequently related their experiences in the program, often with a critical attention to power dynamics. I had also given a public talk about my work in 1996 which was well-attended by midwifery students separately for the following groups of interview subjects: white midwifery board members, board members of colour, white practising non-elite midwives, non-practising white midwives, white midwifery students, midwifery students of colour, immigrant midwives of colour who participated in the College of Midwives' post-legislation Prior Learning and Experience Assessment program or its pre-legislation Michener midwifery integration program, immigrant midwives of colour who did not participate in the Prior Learning and Experience process, and U. S. African American midwives.
and I had responded positively to a request by one of them to circulate a paper based on the talk. Because my work was well known and because I had friends and former students in the Midwifery Education Program, I had no trouble assembling six students for a focus group\textsuperscript{16} in 1998 and through them contacting five more students to interview in Southern and Western Ontario. I even received two e-mail requests from students asking to participate in the research, which they saw as important in the struggle to diversify the profession. Their candid responses to the one question I posed: "How have you policed your identity as a student in the Midwifery Education Program?" might not have been elicited by an unknown interviewer or by one whose research was not so firmly linked to an anti-subordination agenda.

Booking and conducting interviews with immigrant midwives of colour and with some of the few women of colour who participated on midwifery boards posed different challenges. Some of the interviews were conducted with students or colleagues with whom I shared a concern about the exclusions of women of colour from midwifery. Indeed we had explored these concerns frequently in the classroom or the meeting room. The interviews with these women were easy to negotiate.\textsuperscript{17} The remaining interviews with immigrant midwives of colour were largely brokered for me by these women.\textsuperscript{18} In most cases, their "recommendation" opened a door that might otherwise have been closed. However, the recommendation did not always yield an immediate agreement to meet. One woman expressed interest in being interviewed and told me she had

\textsuperscript{16} This was the only group interview conducted; the remaining interviews were conducted individually.

\textsuperscript{17} All of the interviews I conducted with immigrant midwives of colour who were not previously known to me took place in their homes in the Greater Toronto Area, largely in the eastern and western suburbs of the city. The one remaining interview took place in a shopping mall in Eastern Ontario.

\textsuperscript{18} I also attempted to solicit interviews beyond my personal contacts. A leaflet was posted for me in several hospital labour and delivery departments in the Toronto area by nurses with whom I was acquainted. See Appendix B.
"a big story" to tell. She was concerned, however, that she might jeopardize herself by agreeing to be interviewed. We spent an hour on the telephone discussing the various ways in which her identity would be disguised (neither her name,19 nor names of colleagues or institutions where she worked, would be used; no country of origin would accompany her quotes in the text of the thesis; if she wished, she could see the quotes as I had contextualized them). She told me to call back in a month. I sent her a copy of a paper I had written on racist exclusion in the Ontario midwifery movement and a letter introducing the research (see Appendix A). By the time of the next call, she had had some extremely negative experiences with a midwifery practice and agreed eagerly to the interview. After this experience, I continued to send the paper and the introductory letter after the initial phone contact. I credit establishing myself with potential interview subjects as a critic of midwifery's exclusionary policies, rather than as a neutral researcher, with gaining me access to interviews with some white students20 and with most women of colour.

All participants were sent transcripts of the interviews and were invited to change, excise or add material, which about half did. Most made corrections to their grammar or crossed out the names of institutions that they had mentioned.21

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19 In identifying the interviews in the text of this thesis, I use numbers (i.e., Interview No. 1, etc.) in order to avoid assigning or having participants choose names which might, through being linked to ethnicized identity, inadvertently make the participant more likely to be recognized.

20 Indeed students reported being overwhelmed with requests from social science researchers for interviews and indicated that they had become reluctant to grant them.

21 I have standardized the English usage in material taken from the interviews with women for whom English was not a first language. Nuance and creative uses of language will no doubt have been lost. However, given that English testing has been the most formidable barrier facing immigrant midwives of colour, I felt that displaying any non-standard English usage might function to inferiorize them undeservedly inasmuch as in only one case did I feel that communication was less than satisfactory owing to a language barrier. In the quoted interviews an ellipsis indicates a pause in the narrative while an ellipsis contained in brackets [...] indicates a place where text was excised for clarity or brevity.
However, some women felt that they had told me more in the interview than was safe to tell. Twice, women called me to express their hesitation around having their words made public. They felt that they might be identified or, in one case, held liable for providing information covered by a non-disclosure agreement. In each case the women chose to stay in the study but laid down specific conditions about how the information was to be displayed. In one case, as per our agreement, I sent a woman the exact text where her quote appeared and asked that she telephone her approval to me before I submitted the manuscript which contained her quote for publication as a book chapter.

If my reputation as a critic gained me interviews with those who had experienced exclusion or those who opposed it, it blocked my access to midwifery's elite. While, as I have explained, I decided to limit the number of interviews with key midwifery activists, I felt obligated to hear how at least a few of them explained the absence of women of colour from the profession. I was frankly reluctant to make these contacts, inasmuch as friends and former students had told me in what disparaging terms my work had been discussed by two of the three women I hoped to interview. Indeed, I waited until late in the study to attempt these interviews as I wanted to feel completely sure about the claims I was making. Only one woman agreed to talk to me. Early on in our interview, I abandoned my list of questions because each response was so intractably embedded in a heroic tale of midwifery and in an anti-reflexive analytical frame that it seemed absurd to proceed. What was recounted was the official story that I had read in a hundred versions before arriving in her office. I also contacted two women who occupied key roles in the midwifery bureaucracy and the education program. I left telephone messages for these women on three occasions, then sent each a letter and one of them an e-mail message. Approximately seven weeks later one of the women responded, but an interview was refused and a letter offered in its place. I was not surprised by these (non

22 Two employees of the College of Midwives did meet with me in 1998 to clarify aspects of the Prior Learning and Experience Assessment program.
responses, rather they confirmed to me that in order to preserve midwifery's coherent identity as progressive, feminist and moral, critique could never be tolerated or abetted.

Clearly, I have not occupied the role of distanced and "objective" researcher in the production of the work at hand. My anxieties about this project, which are linked to betrayals, both potential and real, have shaped these pages in innumerable ways. I have wrestled on a daily basis with the fear that I might betray the women of colour whom I have interviewed by misrepresenting them or representing them so well that they would be recognized. Indeed, they reminded me over and over again through negotiating the conditions of the research, that I must assume responsibility for mitigating the potential risks that they took by agreeing to be interviewed. I hope that I have accomplished this task adequately. I have also struggled greatly with my own "betrayal" of the midwifery project. Indeed my traitorous stance was brought home to me after my first public talk about the research. A midwifery student with whom I was friendly called to ask whether "they" (meaning the midwifery educators\textsuperscript{23} who had attacked my research the next day in the Midwifery Education Program) were "burning crosses" on my lawn. The imagery of racist and anti-Jewish violence which framed the student's question jarred me, but I don't believe that she chose her words carelessly. Images of burning crosses no doubt captured for her the intensity of what she had witnessed. It is my guess that such a response reflects the deep resistance that white women have to acknowledging the limits of our own innocence as well as the resistance that we mount to viewing charges of racism as something more than the biased or

\textsuperscript{23} The reaction of some faculty members in the Midwifery Education Program should not be viewed as representative of the response my research has elicited within the (white) midwifery community. Some veteran white midwives have been supportive of my work and continue to give me encouragement and feedback. However, the most enthusiastic support has come from midwifery students who year after year have contacted me to discuss my work. Indeed, midwifery students have demonstrated a significant degree of resistance to white dominance in midwifery and have organized anti-racism initiatives in both the Ryerson University and McMaster University midwifery education program sites (Nestel, 1996/7).
hypersensitive imaginings of people of colour and anti-racist whites (Essed, 1991, p. 272). While these resistant responses have both troubled and frightened me, I myself have not been immune to resistant urges. These have surfaced in the form of a nagging doubt about the veracity of seemingly incontrovertible facts and incontestable interview data that I gathered about the exclusions suffered by racialized minority women. I needed constant reassurance that my claims were not exaggerated and that what I was describing was indeed racism, and not some other phenomenon. While this doubt has driven me to be exceedingly cautious in formulating my claims, it has also forced me to confront how deeply committed we who enjoy race privilege are to versions of racism that allow us to refuse implication in the racialized order of things.

**The thesis chapters**

In Chapter Two, I attempt to show the inadequacy of theoretical models and political projects which view gender as a discrete identity category and not as one constructed in and through other social categories. I trace the outlines of a more efficacious "interlocking" methodology, and I discuss its application to the problems this thesis raises. I also suggest how legacies of imperialism, including the economic conditions of globalization and the global migrations these produce, work together with local processes of racist exclusion to construct a race and gender stratified health care labour force in Ontario. Chapter Three offers a detailed and chronological documentation of the way racist exclusion has worked in the Ontario midwifery project. I attempt to show here how the very terms of self-definition midwives developed and deployed precluded the participation of immigrant midwives of colour. I also demonstrate how attempts at including the voices of marginalized groups in the midwifery project largely served to secure rather than undo white dominance. In Chapter Four, I detail how some midwives' mobility within the health care system has been linked to access to the bodies of Third World
mothers. Ontario midwives\textsuperscript{24} were transformed into more respectable health care professionals through travel to midwifery clinics in Third World spaces where they could gain status and expertise not available to them at home. Chapter Five looks at the construction of a normative midwifery subject and tracks how white midwives who threatened midwifery respectability were either purged or transformed through a set of disciplinary practices which continue to be applied to students entering the Midwifery Education Program. In Chapter Six, I examine how midwives of colour have been regulated by racist exclusion and I document their descriptions of and responses to this process. In Chapter Seven I offer a summary of the research and discuss its implications in addition to positing some suggestions for how white resistance might be conceptualized and deployed from within the structures that constrain us.

\textsuperscript{24} While I will use the term "Ontario midwives" to designate the predominantly white group which practised midwifery outside of the medical system and organized the profession's legalization campaign, I acknowledge the contradictory nature of the term. I would argue that midwives trained outside of the province who wish to practise, but who are not registered, also need to be regarded as Ontario midwives (although legally proscribed from using that term) inasmuch as they have undergone formal training and are residents of the province.
Chapter Two

Theorizing Hierarchical Relations Among Women

*How do you get to be the sort of victor who can claim to be the vanquished also?*

Jamaica Kincaid (1991)

Introduction

It is the intent of this thesis to demonstrate that feminist projects which posit a shared female identity across categories of difference, and fail to take into account how women are positioned as both dominant and subordinate in relation to one another, are themselves fated to reproduce relations of domination. Epistemological frameworks which see gender as a discrete category and not as one produced in and through other dimensions of social identity such as class, sexuality and race, can easily subsume differences between women. Consequently, research aimed at undoing subordination requires theoretical models which conceptualize social identities as relational categories rather than autonomous ones. This chapter attempts to identify the elements of a theoretical framework that might adequately explain the interlocking nature of social categories and the systems of subordination and domination to which they are attached. Evelyn Nakano Glenn (1992) has noted the extraordinary challenge posed by the quest for such a framework. "Holistically," Glenn argues, "race and gender have developed as separate topics of inquiry, each with its own literature and concepts. Thus, features of social life considered central in understanding one system have been overlooked in analyses of the other" (p. 1). This chapter, then, will explore the relational nature of systems of domination in the belief that an explication of how such systems require one another not only productively challenges the inadequacy of some social science theories (Collins, 1990, p. 222), but also creates a conceptual space from which we might begin effectively to unravel structures of power and privilege.
This chapter reviews recent feminist theoretical work which addresses the interlocking nature of oppressions. I begin with the methodological approaches suggested in the interdisciplinary work of two American scholars - Ann Laura Stoler and Anne McClintock - and continue with an examination of work in the area of critical race theory and critical legal theory produced by Sherene Razack and Mary Louise Fellows. This body of work is distinguished by its clear explication of interlocking systems of domination, by its comprehensiveness, and by the interdisciplinarity of its approach, the elements of which will be explored in detail below. While only Razack (1998a) and Fellows and Razack (1998) apply historical insights to contemporary problems, all of these scholars are concerned with the production of the bourgeois subject in the 19th century through imperial conquest and the regulation of domestic space in both empire and metropole. As McClintock emphasizes in the introduction to her recent book *Imperial Leather: Race, Gender and Sexuality in the Colonial Conquest*, "the story is not simply about relations between black and white people, men and women, but about how the categories of whiteness and blackness, masculinity and femininity, labour and class came historically into being in the first place" (McClintock, 1995, p. 16).

Stoler, who has published a series of articles about the construction of European identities in the imperial contexts of the Netherlands Indies and French Indochina, has described her work as striving to show "that the categories of colonizer and colonized were secured through notions of racial difference constructed in gender terms" (Stoler, 1991, p. 85).

Arguing that we must "treat metropole and colony in a single analytic field" (Stoler, 1995, p. xii), in her recent book, *Race and the Education of Desire*, Ann Stoler critiques Foucault's (1980) chronology of the discursive production of European bourgeois sexuality as a site of power/knowledge for its failure to consider how such a discourse could have been formulated "without...reference to the libidinal energies of the savage, the primitive, the colonized - reference points of difference, critique and desire" (p. 138). *Race and the Education of*
Desire argues theoretically for an understanding of the ways that discourses of race and sexuality were central to, and emerged in conjunction with, the imperial order of the 19th century (p. 9).

Why, we might ask, has historical scholarship which explores the imperial history of the 19th century produced a theoretical approach which can be successfully utilized in analyzing contemporary relations of domination? One obvious parallel is the way in which racial, gender, and class categories continue in the 20th and 21st centuries, as in the 19th century, to be perceived as autonomous, despite the apparent overlaps and intersections which characterize social identities (Cooper & Stoler, 1997). Indeed the production and maintenance of such categories remain a pivotal contemporary concern. Issues of "difference" are productively explored only by asking who is defining difference and to what end notions of difference are deployed (Brah, 1996). It is perhaps, their success in explicating the construction of categories which make the methodological approaches examined below so useful for feminist/anti-racist analyses of contemporary issues.

Scholarship which explores 19th century realities can be utilized in understanding contemporary social relations for at least one additional reason, namely, that the contours of the imperial world and the very categories and spatial boundaries that it created and policed continue to hold sway. As Sherene Razack (1998a) has noted

the securing of nation states in the late twentieth century depends on the same spatial configurations that were necessary to uphold white bourgeois masculinity in the nineteenth century. That is to say, the spatial arrangements of the city, of the First World and the Third World, of public and private spaces establish who is respectable and who is not (p. 367).

While allowing for local/historical variation in the interpretation of the terms, continuity between 19th and 20/21st century relations of domination can be seen
to be expressed in concerns with "pollution, sanitation, purity and cleanliness, degeneration and gentrification" (Goldberg, 1993, p. 200). In the 19th century, such concerns fuelled a variety of technologies for the identification and management of "degenerate" populations in both empire and metropole. This system was dependent on the production of a pantheon of gendered and classed identities, all of which were articulated in the language of racial hierarchy (Razack, 1998a).

The construction and verification of racialized subjects is a thriving contemporary project. The production of whiteness as a social identity in the late 20th century, an important theoretical concern in the work to be described here, has direct historical links to an imperial past in which racialized subjects provided the counterpoint against which bourgeois identities could be recognized in both colony and metropole. It is the very content of bourgeois identities and the interlocking of systems of domination which continue to be in evidence today. In the 19th century, defending bourgeois society from moral pollution and racial degeneration required the strict regulation of female sexuality and cross-class social intercourse. Consequently, systems of gender, race and class domination never existed in pristine isolation from one another, but rather required each other for their successful operation. Gender and class identities continue to be inflected by racial ones, and social hierarchies have not ceased to require each other for their successful operation. Historical methodologies, and the genealogies they enable, can assist us in keeping track of these relations.

Stoler (1995) has suggested that the current vogue for studies of colonialism and race may, in some instances, represent a retreat from politically engaged scholarship and actually constitute a "voyeurism of the past" (p. 197). However, scholarship which attends to histories of colonialism and racialized relations of domination contributes more than just methodological suggestions for the analysis of contemporary social phenomena. In its genealogical work of tracing the historical layering of discourses involved in the creation of subjects, it
provides those doing contemporary interdisciplinary inquiry with a more complex understanding of the catalogue of historical discourses which make contemporary subjects intelligible.

The work of Sherene Razack, including her collaborations with Mary Louise Fellows, is extremely useful in demonstrating how to bring these emergent methodologies to bear upon our contemporary analyses of relations of subordination and dominance among women. Because such relations constitute the topic of my research, the work of these theorists, whose scholarship is situated largely in the area of law, is key to the methodological framework of this thesis and will be explored below. Fellows and Razack have demonstrated that an understanding of how "systems of oppression come into existence in and through one another" (Fellows & Razack, 1998, p. 336) must become foundational to a feminist politics of accountability in which we can begin to see how hierarchical relations among women are fundamental to maintaining interconnected relations of dominance.

This chapter then offers the following: a survey of recent critical appraisals of additive models of social oppression, a review of some earlier successful applications of feminist methodological approaches to the interlocking nature of oppressions, an explication of the methodological strategies articulated in the works of Ann Laura Stoler and Anne McClintock, and an examination of the suggestions offered by Sherene Razack and Mary Louise Fellows for the application of such methodologies to contemporary dilemmas. It will conclude with suggestions for how such an interlocking methodology might be applied to an analysis of racist exclusion in the recent feminist movement to legalize midwifery in Ontario.
The inadequacy of additive models of race, class, and gender oppression

Additive models of race, class and gender oppression appeared in feminist theorizing as a corrective to the obvious elisions demanded by a theoretical approach which saw women across time and space as sharing an unproblematized social identity (Anthias & Yuval-Davis, 1992). Such models, in which gender as a bedrock social identity is seen to be doubly, triply or quadruply burdened when other marginalized social identities are present, have recently been targeted for their theoretical inadequacy. Women of colour, responding to white feminism's failure to theorize the difference that "difference" makes, have been at the centre of a critical articulation of the conceptual inadequacy of additive models. In one such critique, Deborah King (1988) argues that:

"Most applications of the concept of double and triple jeopardy have been overly simplistic in assuming that the relationships among the various discriminations are merely additive. These relationships are interpreted as equivalent to the mathematical equation, racism plus sexism plus classism equals triple jeopardy. In this instance, each discrimination has a single, direct and independent effect on status, wherein the relative contribution of each is readily apparent. This simple incremental process does not represent the nature of black women's oppression but, rather, I would contend, leads to nonproductive assertions that one factor can and should supplant the other. For example, class oppression is the largest component of black women's subordinate status, therefore the exclusive focus should be on economics. Such assertions ignore the fact that racism, sexism and classism constitute three interdependent control systems. (p. 47)"

While revisions of additive models might argue for the "simultaneity" of axes of oppression and against a hierarchy of oppressions, additive models are distinguished by several shortcomings: (1) their problematic enmeshment in essentialist categories and the imperative to ranking and ordering endemic to such categorization (Collins, 1990); (2) their consequent inability to theorize the ways in which social subjects simultaneously occupy a multiplicity of subject
positions, both subordinate and dominant, and how "each of us is implicated in the dominance of others" (Razack & Fellows, 1994, p. 1065); (3) their failure to capture the ways that oppressive systems, both material and symbolic, operate in and through one another; and (4) the inability of such theorizing to reckon with historically specific relations of domination and their overdetermination for any element in a given instance.

Feminist theorists have grappled, with varying degrees of success, with some of the shortcomings noted above. I will confine my critique to a limited number of recent theoretical works, some of them produced by Canadian scholars, which offer methodological suggestions and empirical research which go beyond an additive-models analysis.

Daiva Stasiulis (1990) has attempted, from a neo-Marxist position, to address debates as to whether race should be regarded as having an analytical status autonomous from class or if racial subordination is an effect ("superexploitation") of class relations. Emerging as an opponent of "economistic and class-reductionist tendencies" (p. 275), Stasiulis uses her 1990 essay "Theorizing connections: Gender, race, ethnicity, and class" as an opportunity to extend this complex debate to include the question of gender subordination, arguing that the "race and class debate has thus far not taken gender seriously" (p. 280).

Turning her attention to white feminist movements in North America and Britain, Stasiulis acknowledges the racist exclusion endemic to their politics, urging white feminists to "come to terms with the complexities and contradictions of power relations involving intersections of gender, race, and class, where white women may simultaneously be privileged and oppressed" (p. 283). She also acknowledges the contribution of what she terms "Black feminism" to pointing out the failure of white feminist ideologies to "account for the differences and hierarchical structuring in material and discursive conditions that govern Black
and white women's lives" (p. 288). Stasiulis has acknowledged as well how racial segmentation in the labour market co-structures the working lives of white women and women of colour. In a recent extension of this analysis, she and Abigail Bakan have gone on to make a significant theoretical and empirical contribution to the understanding of interlocking systems of oppression (Bakan & Stasiulis, 1995).

In recognizing how material oppressions structure one another and by flagging the inability of social movements to effect profound change without incorporating analyses of various power dynamics, Stasiulis offers some clues as to how an adequate theoretical analysis of race, class and gender might be structured. However, despite devoting many pages to critiquing the errors of omission specific to classical Marxist race theory and neo-Marxist race theory, Stasiulis cannot resist bringing the debate back to issues of class. Arguing in the final paragraphs, that we need to "comprehend the class character of all oppressions" and "recognize the inevitable intrusions of capitalist relations within the construction of intersecting forms of oppression" (p. 294), Stasiulis seems to be lobbying not for a theory of how structures of oppression require each other, but for a more complex materialist approach, better able than traditional marxism to address the concerns of the new social movements which have arisen in the last several decades.

The concept that "capitalist relations" can "intrude" upon other oppressions conjures up the notion that class is an autonomous social phenomenon, a metastructure that somehow orchestrates relations of domination from a site of omnipotence. Avtar Brah (1994), however, has argued that such a view represents a form of reductionism. Indeed, she reasons that

there are serious questions as to how class is to be understood in an age where knowledge and information are the key dynamics of economic growth as well as means of social control, and where there is an intensification of the processes of gender segmentation
of the labour market in and through constructions of 'race' and ethnicity. (p. 812)

Such reductionism can only be corrected, Brah asserts, by addressing how relations of domination related to class, race, gender, sexuality, etc. "figure in the construction of changing political orders, global regimes of accumulation, and cultural formations of the late twentieth century" (p. 812). Stasiulis' later work, which, as noted, will be explored below, addresses precisely the questions which Brah posits.

Floya Anthias and Nira Yuval-Davis (1992) have also made a distinctive contribution in arguing for the complication of the categories of gender, race, class and ethnicity. They recommend a historicization of categories of difference which "draw[s] on the analytical distinctions between categories and their social effectivity and begin[s] to theorize particular ways in which they interrelate in different contexts" (p. 99). Focusing on these interrelations, they have argued that ethnic boundaries are constituted through gendered processes, and that "much of ethnic culture is organized around rules relating to sexuality, marriage and the family, and a true member will perform these roles properly" (p. 113).

While this is a useful theoretical formulation, it needs to embrace the converse as well - that gender is constituted through a process of racialization. Indeed, Avtar Brah (1996) has argued that "[t]he figure of woman is a constitutive moment in the racialized desire for economic and political control" (p. 156). In Anthias and Yuval-Davis' (1992) explanation of the intersections of race, class and gender, a pre-discursive female body is the conduit for the enactment of ethnic processes rather than an embodied social identity which is produced at the intersection of discourses. The fluid and interrelated nature of the categories of gender, race and class is missed as well in this formulation. Racialization can work through the assigning of "feminine" attributes to males of a given subordinate group or "masculine" ones to specific females. Such attributes are frequently constructed in relation to appropriate/inappropriate labour. Anthias and
Yuval-Davis' (1992) statement that class, unlike race and gender, is not related to "a particular representation of a 'biological, 'physiognomic,' or 'natural' difference" (p. 112) belies a large body of work which will be described below, demonstrating the genealogical relationships across these categories.

**Theorizing and empiricizing interlocking oppressions.**

In her ground-breaking work, *Black Feminist Thought* (1990), African-American sociologist Patricia Hill Collins has offered useful theoretical suggestions for constructing a methodology capable of considering race, class and gender as "part of the whole fabric of experience for all groups, not just women and people of color" (Anderson & Collins, 1992, p. xii). Placing African-American women at the centre of her analysis, Collins formulates the interlock of relations of domination thus:

Viewing relations of domination for Black women for any given sociohistorical context as being structured via a system of interlocking race, class, and gender oppression expands the focus of analysis from merely describing the similarities and differences distinguishing these systems of oppression and focuses greater attention on how they interconnect. Assuming that each system needs the others in order to function creates a distinct theoretical stance that stimulates the rethinking of basic social science concepts. (p. 222)

Collins has documented the interlock in a variety of locations but offers a particularly astute commentary when analyzing the ways in which class and race identities are sexualized and how race and class differentiation is accomplished through the pathologizing of sexuality and reproduction. She has argued that the stigmatizing of African-American family structures serves to maintain the "mythical norm of the financially independent, white middle-class family organized around a monogamous heterosexual couple" (p. 165), thus capturing the relational character of systems of oppression.
Collins productively argues that placing marginalized groups at the centre of analysis offers the possibility a "both/and" conceptualization of how bodies are positioned in the social field. Such an approach helpfully ruptures the binariness of categories like race, class and gender, encouraging a historically specific inquiry into the workings of power relations in a given moment and allowing the conceptualization of subjects who, in Collins' words, "possess varying amounts of penalty and privilege in one historically created system" (p. 225).

The utility of such an approach can be seen as well in recent feminist theorizing about how women might communicate and engage in transformative politics across difference. Defining a "difference impasse" as the difficult site where women confront "our different socially produced locations" (p. 1048), Razack and Fellows (1994) have argued that merely acknowledging and cataloguing their difference and diversity allows women - even those avowedly struggling against a variety of social oppressions - to deny their own dominant social locations from behind their enunciated space/s of marginalization. They have dubbed this maneuver "the race to innocence," explaining that it occurs when "women challenged about their domination respond by calling attention to their own subordination" (Fellows & Razack, 1998, p. 339). "The impasse that results," they explain, "depends on the idea that if a woman is subordinate herself, she cannot then be implicated in the subordination of others" (p. 339). What is needed, they have argued, is a framework which "enables women to explore and confront their complicity in each other's subordination" (Razack & Fellows, 1994, p. 1075). Such insights underscore the need for analytical methods which successfully conceptualize how categories, and the systems of domination they enable, come into being in and through one another.

Recent work in the area of race, gender and reproductive labour has merged a theoretical concern with the relational nature of systems of oppression with a critical empiricism. Evelyn Nakano Glenn (1992) has demonstrated how, in the first half of this century, many African-American, Mexican-American and
Japanese-American women were compelled by economic hardship and racist educational and employment practices to work as domestic servants in white middle-class households. Race, class and gender identities were interlinked in these sites in inextricable ways. Oppressive discourses of racialized femininity constructed racial-ethnic women as suitable to degraded labour, and new modes of racist expression were generated in the interaction between employer and employee. Glenn demonstrates how notions of femininity have historically been racialized by emphasizing the disregard that white employers displayed for the childrearing and homemaking responsibilities of their racial-ethnic servants in an era which designated "women's" proper role to be that of wife and mother.

The racial division of reproductive labour, in turn, held in place other systems of oppression. Glenn argues that on the material level, racial-ethnic women's cheap domestic labour in middle-class white households upheld white male privilege and the public/private divide by relieving white women of the worst kinds of domestic labour. White women's avoidance of this labour allowed them a superior gendered identity "giving them a stake in the system that oppressed them" (p.34). Racist ideologies, in turn, sufficiently "defeminized" racial-ethnic women, resolving any contradictions between the type of labour they were required to perform and an idealized "womanhood."

Glenn has emphasized the relational nature of these structures by arguing that because racial-ethnic women's labour has been pivotal in placing white women in a structurally and symbolically superior social location, race must be seen to be key to the construction of gender identities for both white and racialized minority women. This relationship, in turn, bolsters white male privilege in the home and the workplace.

In concluding, Glenn argues that the relational nature of race and gender requires that conflicting interests among subordinate groups must be addressed. She notes that feminist strategies to equalize the wage differential between
traditionally male and traditionally female occupations through a demand for equal pay for work of equal value cannot effect significant change because a lateral move to equalize pay between men and women ultimately leaves other hierarchies intact:

[T]he division between "skilled" and "unskilled" jobs is exactly where the racial division typically falls. To address the problems of women of color service workers would require a fundamental attack on the concept of a hierarchy of worth; it would call for flattening the wage differentials between the highest- and lowest-paid ranks. [...] These examples suggest that forging a political agenda that addresses the universal needs of women is highly problematic not just because women's priorities differ but because gains for some groups may require a corresponding loss of advantage and privilege for others. [...] Appreciating the ways race and gender division of labor creates both hierarchy and interdependence may be a better way to reach an understanding of the interconnectedness of women's lives. (p. 37)

Bakan and Stasiulis' (1995) recent work, part of an ongoing project entitled "Women of Colour, Work and Citizenship: Filipino and West Indian Domestic Workers and Registered Nurses in Toronto," has demonstrated, in concrete terms, how systems of subordination interlock in the case of foreign domestic workers in Canada. They describe how a need for child care in dual-income middle-class families comes to be filled by female migrant workers from Third World countries. The "suitability" of these women to degraded household labour, a key ideological component of the process that Bakan and Stasiulis describe, is linked to the role of domestic placement agencies in reproducing "a highly racialized set of practices and criteria in the recruitment and placement of female noncitizen domestic workers in Canadian households" (p. 305).

Bakan and Stasiulis' (1995) demonstration of the link between discursive and material practices is of extreme value. They have shown that the decline in the number of domestic workers entering Canada from the Caribbean under the
Live-in Caregiver Program,\textsuperscript{25} and the concomitant rise in entrants from the Philippines is directly linked to domestic placement agencies' deployment of racist stereotypes. While the agency owners (and potential employers) differentiate between Filipina and (African-) Caribbean applicants in equally racist ways, they have utilized racist discourses about African-Caribbean applicants which have produced these women as unsuitable for employment as domestic workers. Such pernicious discourses, argue Bakan and Stasiulis, while drawing on a variety of long-circulating ones, seem to have arisen simultaneously with organized resistance on the part of Caribbean domestic workers to inhuman conditions of employment and unfair immigration practices.

The complicity of middle-class Canadian women in the oppression of Third World women is clearly demonstrated in Bakan and Stasiulis' work. The employment of migrant women as domestic workers enables some modification of the gender division of labour through white women's entry into the labour force. However, this transformation of the gendered division of labour leaves the racial division of labour unmodified. An array of systems, to return to Glenn's (1992) analysis, continues to connect women in ways which are both "hierarchical and interdependent" (p. 37). Creating child care solutions which do not demand hierarchical relations between women would require a reconfiguration of all the systems described above. Adequate methods for uncovering interlocking axes of oppression are fundamental to this project.

Bakan and Stasiulis' work on foreign domestic labour also clearly illustrates how "the international is personal" (Enloe, 1989, p. 196). That some white women's occupational mobility has been enabled by the social reproductive labour of women from Third World countries has been increasingly

\textsuperscript{25} The Live-in Caregiver Program (formerly the Foreign Domestic Movement) was initiated in 1981 to recruit female migrant workers to Canada as live-in domestics and nannies (Bakan & Stasiulis, 1994, p. 10)
acknowledged in feminist scholarship. The case of foreign domestic workers however, is only one example of the ways in which global processes interact with local ones to produce a local labour force stratified by gender, race, class and access to citizenship rights. While the intense focus on foreign domestic labour has been of critical importance, such a focus needs to be widened so that we can begin to account for the ways in which the same dynamics have operated within other sectors, including the health care labour force with which this thesis is concerned.

Transnational processes have had an unmistakable impact on the health care labour force in Canada. The massive debt load of former colonies to financial institutions like the World Bank and the structural adjustment policies demanded by these institutions have produced an economic upheaval in which masses of migrant workers, including highly skilled ones such as the immigrant midwives/nurses of colour with whom this thesis is concerned, seek a living outside of their home countries in the South. Medical workers' decisions to

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27 Economists have argued that immigrants from Third World countries represent a significant source of highly skilled labour for Canada (Akbar & Devoretz, 1993; Badets & Howatson-Leo (1999). Immigrant midwives of colour (most of whom also have nursing training) are part of the phenomenon of medical "brain drain" from the South which can be seen to be embedded in very specific neocolonial economic conditions. Estimates of the number of nurses who have left the Philippines to work in other countries indicate that almost 70% of the total nursing labour force of 130,000 has sought work elsewhere (Chang, 1997, p. 137; Gonzales, 1992 p. 23; Ortin, 1990, p. 340). Nearly twenty percent of all hospital-employed registered nurses in New York City come from Asia, with the vast majority coming from the Philippines (Ong & Azores, 1994, p. 182; The
migrate, however, cannot be simply seen as the "free choice" prerogative of an occupational elite. The migration of doctors, nurses, midwives and other health care professionals to First World countries must be viewed as part of a global movement of migrants seeking employment whose numbers have doubled in the last decade to nearly 100 million (Sharma, 1995, p. 22). Indeed, the movement of medical workers takes place in a very specific economic context in which benefits accrue to First World "receiver" countries while the living conditions of most residents of Third World "sender" countries are further degraded.28

While some feminist theorists continue to insist that the gender division in health care mirrors "the traditional division of labor between men and women in the family" (Butter, Carpenter, Kay, & Simmons, 1987, p. 140) (with women responsible for such tasks as cleaning, education, caring, counselling, etc. and

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Urban Institute, 1992, p. 6). An astonishing 95% of Jamaica's professional nurses migrated between 1975 and 1985, predominantly to the U.S. and Canada (Deere, Antrobus, Bolles, Melendez, Phillips, Rivera, & Safa, 1990, p. 77).

As Cynthia Enloe (1989) has pointed out, "[i]nternational debt politics has helped create the incentives for many women to emigrate, while at the same time it has made governments dependent on the money those women send home to their families" (p. 184). Remittances sent by migrant workers and immigrants account for a sizeable proportion of the gross domestic product of supplier countries. The Philippines, for example, receives over 2.9 billion dollars yearly in remittances from migrant labourers, making migrant labour its primary source of foreign currency (Chang, 1997, p. 136) and a critical resource for servicing its international debt. The export of skilled professionals such as nurses then can be seen as yet another way that poorer countries subsidize the high standard of living in economically advantaged ones inasmuch as high training costs associated with producing skilled labour remain with the sender countries while receiver countries benefit (Sassen, 1988, p. 39).

28 In 1989 more than half the positions for pharmacists, medical technologists, registered nurses, nursing assistants and public health inspectors went unfilled in the Jamaican health care system (French, 1994, p. 169). A similar situation exists in the Philippines where the lack of nurses has created a burden on those remaining as they endure heavier workloads, overtime, absenteeism, burnout, and increased illness (Ortin, 1990; Ong & Azores, 1994). Migration politics also drive curriculum design in Philippines nursing schools where the emphasis is predominantly on hospital-based curative nursing suitable to health care systems in industrialized and oil-exporting nations, with much less significance assigned to rural and community preventive practice appropriate to the needs of many Filipinos (Ortin, 1990, p. 341).
men accountable for the more prestigious and intellectually demanding "curative" work), I contend that the health care labour force resembles not the "traditional" family but the newly reconstituted bourgeois family in which immigrant women of colour and other marginalized women perform the fundamental caring duties, allowing the (white middle-class) "woman" of the family to pursue more prestigious, lucrative and autonomous forms of work. Such a claim must be considered in relation to the decreasing enrollment in schools of nursing (Kerr & MacPhail, 1996; Sibald, 1999), the overrepresentation of immigrant women of colour in the health care labour force (Preston & Giles, 1997) and their lack of representation proportional to their numbers in managerial positions in nursing. What must be taken into consideration as well is the streaming of nurses of colour into low-status units such as chronic care, rehabilitation, and geriatric care where advancement is unlikely and occupational injury more common (Caissey, 1994).

Indeed, such a trend is discernible in Canadian women's employment trends in recent years. There is evidence that some Canadian women have been able to move into what were formerly male-dominated (as well as more lucrative and prestigious) professions. There has been a sizeable increase, for example, in the number of female physicians in Canada, which rose from 12.2 percent in 1971 (Statistics Canada, 1990, p. 50) to just under 30 percent in 1996 (Statistics Canada, 2000). Between 1971 and 1987 the number of women in engineering rose from 1.2 percent of all graduates to 12.2 percent and in law the increase in that period was from 9.4 percent to 47.7 percent (Statistics Canada, 1990, p. 50).

Unpublished Statistics Canada data provide a very broad picture of the how those nurses described as members of "visible minorities" participate in the nursing labour force. Out of a total of 89,725 registered nurses (RNs) in Ontario, 14.3% (12,845) are members of "visible minority" groups. Of the 19,560 licensed practical nurses, (LPNs, formerly known as registered nursing assistants) 12.4% (2430) are members of racial minorities. While RNs and LPNs of colour compose 17.5% of the total nursing labour force in the province, only 7.8% (490) of head nurses belong to a racial minority. Inasmuch as 75% of RNs and LPNs work in the Toronto Census Metropolitan Area, the provincial statistics are of little use in understanding the participation of nurses of colour in nursing labour in Toronto where 32.8% (9,685) of registered nurses and 37.8% (1835) of registered nursing assistants are nurses of colour. In Toronto where nurses of colour make up 33.5% of the total nursing population, they account for only 18% (340) of head nurses. Further statistical research needs to be done to clarify how different racial/ethnic groups are situated within the nursing labour force and whether new trends can be discerned from 1996 Census data. Source: Statistics Canada 1991 Provincial Employment Equity Ontario Part 2 and Census Metropolitan Districts, Statistics Canada: 1991 Employment Equity Data Report on Designated Groups.
As provincial and federal budget cuts shift health care from institutions to the home, women increasingly experience the burden as unpaid labour. And, while this unequal burden reflects a gendered division of labour, it is also unequally distributed across class and race boundaries (Glazer, 1988). Those who can afford to do so will hire registered nurses, nursing assistants or home aides to perform work created through these policies. Immigrant nurses who are prevented from becoming registered (because of level of English proficiency, lack of resources to prepare for and pay for licensing examinations, etc.) may come to perform these jobs in unregulated and/or non-unionized workplaces where conditions and remuneration are substandard. The interlocking relations of domination as they relate to hierarchies of class, race and gender can be seen with unstinting clarity in relation to the health care crisis which has been precipitated in Canada in recent years. There is a need to examine in detail the many ways in which nursing has been a critical site for constructing raced and gendered identities and one which both depends on and reproduces an international division of labour in which the work of Third World women plays a major role.

Towards an adequate methodology of interlocking oppressions

As has been noted above, the respective work of Ann Stoler and Anne McClintock is primarily concerned with how race, class and gender come into existence in and through each other, constituting what McClintock (1995) calls "articulated categories" (p. 5). In this section I will outline the contours of their work and attempt to catalogue the components which emerge from a reading of their methodological approach. I will also show, utilizing the work of Sherene Razack (1998a) and Mary Louise Fellows and Sherene Razack (1998), how the historical continuities between 19th century social hierarchies and contemporary
ones make Stoler and McClintock's historical methodologies useful for sociological inquiry.

Stoler, an anthropologist and historian, and McClintock, whose academic discipline is English, have utilized similar tools in their respective work to analyze how, in the 19th century, imperial conquest, investment capital, the invention and enforcement of public and private spheres, and the containment of social deviance were inextricably linked to one another in the production of a bourgeois order. Both are concerned primarily with how bourgeois identity was secured. Stoler (1989, 1991, 1992, 1995) is largely focused on how "Europeaness" was preserved under conditions of metissage (racial mixing) in the colonies, while McClintock is primarily (in the context of imperial relations) concerned with metropolitan strategies of bourgeois identity formation, particularly as they relate to forms of domesticity. In the opening pages of Imperial Leather, McClintock (1995) introduces her project thus:

[I]mperialism and the invention of race were fundamental aspects of Western industrial modernity. The invention of race in the urban metropoles...became central not only to the self-definition of the middle class but also to the policing of the "dangerous classes": the working class, the Irish, Jews, prostitutes, feminists, gays and lesbians, criminals, the militant crowd and so on. At the same time, the cult of domesticity was not simply a trivial and fleeting irrelevance belonging properly in the private "natural" realm of the family. Rather, I argue that the cult of domesticity was a crucial, if concealed dimension of female identities - shifting and unstable as these were - and an indispensable element both of the industrial market and the imperial enterprise. (p.5)

McClintock has worked out these relations by exploring a number of sites. She begins her book with a review of conquest narratives by European explorers of the "new world," juxtaposing these with other literary texts, most notably Henry Rider Haggard's 1885 novel, King Solomon's Mines as well as with visual representations of imperial conquest. In framing her approach to the interlock of empire, sexuality and commerce,
McClintock notes the profoundly gendered nature of the conquest narratives, which situate women at the borders of the "virgin lands" which are, in turn, waiting to be conquered/discovered. The concept of "virgin" space effectively elides the presence of autochthonous peoples on conquered land and nullifies their claims to territorial rights.

This double disavowal of the agency of both women and colonized populations is a central theme in McClintock's work. She brings these into focus by exploring the highly transgressive relationship between Arthur Munby, a Victorian barrister and Hannah Culliwick, a domestic servant. Their relationship and the odd rituals which structured it are detailed in Culliwick's diaries and Munby's photographs in which Culliwick is displayed alternately as slave and gentlemen, drudge and lady. "Fundamentally," argues McClintock, "the scripts for their fantasy life involved theatrically transgressing the Victorian iconographies of domesticity and race, and their fetish rituals took shape around the crucial but concealed affinity between women's work and empire" (p. 138). McClintock's energetically non-linear narrative situates this unseemly pair within the spaces of abjection which were fundamental to the creation a bourgeois order. She goes on to examine these themes in a number of contexts, including: the symbolic role of soap and other commodities in linking the cult of domesticity to empire, the double disavowal of race and gender in the life of South African writer Olive Schreiner, Black South African women's resistance, and the construction of Afrikaner national identity.

Starting from the assumption that the everyday relations of empire blurred the boundary between colonizer and colonized, Ann Laura Stoler has produced a body of work which sees these not as dichotomous entities but rather as a "historically shifting pair of social categories that needs to be explained" (1989, p. 136). In her work on the maintenance of colonizer/colonized boundaries in the colonial cultures of French Indochina and the Netherlands Indies, Stoler has shown how, when white male power began to be threatened by the blurring of
race categories effected through mixed-race unions (predominantly between European men and native women), European supremacy was secured in a variety of ways. Notably, in these settings, measures were invoked which were seen to protect the European population from forms of "degeneration".

"Degeneration," Stoler (1991) argues,

was defined as 'departures from the normal human type...transmitted through inheritance and lead[ing] progressively to destruction.' Due to environmental, physical and moral factors, degeneracy could be averted by positive eugenic selection, or negatively by eliminating the "unfit" and/or the environmental and more specifically cultural contagions that gave rise to them. (p. 72)

Preventing degeneration in the colonies then, required the regulation of sexuality and the vigorous control of hygiene and domestic organization. European women, once barred from the colonial enterprise, became the local agents for the moral, physical and cultural regeneration of colonial life. The redefinition and strenuous affirmation of race and gender categories was central to such a project.

Stoler (1992) has also brought to the forefront questions about the role of "cultural competency" in the racialization process. Disputing that racism represents a primarily visual ideology, Stoler has argued that in a racist economy of meaning, physiognomies are merely signs of the more salient axes of inferiority upon which racism rests. She has shown that in colonial settings where a significant métis population claimed legal standing as Europeans, adequate immersion in European culture through education and proper domestic environment and a concomitant and unequivocal rejection of all things native were seen as absolutely necessary to the claiming of European status. While white women held the key to preventing racial degeneration, native women were seen as its source. In a time when technologies of child rearing were intimately linked to the preservation of national character and to the very survival of the
nation, native women's potential to subvert both racial identity and national allegiance militated against their having extended contact with colonial offspring (Stoler, 1995, p. 163).

Bourgeois cultural competencies inculcated by European women were required for the preservation of European hegemony in the colonies. But, the colonial necessity for the construction of borders around "Europeaness" had significant metropolitan echoes as well. Stoler's (1995) important insight about the necessity of treating "metropole and colony in a single analytic field" (p. xii) requires that we acknowledge how concerns with race and sexuality in the colonial setting, rather than affirming an extant metropolitan identity, were critical to its very construction. In other words, bourgeois selves emerged in the 19th century primarily in relation to the perceived "cultural competencies, sexual proclivities, psychological dispositions and cultivated habits" of the colonized (Stoler, 1995, p. 8). This is not to ignore that subaltern populations in the metropole were also racialized by these discourses, but rather to place this racialization in historical context. However, one criticism of the work of both of these authors is that discursive processes are foregrounded and material ones largely minimized in their explanations. How the bodies subjected to subordinating discourses are violated as a result of their subjectification is not always adequately addressed, as Razack (1998a) has noted in relation to McClintock, whom she faults with claiming that the only harm visited on Victorian prostitutes was their characterization as "especially atavistic and regressive" (p. 364).

Razack (1998a) and Fellows and Razack (1998) offer analyses of prostitution which constitute complex and important methodological interventions into feminist theorizing of relations of domination. Razack (1998a) draws on historical methodologies which examine 19th century social relations to explain how prostitution depends not just on gendered relations of domination but on those related to class and nation as well. It is in the 19th century, she argues, that
"bourgeois bodies, the home, the class, and ultimately the nation all had to be protected from the contamination of the lower orders as well as from the degeneration of the aristocracy" (p. 360). Not only were bourgeois subjects made possible through their comparison to degenerate ones, excursions into degenerate zones and contact with degenerate "others" reaffirmed to them the inviolability of their dominant positioning.

Applying these insights to contemporary relations, Razack (1998a) amplifies this argument by positing that sex tourism in Asia and prostitution in racialized urban zones in the West cannot be viewed as linked primarily to gender relations but, rather, must be seen to confer imperial subjecthood and bourgeois white masculinity on those who can move in and out of these spaces of prostitution with relative impunity, always with a renewed sense of their own gender, racial, national and economic dominance. As Fellows and Razack (1998) argue, "race must be understood not simply as complicating prostitution but as enabling it" (p. 339).

Razack (1998a) also argues that feminist depictions of prostitution as transgressive labour see only gender at work in the production of prostitution, and consistently ignore other systems of domination which the practice upholds. This representation of prostitution as agentic, argue Fellows and Razack (1998), confers upon those who deploy it a "toehold on respectability" inasmuch as it "depends for its success on marking the distinction between ourselves and other women who can then be labeled degenerate" (p. 350). Feminist analyses of prostitution which construct it as women's "choice" or as a subversion of middle-class respectability can only be offered, Razack (1998a) argues, by those who occupy a respectable space, inasmuch as racialized and poor women (each differently racialized) presumed to be sexually available outside of marriage (in discourses of slavery and colonialism, for instance), are already thought to inhabit the space of prostitution. Their choice to inhabit what is already
presumed of them cannot be read as transgressive but as conforming to the structures of patriarchy, capitalism and imperialism. (p. 348)

Fellows and Razack (1998) theorize that within feminist struggles, women frequently discount the tales of subordination that other women tell. "Because we do not experience the specific forms of oppression that other women do, and are in fact privileged in that respect," they reason, "we are likely to consider their claims unfounded" (p. 340). As has already been noted, they dub this move "the race to innocence" (p. 335) and concede that the impulse to innocence is not surprising. Given the effort required to challenge subordination, few want to mitigate claims to subordinate status by admitting to dominance. However, they argue that

the race to innocence depends on the idea that the systems of domination are separate. This leads to women making a truth claim that they are subordinate in one system and failing to see their domination in another. [...] Although we are advancing our own claim for justice by distinguishing ourselves from other women, we are assuring injustice for all. (p. 340)

The identification of "the race to innocence" and the theorizing of feminist epistemologies which confer a "toehold on respectability" are important innovations in foregrounding how oppressions are interdependent and for demonstrating the limited liberatory potential of social movements which do not take this interdependency into account

Utilizing interlocking methodologies

Fundamental to the work discussed above is the understanding that systems of domination require each other to operate. In the 19th century, not only did the material wealth produced through imperial conquest create the very conditions under which bourgeois domesticity and commodity culture flourished, the symbolic systems which created a "natural" hierarchical order inevitably
invoked the colonial context through reference to the "racial" difference of women, labourers, sexual deviants, and Jews. The control of these groups, accomplished notably through the production of urban and domestic space, was central to the maintenance of bourgeois respectability and the racial purity it required. Race, class, gender and sexuality then, are clearly seen to be interlocked in the production of 19th century relations of domination. The methodological directions for contemporary analysis which can be derived from this insight have been explored above in relation to the work of Glenn (1992) and Bakan and Stasiulis (1995) and notably in the scholarship of Razack (1998a) and Fellows and Razack (1998). Below, I will outline additional elements of this approach and expand on the methodological implications of these elements for an analysis of contemporary social phenomena.

I see the following themes emerging from work on interlocking relations of domination:

(1) Categories of race, class and gender must be understood historically in relation to empire.
(2) The categories of race, class and gender were never discrete, but rather were inflected by one another in historically specific ways, reflecting both the interrelated nature of the oppressive systems and 19th century scientific discourses.
(3) In both metropole and colony, class, sex, and gender deviance were understood in terms of racial degeneracy.
(4) The creation of such categories and their relation to degeneracy was intimately related to the construction of boundaries between the bourgeoisie and a collection of racialized others. Identities, critical to such boundary formation, were always being produced as oppositional couplets.
(5) The demarcation of the divisions between respectable and non-respectable groups continues to hold sway. Subordinate groups can rely on their own
contingent respectability to gain advantage over those positioned as more "degenerate" than themselves.

**Legacies of colonialism and interlocking methodologies**

Both Stoler and McClintock repeatedly emphasize that metropolitan identities, constructed along axes of class and gender, were "tacitly and emphatically coded by race" (Stoler, 1995, p. 7). Such an encoding continues to this day and bespeaks the enormous and abiding impact of the colonial endeavor. A number of scholars, notably Edward Said and Toni Morrison, have lobbied for a reappraisal of how the "other" has been instrumental in the construction of white Western bourgeois identity. Morrison (1993) has powerfully argued that

Africanism is the vehicle by which the American self knows itself as not enslaved, but free; not repulsive, but desirable; not helpless, but licensed and powerful; not history-less but historical; not damned, but innocent; not a blind accident of evolution, but a progressive fulfilment of destiny. (p. 52)

Said (1993) also has urged that attention be given to the "the infinite number of traces in the immensely detailed, violent history of colonial intervention...in the lives of individuals and collectivities on both sides of the colonial divide" (p. 22). Morrison's and Said's incitements, coupled with those of Stoler and McClintock discussed above, must encourage scholars not only to consider the ways in which histories of colonialism and contemporary relations of neo-colonialism figure in modern social formations, but how race, as a consequence, is central to any deliberation on contemporary economic, political or cultural issues.

Such an undertaking requires genealogical inquiries into the racial meanings of social phenomena. In my own work, I have been able to demonstrate, for example, how arguments and visual representations used to
promote natural childbirth in the West have relied on racialized knowledge about the reproductive lives of women in so-called "primitive" societies (Nestel, 1995). This "primitive" ideal has been constructed from old and new anthropological information made available because of the historical fact of European colonization in Africa, Asia, and South America as well as that of the conquest of indigenous peoples in North America. This knowledge and its utilization both reference and reify the existence of what Michel-Rolph Trouillot (1991) has called a "savage slot" (p. 39), that mechanism by which the West comes to know itself as the West. That such a complex set of racial referents dwells within such a seemingly benign discourse as that of childbirth reform demonstrates the profoundly racialized nature of contemporary social formations and the need to inquire after the status of race in every kind of social inquiry.

**Race, class, and gender as articulated categories**

A key feature of modernity, argues Ali Rattansi (1994), has been "the striving for stable classificatory systems, articulated with modern projects of constructing disciplined, managed, healthy nations (and) involving the weeding out of contaminated 'Others' who appear to disturb the social order" (p. 25). Scientific technologies of measurement produced, in the 19th century, physiological "evidence" of human hierarchies of development. Using anthropoid apes as the threshold standard against which various human groups might be measured, 19th century scientists created analogies between ape physiology and that of women, "lower races," criminals, the working classes and children (Stepan, 1993, p. 363).

White women were seen to demonstrate physiognomic and psycho-social characteristics of "lower races," thus relegating both groups to a lower rung on the evolutionary ladder. Concomitantly, the male "lower races" were viewed as conforming to a female type and not imbued with the innate masculinity found in white men. A complex system of analogical links ranked women, Jews, non-
Europeans, the insane, criminals and the sexually deviant below middle-class white men in the social hierarchy (Stepan, 1993, p. 361). McClintock has described the conceptual zone into which these inferiorized beings were grouped as 'anachronistic space,' "a permanently anterior time within the geographic space of the modern empire" (p. 30).

As McClintock has demonstrated in her reproduction of Munby's sketches of working class women, racial signification was the means by which class difference was signaled. Their transgressive labour, a violation of Victorian gender norms, marked the female miners that Munby sketched as indisputably primitive. Their darkened faces and masculinized bearing signaled their assumed degenerate racial and gender status. The putative link in 19th century discourses of inferiorization between blackness, women's transgressive labour, and a degenerative sexuality has been traced notably by Sander Gilman (1992). Gilman has famously argued that 19th century racist assessments of black women's physiognomy as primitive and anomalous interlink, through discourses of disease, to the European prostitute. Thus disease is the vehicle which racializes the transgressively sexualized European prostitute's body and constructs her as degenerate. The centrality of the concept of degeneration to the creation of bourgeois subjectivity and the boundaries required by this project will be discussed below. What must be noted at this juncture however is that degenerative gender and class identities consistently come to be recognized through their attachment to racialized ones.

A methodological strategy that uncovers these links is important to any analysis of contemporary relations of domination and subordination because it helps demonstrate how race, class and gender divisions are produced in and through each other. I return here to the example of nursing because it constitutes a particularly dense site of meaning-making in relation to race, class and gender. The following quote from a first-year Wellesley College student offers a perfect example of how gender requires race and class for its intelligibility: "If I were to
say, I wanted to become a nurse...my professors and fellow students would think that I was crazy. To them, it would be like saying I wanted to be a janitor" (Gordon, 1991, p. 124). Nursing, seen as a subservient form of female employment and one unsuited to middle class women who have more attractive occupational options, is coded by race through the speaker’s references to janitorial work, a job frequently done in the U.S. and Canada by racial minority workers and immigrant people of colour. It is by negative reference to an array of degraded/degenerate identities structured in and through class, race and gender that a middle class white female identity emerges.

It is appropriate at this juncture to return to the issue of degeneracy, inasmuch as it is this notion which produces those categories which bound and define normative ones. In the contexts that both Stoler (1989, 1991, 1992, 1995) and McClintock (1995) describe, degeneracy is the linchpin which secures various relations of domination. Degeneracy, in its emergent form as a pathologizing discourse of 19th century medicine, was used to "sharpen the distinction between normal and abnormal, between the bourgeois virtues which led to progress and the vices which led to the extinction of the individual, the family and the national community" (Mosse, 1985, p. 35). McClintock (1995) argues that

[In the metropolis, the idea of racial deviance was evoked to police the "degenerate" classes - the militant working class, the Irish, Jews, feminists, gays and lesbians, prostitutes, criminals, alcoholics and the insane - who were collectively figured as racial deviants, atavistic throwbacks to a primitive moment in human prehistory...

In the colonies, black people were figured among other things as gender deviants, the embodiments of prehistoric promiscuity and excess, their evolutionary belatedness evidenced by their "feminine" lack of history, reason and proper domestic arrangements. (p. 43)

Degeneration, and the class, race and national extinction it threatened, were prevented in the 19th century in both metropole and colony through the
construction of geographical as well as conceptual "spaces of respectability," notably those related to the reproduction of the bourgeois body, i.e., the bourgeois home (Razack, 1998a). Such spaces were demarcated from spaces of degeneracy (the street, the ghetto, the casbah, Chinatown, etc.), and from the contagion they represented, by liminal figures such as the servant and the nanny, who represented links between a respectable bourgeois world and the abjected spaces which made it intelligible.

I would like to propose that degenerate classes are no less necessary to the creation of social boundaries and to the definition of the white bourgeois subject in the contemporary period than they were in the 19th century. Stoler (1995) argues that "civilities and social hygiene" were of primary importance in securing the healthy bodies of the white bourgeoisie and that these were always "measured in racial terms" (p. 115). The production of contemporary bourgeois identities is evident in the recent project of constructing a new elite configuration of nursing professionals. In this example, "civilities and social hygiene," always embedded in a matrix of racial meanings, are invoked in the process of securing middle-class female identities within an increasingly proletarianized and racialized nursing profession.

As I have noted above, racial segmentation is a prominent feature of nursing in both Canada and the U.S. The majority of highly skilled nursing labour is performed by white registered nurses while lower skilled nursing and caretaking tasks are performed by licensed practical nurses, nurses’ aides, and home care workers, significant numbers of whom are women of colour (Calliste, 1996). The recent thrust to create a nursing elite involves the construction of a definitive border between the proletarianized aspects of nursing labour and its more scientific and intellectual ones. Elite nurses are seeking to assume more of the curative labour traditionally performed by physicians by claiming a unique body of scientific nursing knowledge (Carpenter, 1993). Managerial expertise and scientific knowledges secured through elite educational routes have
characterized the move to disengage a new configuration of nursing practice from its proletarian underpinnings. That nursing elites depend on a "toehold on respectability" (Fellows & Razack, 1998) to distinguish themselves from subordinates seems evident here.

What must be abjected in order to produce a nursing profession in which women perform non-subservient intellectual/caring labour - the appropriate labour for white middle class women? The borders are clearly drawn here between those with university training and those whose education is acquired in more accessible and less prestigious institutions like community colleges; between labour in which traditional female caring skills are the major component and labour which is more medical and managerial in nature; between work that involves significant contact with dirt and human effluvia and work which is relatively clean. The outlines of degenerate identities from a previous era are detectable and they emerge along the intersecting lines of class (manual, versus mental labour) and gender (servile, versus resistant womanhood) in which the subordinate positioning in each couplet has a racial referent in society. In Canada, such borders are also drawn along the highly racialized lines of citizen/non-citizen, inasmuch as foreign-trained nurses frequently have great difficulty in having their credentials recognized (Task Force on Access to Professions and Trades in Ontario, 1989, p. xii).

31 In 1982, the Canadian Nurses Association adopted what has become known as the "Entry to Practice" position (Baumgart & Larsen, 1992, p. 392). The position stipulates that the preferred basic credential of nurses entering practice in the year 2000 and beyond be a baccalaureate degree in nursing. A university degree continues to represent an elite attainment for women in Canada where only one woman in 10 holds a university degree (Statistics Canada, 1995). While the Entry to Practice position has held sway in Canadian nursing for nearly 20 years, evidence that women are entering nursing through the baccalaureate route or that RNs and RNAs are rushing to upgrade their credentials has not been forthcoming. Students in basic RN and post-RN baccalaureate programs continue to constitute only 29.3% of all nursing students (Kerr & MacPhail, 1996 p. 328). And, whereas in 1989, just 14% of RNs were baccalaureate prepared Sedivy-Glasgow, 1992, p. 28), that percentage had only risen to 20.8% in 1998 (Canadian Nurses Association, 1999).
There is not adequate room here to explore the entire range of dividing discourses which continue to distinguish respectable bodies from degenerate ones. But now, as in the 19th century, "cultural competencies, sexual proclivities, psychological dispositions and cultivated habits" (Stoler, 1995, p. 141) position variously embodied subjects within a shifting matrix of respectability. Social boundaries continue to be configured along lines which have a genealogical connection to 19th century discourses of degeneracy in which healthy nations distance those who imperil normative configurations. In Chapter Five, I take up these issues in greater detail as they pertain specifically to the construction of midwives' respectability.

What must be highlighted here, and is central to all of the interlocking methodologies discussed thus far, is the need to de-essentialize identities - to see them not as natural or given but as cobbled out of a variety of historical discourses, material conditions, and forms of resistance. Stuart Hall (1996) has suggested that attending to processes of identification, rather than to "'identity itself," can yield more complex forms of analysis which “employ both the discursive and the psychoanalytic repertoire, without being limited to either” (p. 2). While this thesis touches only fleetingly on psychoanalytic readings of the topic under discussion, there is no doubt that recent theoretical moves to merge discourse theory and psychoanalytic theory have been highly productive. The concept of abjection, for example, explains how identities and social groupings are formed through the relegation of vilified groups to the borderlands of the social. The contradiction represented in this process is that without the abject, the social entity itself would not exist; the very process of abjection is what creates the self (Butler, 1990, 1993). The utility of psychoanalytic theory in a postmodern analytical framework, then, lies in its ability to reveal the seemingly coherent subject as a fragmented one through examining unconscious processes such as desire and fantasy which belie the existence of a unitary self (Brah, 1996, p. 121). Consequently, any scholarly exploration of social phenomena in which identity construction is a key component must consider numerous
questions, including: "What conditions of belonging are foreclosed and which hierarchical structures are erected when a given subjectivity is invoked? And, How do idealised relationships to a romanticized "other" represent eruptions of ambivalence when identity is founded on the expulsion of bodies from particular social spaces? This thesis attempts to address these questions while focusing on the hierarchical relations produced in the process of identification.

Conclusion

This research makes extensive use of the methodological frameworks reviewed above in which systems of domination are conceptualized not as separate and discrete, but as interlocked. I conclude this chapter by reviewing the relevance of these frameworks to this thesis.

Stoler's incitement to view metropole and colony in a single analytic field, coupled with important work on gender and global relations of domination such as that of Swasti Mitter (1986), Cynthia Enloe (1989), Inderpal Grewal and Caren Kaplan (1994, 1996), Shellee Colen (1995), Gayatri C. Spivak, (1996, 1999) and others, demands an explication of the transnational link in the interlock of class, race and gender oppression. Specifically, in my own work this means that the very achievement of legalized midwifery must be viewed in relation to both discursive and material processes in which Third World women, including those displaced to the North by oppressive transnational economic policies, have played significant roles. These groups have served both conceptually as the definitional "other" of middle class white women's midwifery identities (and contradictorily as their fantasized ideals) and structurally, within the health care system and elsewhere in the economy, as those who buttress dominant female positions, including those of white midwives. In addition, the bodies of Third World women have frequently provided the clinical experience which Ontario midwives who travelled to the South later traded for professional status in the province.
By tracing the identity categories into which those excluded from midwifery are structured, we can bring some dimensions of the interrelationship of race, class and gender into view. While the disqualification of many, if not most, midwives of colour represents a discrete dimension of the re-emergence of midwifery in Ontario, nurses, rural women, counterculture women and women who have not attended institutions of higher education have been subject to exclusionary treatment as well. The proximity of these identity categories to the discourses of "degeneracy" explored here is striking and, as noted, will be explored in some detail in Chapter Five. The necessity of constructing boundaries between "degenerate" female subjects and white middle class ones - the establishment of a "toehold on respectability" - can be seen to be fundamental in the process which has established Canada's first registered midwives.

Finally, a theory of interlocking relations of domination offers a road map to the racialized highways and byways of women's attempts to undo gender domination. The movement to legalize midwifery in Ontario represents a cogent example of the potential pitfalls of projects intended to address "the universal needs of women" (Glenn, 1992, p. 37). Unable to see past their own sense of oppression, midwifery activists chose a political route which sustained rather than challenged systems that marginalized other women. Racial segmentation in the nursing labour force, the de-skilling of immigrant workers, and derogatory and retrograde representations of women of colour are but a few of the systems which the Ontario midwifery movement relied upon in its bid to challenge a patriarchal maternity care system. It should come as no surprise that the benefits of this movement have not accrued universally to all women but rather to a highly circumscribed elite.
Chapter Three

"A New Profession to the White Population in Canada": Constructing Ontario Midwifery as a White Space

The simple questions we should be asking are: who are places for, whom do they exclude, and how are these prohibitions maintained in practice?

David Sibley (1995)
Geographies of Exclusion

Introduction

In November of 1987, Betty-Anne Putt,\textsuperscript{32} practising midwife and active member of the Association of Ontario Midwives, addressed a conference convened in Montreal in support of the shift of Aboriginal health programs to the control of First Nations' authorities (Association of Ontario Midwives, 1988). Putt, a non-Aboriginal woman, urged the participants to reject the medical practices of "the white man's institutions" and to return to "practices closer to [First Nations] culture and spirit" (p. 8). Identical intentions, she claimed, had shaped the re-emergence of midwifery in Ontario where women had striven to move childbirth closer "to the way our ancestors did it" (p.8, emphasis in the original). Women's lobbying and political action, Putt explained, had led to governmental recommendations designed to protect normal birth, and to the creation of a "new profession to the white population in Canada" (p. 8).

Putt's remarks are both highly problematic and unwittingly accurate. Problematic is her portrayal of Aboriginal cultures as static and curiously unaltered by centuries of colonization and genocide. Equally troubling is her contention that white women and First Nations people have been victimized in parallel ways by "white man's institutions," and the concomitant elision of the ways in which white women both benefit from race privilege and have participated historically in racial

\textsuperscript{32} Putt was later known as Betty-Anne Daviss.
dominance. Rey Chow (1993) deems such discursive strategies to be a form of "self-subalternization which draws on notions of lack, subalternity, [and] victimization" to gain authority and power for dominant subjects (p. 13). Unwittingly accurate, however, is Putt's description of the re-emergence of Ontario midwifery in the last two decades as the creation of "a new profession to the white population in Canada." "In creating a movement," admitted one midwifery activist, "white, educated, able-bodied, middle-class women have tended to attract the same, leaving many voices behind" (Ford, 1992, p. 50).

Among the "voices" which have been left behind are the hundreds, if not thousands of immigrant women of colour who possess formal midwifery credentials from their countries of origin in the South. Indeed, their meager representation among registered midwives in the province represents a frank paradox. While "visible minority" people account for approximately 15% of Ontario's total population (Statistics Canada, 1999), in Toronto, the historical centre of midwifery activism, they account for nearly 40% of all residents (Omstein, 2000, p. 12). However, the numbers of midwives of colour expressing an interest in having their credentials recognized in the province has, since 1986, outstripped their proportion in the population at large, accounting for nearly half of those who, by 1994, had sought information from the College of Midwives and its predecessors about credentials assessment (Task Force on the Implementation of Midwifery in Ontario, 1987, p. 331; College of Midwives, 1994a). Relatively few of these women, however, have succeeded in becoming registered as midwives.

The integration into the midwifery profession, by all available routes, of both immigrant midwives of colour and other racialized women has been, and continues to be a protracted and problematic process.33 Prior to the graduation

33 The three routes which have been available for those wishing to enter the midwifery profession include (1) a one time "grandparenting-in" process made available to some practising midwives in the period immediately prior to the legal proclamation of midwifery in Ontario on December 31, 1993, (2) A four-year baccalaureate program currently
in September 1996 of the first class of the baccalaureate-granting Midwifery
Education Program, only one out of the 72 registered midwives in Ontario was a
woman of colour. By December 1996, there were 92 registered midwives of
whom three (3.3%) were women of colour. By May 1998, there were 126
registered midwives, among whom were 12 women of colour and one was a First
Nations woman, bringing the percentage of non-white midwives to 10.3%. While
at least one CMO official had predicted that by the end of 1998, 18.3% of all
Ontario midwives (33 out a predicted 191 registered midwives) would be women
of colour or Aboriginal women (personal communication, Holliday Tyson, July 9,
1998), the percentage of these women who have actually become registered
remains, by my estimate, at approximately 10.5%. 34

The picture that emerges then is one of a predominantly white midwifery
apparatus in a geographic environment whose multiracial character is one of its
most frequently invoked social signifiers (Abate, 1998, p. A6), as well as one in
which, as I will demonstrate, immigrant midwives of colour are in abundant
supply. The processes which (re)produce racially exclusive spaces result from
both deliberate choices and seemingly-benign inertias, but neither of these are
necessarily linked to an intention to enact racism. Rather, racist exclusion must
be understood as unavoidable when race-blind epistemologies guide actions.
The epistemological stance within which Ontario midwifery was locked dictated
that women were oppressed in similar ways and that race, class and sexuality
only complicated a foundational gender oppression. Such a stance does not
require that relations of domination between women be taken into account and
therefore a path is cleared for racial domination to be reenacted within a feminist

34 In addition, it is important to note that these figures do not necessarily reflect the
actual number of women of colour who have succeeded in becoming employed as
midwives in the province. Barriers to employment and the experiences of some women
of colour who have worked as midwives will be discussed in Chapter Six.
context. What I argue then, in this chapter and in the ones which follow, is that because the Ontario midwifery movement understood its project as one which benefited all women equally, failing to take into consideration that women's stakes in the politics of midwifery (whether as providers or consumers of midwifery care) reflected the ways in which they were positioned by race, it could not avoid enacting racist exclusion. As a project which aimed to address the "universal needs of women" (Glenn, 1992, p. 37), it required a universal woman as the protagonist of its "heroic tale," in which autonomous subjects, constrained only by gender inequity, pursue and win their goal through dedication and courage. As is often the case when gender-based paradigms reign, that "universal woman" "embodie(d) the characteristics of the most privileged women" (Razack, 1998a, p. 340). Engagements with subordinate groups such as First Nations women and immigrant women secured rather than challenged such privilege and were instrumental in producing midwives as bourgeois First World subjects.

From its inception, midwifery's self-definition and the material requirements for participation in the Ontario midwifery movement worked to define immigrant midwives of colour on the margins (if not outside) of the movement's perimeters. They posed both a material and symbolic threat to the heroic tale and to its victorious resolution through legalized midwifery. As I will demonstrate, an initial unease with the threat of immigrant midwives of colour entering the movement escalated into a full-blown set of discriminatory structures which facilitated their exclusion from practice after legislation. This chapter then, examines the technologies of domination, including the enactment of exclusionary policies and procedures and the formulation of rationalizing explanatory schemata, among others, which produced a largely white midwifery movement in the province. In an effort to de-mystify how racism works, this chapter will plot the many nodes of action and inaction which constitute an identifiable trajectory of racist exclusion in the re-emergence of midwifery in Ontario.
Theories of racist exclusion

Recent work by scholars in the field of critical race theory has caused significant shifts in how racism can be understood. Such shifts have important consequences for selecting productive methodological frameworks in which to identify and explain racist processes. Nonetheless, dominant definitions of racism persist. Goldberg (1993) has defined several dimensions of the dominant definitions of racism that necessarily restrict the efficacy of explanatory models which rely on such definitions. Perhaps the most widespread of these dimensions is the belief that racism is primarily an expression of personal prejudice. Indeed, as Ruth Frankenberg (1993) has reasoned, “essentialist racism—particularly intentional, explicit racial discrimination remains...paradigmatic of racism” (p. 139). This dominant definition renders institutional and structural forms of racism difficult to discern. It also, as Goldberg argues, obscures the very rational way that racism has functioned as a constitutive element of modernity (p. 94). If the measure of modernity is the extent to which “modern man” is “free, productive, acquisitive, and literate,” then these qualities constitute the criteria for inclusion into or exclusion from modernity of a variety of racialized groups (p. 109). These classifications, argues Goldberg, do not necessarily require a reference to biological inferiority to relegate these groups to the margins of modernity.

In order to understand the proliferation of racisms and the tenacity of racialized social formations, argues Goldberg, we need to articulate a definition of racisms as individual and institutional practices which “involve promoting exclusions, or the actual exclusions of people in virtue of their being deemed members of different racial groups, however racial groups are taken to be constituted” (p. 98). Departing fundamentally from the personal prejudice model of racism, Goldberg insists that intentionality cannot be the only grounds upon which individual or institutional practices can be judged to be racist. Rather, these practices must be judged on the basis of the effects which they produce. Institutions, argues Goldberg, can reasonably be presumed to be racist or to
promote forms of racism when “institutional practice gives rise to racially patterned exclusionary or discriminatory outcomes, no matter the institutional aims, and the institution does little or nothing to avoid, diminish, or alleviate these outcomes” (p. 99). The grounds for exclusion are of utmost importance in this formulation as they often appear, in Goldberg’s words, as a “patterned by-product of bureaucratization” rationalized as the inevitable effect of the implementation of professional standards, prudent economic measures or expedient politics (p.98).

Writing from the British context, Floya Anthias and Nira Yuval-Davis (1992) concur with Goldberg that forms of racist exclusion have largely supplanted ideological or biological discourses of racial inferiority and now constitute the most common forms of racism. As in Goldberg’s schema, Anthias and Yuval-Davis’ work posits that racist practice does not require racist intentionality. Rather, they argue, “[p]ractices may be racist in terms of their effects and may produce exclusions and subordinations which are coterminous with 'racially' different populations” (p 13). They point out that certain “juridical or formalistic criteria” which regulate access to employment and housing, for example, can impact significantly on racialized groups even in the absence of explicit inferiorizing discourses related to race (p 13).

Like Goldberg and Anthias and Yuval Davis, Philomena Essed (1991) argues that intentionality is not a fundamental component of racism. Racism, claims Essed, includes all acts, intentional or unintentional, which create negative consequences for “racially or ethnically dominated groups” (p 128). Essed emphasizes that because racism operates through a variety of social relations it becoming routinized in ways that naturalize its presence, producing what she terms “everyday racism.” What Essed stresses in her work is that everyday racist practices, whether enacted at the individual or institutional level, reference, rely on and operationalize wider relations of racial domination. Indeed, it is the perpetuation of racial injustice through various microprocesses at the individual
and institutional levels which concern the theorists under discussion here. While Essed (1991) and Anthias and Yuval-Davis (1992) emphasize that the preservation of existing racist structures is emblematic of racist acts and exclusions, Goldberg also insists that those who enact policies which enable the continuation of an historical legacy of racialized exclusion need to be held accountable for their actions and that such actions must be understood as racist (p. 98). While the macroprocesses which have contributed to the exclusion of immigrant midwives of colour from practice in Ontario were briefly explored in Chapter Two, the chapter at hand looks at the ways that microprocesses at the institutional level, many of them utterly lacking in racist intentionality, have produced a system of racist exclusion which bridges easily with historical legacies of racism in Canada.

While this chapter is fundamentally concerned with exclusions, it is as much concerned with what is produced through them as what is denied by them. Through its cataloguing of exclusions, this chapter will attempt to make visible the spatial practices of the social movement to legalize midwifery in Ontario, as well as those of midwifery-related, state-funded regulatory bodies and midwifery’s professional organization. Explicating Henri Lefebvre’s concept, Edward Soja (1996) describes spatial practice as “producing a spatiality that ‘embraces production and reproduction, and the particular locations...and spatial sets...characteristic of each social formation’ “ (p. 66). In other words, spaces of human sociality are not naturally occurring but require constant vigilance and a variety of repetitive moves to secure their reproduction, usually through practices of exclusion. In the case at hand, spatial practice can be understood to be about the production of spaces which are hospitable to white women and the exercise and consolidation of group power that may be named as “whiteness” (Lipsitz, 1998).

Naming “whiteness,” Ruth Frankenberg (1993) has argued, is critical to conferring a material reality upon practices of racial domination whose invisibility
is, in turn, a mark of dominance (p. 6). Whiteness, the subject of much recent theorizing, is described by Frankenberg as “a location of structural advantage, of race privilege” as well as a “a ‘standpoint,’ a place from which white people look at ourselves, at others and at society.” “Third,” Frankenberg argues, “ ‘whiteness’ refers to a set of cultural practices that are usually unmarked and unnamed” (p. 1). If, as Cheryl I. Harris (1993) argues, the structural advantage that whiteness proffers is of particular value to those white people to whom access to power and privilege is restricted, it must come as no surprise that white women seeking access to forms of influence previously denied to them will cling tenaciously to those benefits that whiteness confers. Historically, Harris has argued, such advantage has translated into substantial material benefit in the form of property.

There can be no doubt that the advantages that whiteness has made available to midwifery activists and that accrue to them as a result of their structural positioning take the most tangible of forms including: greater access to financial resources and education, links to influential political players, unproblematic border crossings for the purpose of gaining professional expertise, and a wide range of cultural competencies that structure access to the privileges listed here. Most of these benefits are understood by the dominant group of Ontario midwives (and indeed by most whites) not as unearned privilege but as competencies, proficiencies or entitlements acquired through hard work, dedication and/or "natural" right, including the right of citizenship. It is this understanding that enables the promulgation and continuing circulation of the “heroic tale” of midwifery, a story of meritocratic achievement by a determined, long-suffering and dedicated group of women. While personal sacrifice undoubtedly has played a role in the re-emergence of midwifery, we must ask what kind of subject is constituted by the heroic tale and what forms of violence are required to sustain it. As Sherene Razack (1998a) notes, “[t]he spatial system of moral ordering is enabled by the notion in liberal democratic states that we are all free individuals entitled to pursue our own interests” (p 358). Indeed the “moral ordering” accomplished by many of the practices outlined in this
chapter simultaneously constructs both the heroic white midwife, and the obsolete and undeserving immigrant midwife of colour, a woman morally unworthy of admission to the profession and devoid of the individual initiative fundamental to the authentic citizen/subject in the West.

Two contradictions must be suppressed in order to produce such an understanding. The first, in contradistinction to the narrative of unfettered individual advancement in liberal democratic society, is the existence of racist social organization and the impediments to individual and group accomplishments that are its effects. The second is the existence of shared competencies and philosophic congruencies between the heroic white midwife and her purportedly obsolete, and continuously racialized counterpart. In both cases, I would argue, it is easy to suppress such understandings because the bodies who might narrate them are absent. In the absence of such counternarratives, certain stories can be convincingly told, stories which structure social relations through a "system of differentiation" (Foucault, 1982, p. 792). An impeccable example of the power/knowledge nexus described by Foucault in which relations of power "pass via knowledge" (Gore, 1993, p. 54), the stories told around the re-emergence of midwifery in Ontario derive much of their authority from their enmeshment with other circulating discourses of racial inferiority and from the "respectable" identities and access to public discourse of those who tell them. Indeed they have produced a powerful sense of entitlement for white midwives and one that defers any requirement to acknowledge complicity in an exclusionary project. As one midwife of colour who sat on a midwifery board was told by an elite white midwife: "We waited ten years, you can wait ten years" (Interview No. 1).

35 I do not mean to suggest here that the very presence of women of colour might have been sufficient to disabuse white midwives of their notions of the meritocratic nature of their accomplishments. As has been proven innumerable times, white women do not necessarily listen to nor comprehend what women of colour have to say and women of colour may logically choose not say much when they anticipate not being heard.
What follows here then is an attempt to provide a chronological accounting of exclusionary practices in the re-emergence of midwifery in Ontario.

*Technologies of exclusion*

**Pre-legislation midwifery as a white space**

The re-emergence of midwifery in the 1970s in Ontario represents a convergence of multiple and sometimes conflicting forces including: feminist and traditional women's health movements (including those which challenged the medical management of childbirth), counterculture lifestyle practices, and efforts by largely British-trained midwives to have their skills recognized within the health care system. The revival of home birth, systematically eradicated in Canada and the U.S. by the mid 20th century played a key role in midwifery’s revival. In the 1960s and early 1970s some Toronto women, often from marginalized religious communities, and increasingly, women and their partners who sought birth experiences outside of the hospital setting, utilized the services of doctors willing to provide care at home births (Bourgeault, 1996, p 37). In 1976, funding cuts to the Victorian Order of Nurses (VON) meant that home birth doctors lost access to formally-trained assistants, and that their clients forfeited nursing follow-up in the immediate postpartum period. The Home Birth Task Force, organized to lobby for restoration of the VON services, became the springboard for the development of community-based midwifery training and ultimately for the movement to integrate midwifery into Ontario’s health care system.

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36 The Midwifery Act had its first reading in the Ontario Legislature in June of 1990, therefore the period covered in this section spans the very first stirrings of midwifery re-emergence in mid 1970s to the first reading of the Midwifery Act.

In the 1970s and early 1980s, two groups followed quite different trajectories in their quests to give Ontario residents access to midwifery care. Some foreign-trained nurse-midwives, primarily white women from Britain, had formed the Ontario Nurse-Midwives Association (ONMA) in September of 1973 (Ontario Nurse Midwives Association, n.d.). The group went on to gather information and lobby medical and nursing organizations for the incorporation of some form of midwifery care into the health care system. Many were labour and delivery nurses working in hospitals and they assiduously avoided participation in out-of-hospital deliveries for fear of losing their nursing credentials and/or their jobs (Bourgeault, 1996, p. 43). It was not until 1981 that the ONMA connected with the recently-formed Ontario Association of Midwives (OAM), a support group consisting of both women who were working as birth assistants and midwives, and parents and others who supported midwifery. An outgrowth of the Home Birth Task Force described above, the group boasted nearly 200 members by 1982 (Bourgeault, 1996, p. 39). As midwifery chronicler Eleanor Barrington (1985) described them, "by 1980, the majority of midwives and their clients belonged to the middle class. Today's 'wise woman' is likely to be about thirty-five, raised in a suburb and university educated" (p.16). Arguably, most of Barrington's descriptive categories constitute code words for white racial identity. However, that the early midwifery movement was, almost without exception, composed of white women is agreed upon by the veteran midwives and midwifery activists interviewed in the course of this research.38

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Only three of the five white veteran midwives interviewed, all of whom have been active in midwifery since the mid-1970s and are currently practising, were able to recall the presence of women of colour during the earliest years of the movement. Two of the women mentioned the same practitioner, a woman who attempted to become registered in the province but who ultimately withdrew. One Toronto midwife remembered that a colleague in another city had worked with "a black woman who had been a midwife somewhere else and I remember I met that woman just once" (Interview No. 19). In a few cases, when asked to recall women of colour who became involved in midwifery, interviewees described women who might be described as "white others" - not quite proficient in the cultural competencies that would allow them to merge easily into midwifery's mainstream, but also unlikely to be interpellated as visible minority people in a economy of racial differentiation in which skin colour is the primary reference point. One interview subject remembered an Italian midwife who regularly attended OAM meetings but eventually stopped coming. Recalled another veteran midwife, "one of them who was practising was [...] Argentinian and she had also practised in Holland and in Israel and she spoke like five languages...And she actually became quite involved and she got into our circles" (Interview No. 17). Yet another veteran white midwife remembered that "there was one woman who came here from Holland. That was in the '80s. She wasn't black but she...was a practising midwife in Holland" (Interview No. 19). Such responses, I believe, indicate how unusual it was to encounter women who differed in any way from Barrington's description of midwives quoted above. One veteran midwife who admitted that she remembered no one who was not white,  

39 "Activism" in the case of those interviewed varies. While some white midwives interviewed were active members of the Ontario Association of Midwives and later the Association of Ontario Midwives, others confined their participation to attending workshops and conferences or participating in wider childbirth-reform activities. While most of those interviewed would not define themselves as among the most politically active of midwives, all interviewees participated in midwifery-related activities in the province and would have had occasion to meet and interact with women from across the province involved in the re-emergence of midwifery.
educated and middle class quipped: "the most diverse was people coming from the United States!" (Interview No. 21).

Spaces of encounter

Ontario midwives and immigrant midwives of colour did, however, encounter one another, and these encounters occurred most frequently in contexts with unique links to gender and globalization: health care and child care. White midwives frequently accompanied their clients to the hospital where they were prevented from engaging in clinical care but could provide needed emotional and physical support to the labouring woman. In such a setting they indeed met and interacted in the pre-legislation period with midwives of colour who worked as labour and delivery nurses. In Toronto, where more than one third of nurses are immigrant women of colour, these encounters would have been almost impossible to avoid. One white midwife admitted that she just as frequently encountered immigrant midwives of colour working as nannies for her clients as she did as nurses in the hospitals. Describing her interaction with these women, this veteran midwife said: "Sometimes, I would say [they], were very friendly and sort of said 'I was a midwife from my own country, you know!' and there was a very collegial feeling about that [...]. We talked just experiences kind of thing. But sometimes women would say, ...I've been asked like 'who do you contact?' (to become a midwife in Ontario) and whatever" (Interview No. 20).

These postcolonial spaces of encounter themselves structure the stories that can be told about the women who inhabit them (Grewal, 1996). In the pre-legislation period, white midwives and immigrant midwives of colour were structured into the health care system in subordinate, but non-commensurate ways. While midwives of colour working as labour and delivery nurses are subordinate to doctors and frequently to white nurses, they commanded institutional authority in relation to pre-legislation midwives, whose presence in the hospital as labour support was met by staff with varying levels of enthusiasm.
White midwives might have been looked upon, by both doctors and nurses, with suspicion and disdain because of their supposed anti-medical stance and claim to expert knowledge, but their white racial and middle-class identities may have afforded them some advantages.

While the midwife quoted above frequently directed midwives of colour to the various routes to professional practice available to them and has a long record of resistance to exclusionary policies, she appears to be quite singular in that regard. Encounters between white midwives and immigrant midwives of colour recounted in other interviews never involved the exchange of information that might encourage the non-practising midwives to become involved in midwifery-related activities. One immigrant midwife of colour who was among the small handful who participated in pre-legislation midwifery activities recalls that her own training and aspirations to practise, as well as the constraints on her ability to do so, were largely ignored by the white midwives she encountered, some of whom later became key policy makers:

I think I expressed interest certainly, ultimately that I'd like to practise but because of my status, I didn't want to practise in the way that they were practising currently because I was just afraid about earning an income and not having my status. I was only allowed to work...I was only supposed to work as a babysitter. But it was so tenuous as well and because I really wanted to stay in Canada, I didn't want to do anything to jeopardize it. [...] I don't recall anybody saying "I want you to come to a birth with me and see how you feel, see if you really want to." People knew, they knew that I really passionately wanted to do midwifery here. [...] It just occurred to me, there was never anything. (Interview No. 6)

Four out of the five midwives of colour interviewed who had worked as labour and delivery nurses before the legalization of midwifery recalled meeting white midwives in the hospital setting. Two of these women remembered that colleagues regarded the midwives with suspicion, seeing legalization as a
potential threat to nursing jobs. However, one did remember the interaction as pleasant and collegial:

[W]e had a delivery, quite nice. So we kind of appreciated them and then they said “Oh, you guys are doing quite well too.” We kind of appreciated each other and then we said “the mechanics of birth are always they same.” [...] They did want to know who we are. And then we did want to know who they are too (Interview No. 2).

Indeed, interactions between midwives of colour working as labour and delivery nurses and white midwives in the pre-legislation period were undoubtedly varied, ranging from indifference and hostility to enthusiastic support.

There were other settings in which these groups met. One white midwife described how she would invite foreign-trained midwives, including women of colour, to share their skills at in-service seminars for empirically-trained midwives. Because they were not practising midwives, these women were barred, later in the seminar, from attending the peer-review session of local midwives which was part of the self-regulatory process in the years before legislation. “I think they felt quite eliminated” the veteran midwife told me, “when they weren’t allowed to be in on those meetings” (Interview No.16).

Why would these two groups not have found enough common ground to forge personal and political links? From the point of view of midwifery activists, it can be argued that a number of discourses, including: inferiorization of nurses, their construction as subservient to doctors and their assumed acquiescence to conventional medicine, converged with racist discourses, including those about Third World medical training, to produce a subject wholly antithetical to the respectable, feminist subject the midwifery movement was struggling to construct. For midwives of colour working as labour and delivery nurses, their own claims to special professional knowledge were undermined by the presence in the workplace of these white, largely empirically-trained midwives. As will be shown below, immigrant midwives of colour interviewed used a variety of
discursive strategies to retain their status as midwives despite being prevented by midwifery legislation from claiming that title. Indeed, immigrant midwives of colour struggling to achieve professional status and workplace security as nurses might have logically desired to maintain their distance from a midwifery movement seen to represent "counterculture" and anti-medical values.

While interactions between immigrant midwives of colour and white midwives were relatively infrequent and took place under circumstances characterized by their complexity, my point here is that they indeed occurred. In some spaces, these groups were structured into the system in ways that virtually guaranteed that they would not seek common ground. But as I have demonstrated above, there were numerous opportunities to explore points of professional convergence. Consequently, I believe, exclusionary policies and attitudes were enacted not from a racially-bounded space of ignorance, but from a position of knowledge, however limited, of the skills and aspirations of the women with whom white midwives came into contact in the pre-legislation period.

While it is clear that few midwives of colour participated in pre-legislation midwifery, neither did the midwifery movement constitute a diverse environment in terms of the clientele that midwives served. While veteran white midwives interviewed, all of whom had extremely active practices (30-40 births a year as primarily care provider) in urban settings, had slightly different estimates of the number of women of colour served in the years before legalized midwifery, these estimates are uniformly low. One veteran reported that she had "about forty births in a year [...] out of those, a couple would not be, would not be...white people" (Interview No. 20). Another midwife estimated the number to be "one percent?! if" (Interview No.19). One of the few immigrant midwives of colour to practice in the pre-registration period indicated that the bulk of her clientele was white, with clients of colour accounting for "maybe five percent, actually" (interview No. 17). Asked why she thought that women from her own immigrant community did not seek midwifery care, she replied that she felt that the cost of
care had been a deterrent to potential clients and that she herself couldn't afford to do as many “free births” as she would have liked (Interview No. 14).

Inaction, ineptitude and imperialism: The Outreach Committee of the Association of Ontario Midwives, 1984-1993

While immigrant midwives of colour had little to do with the midwifery revival in the province, as imagined partners they constituted a useful bargaining chip in convincing the provincial government of the need for midwives. In 1983, the province began a review of health professions with the global aim of revamping how these professions were regulated in Ontario. The Health Professions Legislation Review (HPLR) contacted numerous organizations, among them the OAM and the ONMA, in order to ascertain whether or not midwifery should be regulated as a health profession (Bourgeault, 1996, p. 42). The HPLR proved to be a pivotal event in the re-emergence of midwifery as midwives and their supporters began to direct substantial effort towards incorporation into Ontario’s health care system. The OAM and the ONMA joined with the Midwifery Task Force of Ontario (MTFO), a newly-formed consumer support group, to produce a brief to the HPLR. With the turn toward legalization came what appears to be the first public statement about access by marginalized groups to midwifery care and practice. Unlike equity positions which were articulated by midwifery bodies in subsequent years, this statement clearly identified that marginalized groups’ access to care and their access to midwifery

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40 In November of 1982 the provincial Conservative government announced the formation of a Health Professions Legislative Review which was to construct a new regulatory framework for governing the health professions. The HPLR was to recommend to the government which health professions needed to be regulated, how the existing Health Disciplines Act was to be revised, what new structures were needed to govern health professions and which outstanding issues needed resolution (Bourgeault, 1996, p. 79).

41 This organization is entirely separate and distinct from the provincial Task Force for the Implementation of Midwifery in Ontario, created in 1986.
practice were interrelated issues and it named the material resources that the achievement of equity between dominant and marginalized groups requires:

Given the substantial benefits that accrue to lower-class and immigrant women through midwifery care it seems clear that midwives would be recruited and educated from as broad an ethnic and class range as possible. Access to midwifery education then, for those who might otherwise be excluded, should be guaranteed by means of subsidized training programs; in northern regions of Canada, such programs should be particularly geared to the training of Native women. (Midwifery Task Force of Ontario, 1984, p. 7)

Notwithstanding unsubstantiated claims about midwifery's benefits to "lower-class and immigrant women" and the racializing effects of this form of representation, this statement is perhaps the most progressive and inclusive one documented in midwifery publications. As legalization approached, concerns with equity grew less radical, less urgent and far less pragmatic.

In November of 1984 the OAM and ONMA agreed to merge, creating the Association of Ontario Midwives (AOM) (AOM, n.d., p.1). One of the AOM’s goals, stated in the first issue of its newsletter, was "outreach - to include the many midwives unable to practise their profession in Ontario" among them, those trained outside of Canada (AOM, n.d., p. 4). On the agenda for the group’s first annual general meeting was the establishment of an “Outreach Committee.” While other AOM committees, such as the Legislative and Professional Advisory committees, published reports in the organization’s newsletter, reports from the Outreach Committee were absent from the publication in the organisation’s first few years. The issue of “foreign-trained midwives,” however, did concern the AOM. How midwives would be educated and integrated into the health care system become a pressing matter in 1985. In that year, a coroner’s inquest investigating the death of a baby whose mother was attended by midwives recommended the regulation of midwifery in the province. This outcome influenced a similar recommendation by the HPLR and led ultimately to the
legislature admitting midwives to practice on December 31, 1993 (Bourgeault, 1996, p. 70).

In their 1985 submission to the HPLR, the AOM outlined their plan for the integration of midwifery into the health care system in Ontario. They recommended that "only midwives who have attended a minimum of 50 births, 30 of them as primary caregivers, be considered. These midwives must have been trained and/or practised in the last five years either in Ontario or in a foreign jurisdiction" (MTFO, 1986, p.11). The AOM's plan for legalized midwifery stipulated that foreign-trained midwives who had graduated from accredited schools and who had trained in the previous five years needed only to provide evidence of their certification in order to be eligible for a phase-in training program. As will be demonstrated below, the policy relating to foreign-trained midwives underwent significant revision as midwifery moved closer to integration into the health care system, ultimately preventing many immigrant midwives, among them numerous women of colour, from re-entering their profession with the advent of legalization.

In 1987, the AOM board was concerned with reviving the inactive Outreach Committee and a motion was unanimously passed designating the committee’s main priority to be “the needs and concerns of rural midwives (AOM, 1987a, p.12). This was amended soon after to include “minority group midwives, at this time particularly, the Inuit” (AOM 1987b, p.9). Indeed, the AOM seemed to invest time and resources in the period prior to legislation into forging links with a variety of “traditional midwives.” Its Fall 1987 newsletter reports at length upon Outreach Committee chair Betty-Anne Putt’s travels to meet with traditional midwives in Canada’s North, as well in Nicaragua and at various international conferences (AOM, 1987a, p 10). The newsletter devotes nearly two full pages to these events, as well as to a discussion of Putt’s efforts to establish preceptor sites where Ontario midwives could gain clinical experience in Sierra Leone, Algeria, the Dutch Antilles and Malaysia.
Strong in their belief that in the West, women’s instinctual birth behaviours had been perilously eroded, some Ontario midwives saw themselves as the First World guardians of a form of transhistorical female birthing knowledge, the richest repository of which was Third World midwives. Interactions with Third World midwives, such as those engaged in by Putt, as well as the widespread “midwifery tourism” which will be described in detail in Chapter Four, conferred a significant degree of midwifery authenticity upon Ontario midwives in their quest for validation in a relatively hostile environment. Far from benign, these interactions, I believe, actually represent a form of imperialism where, as bell hooks (1992) has argued, “the suffering imposed by structures of domination on those designated Other is deflected by an emphasis on seduction and longing where the desire is not to make the Other over in one’s image but to become the Other” (p. 25). Indeed the case at hand represents a particular form of feminist imperialism in which First World women’s complicity in global relations of domination are obscured within an epistemological frame which foregrounds women’s shared identity. However, this longing for the “other” had its limitations, inasmuch as the midwife who is desired is the mythical purveyor of unmediated birthing knowledge encountered in situ, not the fully historicized migrant midwife transported to the First World by conditions of globalization.

A short paragraph inserted into the report of Putt’s activities hints, however, at some fleeting awareness on the part of the AOM of the contradictions of pursuing the traditional midwife into her Third World habitat when the Third World has an undeniable presence in the First World. “It will be an important project,” reported the AOM Newsletter, “to contact all the midwives in Ontario who have been trained in other countries as midwives to help them to become incorporated into the new health care system. This has to be discussed” (AOM, 1987b, p.10). In a tacit recognition of the predominance of immigrant midwives of colour among those who might wish to become registered, the
Outreach Committee recommended that ads be placed in “ethnic” newspapers, a suggestion that was followed in Eastern Ontario, but not in Toronto, where, the visible minority immigrant population was far greater.

Throughout 1988, reports of the Outreach Committee in the AOM newsletter dealt exclusively with Betty-Anne Putt’s travels and connections with traditional midwives. Sparse news followed in 1989. One midwifery activist told me that the Committee was disbanded in that year under circumstances that she was prevented by a vow of institutional confidentiality from describing to me (Interview No. 17). The paralysis that afflicted the Outreach Committee was multifaceted. The AOM Outreach Committee never attracted the most politically influential members of the midwifery movement. There was a lingering tension among midwives and their supporters between those who defended regulation and those who regarded it with suspicion. As AOM members were increasingly called upon to serve on provincial boards and committees related to midwifery legislation and implementation, those with political and organizational skills were catapulted into positions of power and influence. Many of the most active were members of the Midwives Collective, a feminist-identified group which paid its members to do political as well as clinical midwifery work and whose members seemed to have fewer domestic responsibilities than did other practitioners in the province (Bourgeault, 1996, p. 46). The Outreach Committee rapidly became a refuge for those who were excluded from public midwifery work because of their purported lack of political acumen, their opposition to incorporation, their geographic isolation or their inability (largely owing to child rearing responsibilities) to devote time to both midwifery politics and midwifery practice. One veteran midwife claimed that it

became this place...it was like a haven for people to come and join with each other and share ideas about what was going on around the province. It became a haven for the rural midwives, it became a

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42 See, for example, J. Mason (1990). The trouble with licensing midwives. Ottawa: CRIAW/ICREF.
place where they felt safe. It became a place where they could talk about what they really wanted to talk about. And at one point it became a place where people joined if they had different ideologies and were really concerned about legislation and were more interested in decriminalization. (Interview No. 17)

In 1990, the Outreach Committee, now under the leadership of Teresa Maloney, proposed yet another mandate:

(1) to make contact and promote exchange between the AOM and midwives and students in Ontario who are isolated by such factors as geography, ethnic origin, or need for support, (2) to provide information about the AOM and encourage involvement and, (3) to work toward equal access to midwifery education and to midwifery care for all those who may be discriminated against on the basis of such factors as language, culture, age, economic status, sexual orientation, gender, geographic location, disability, race or religion. (AOM, 1990, p. 13)

Clearly, this was a much more aggressive and comprehensive equity agenda than any that had preceded it. This new mandate was no doubt influenced by the establishment at the same time of an Equity Committee within the Interim Regulatory Council on Midwifery, the body which had been appointed by the provincial government to integrate midwifery into the health care system. And while the Outreach Committee of the AOM was never an effective body, it became even less functional in the years just prior to legalization, meeting only annually (AOM, 1991, p. 20). In 1992, the struggling committee was again restructured so that regions could implement their own outreach projects, although no “outreach” activities are described in the regional reports in the 1991/1992 AOM Report. The Report does state, however, that in 1993 the mandate for an Outreach/Equity Committee was being drawn up (AOM, 1993, p. 16).

The Outreach Committee, the AOM’s appointed body for dealing with marginalized groups in relation to midwifery, was itself marginal within an organisation increasingly concerned with readying policies that would serve
those already practising in the province. And while internal fragmentation in the AOM may have contributed to the Outreach Committee's inertia, there were compelling conceptual and strategic reasons to neglect the outreach issue. Inasmuch as midwives saw themselves as unfairly and rigorously marginalized, efforts to include racialized midwives could well have been viewed as a low priority. Indeed, as I will argue in Chapter Four, inclusivity may have been seen as a liability to a movement clamouring for respectability.

**Government bodies and exclusionary policies in the integration period**

In 1986, the provincial government accepted the Health Professions Legislation Review's recommendation that midwifery become a regulated profession and established the Task Force for the Implementation of Midwifery in Ontario (TFIMO). The Task Force's mandate was to supply the Minister of Health with information on midwifery education, scope of practice, governance, and a variety of other matters (TFIMO, 1987, p. 29). Chaired by prominent feminist lawyer Mary Eberts, it included a physician, a Canadian nursing professor trained as a nurse-midwife in the U.S., and the chair of the Health Profession Legislation Review. While no midwives sat on the body, they did exercise considerable influence over its proceedings. The Association of Ontario Midwives and its closely-allied support group, the Midwifery Task Force of Ontario, organized numerous submissions to the TFIMO from consumers and local and international organisations (Bourgeault, 1996, p. 74).

In total, 86 organisations, twenty-four of them women's groups, made submissions to the TFIMO. Only five of the submissions came from organizations representing racial minority groups, including: the Union of Ontario Indians, the Multicultural Women's Centre, Women Working with Immigrant Women, and the Association of Iroquois and Allied Indians (TFIMO, 1987, p. 273). Ironically, this was a period in Ontario of intense political organizing by women of colour and the proliferation of community, provincial and national
groups devoted to gaining political rights for immigrant women of colour (Pierson, 1993). Groups such as the National Organisation of Immigrant and Visible-Minority Women, the Congress of Black Women, the United Council of Filipino Associations of Canada, the Women's Committee of the Canadian Ethno-Cultural Council, The Chinese Canadian National Council, and Intercede, a foreign domestic workers advocacy organization, all endeavoured in this period to provide services to marginalized women and to advocate for them on a number fronts (Agnew, 1996, p. 111). Struggles around racism in the feminist movement also moved to the fore. The National Action Committee on the Status of Women (NAC) had been pressured by women of colour to add an Immigrant and Visible Minority Women's Committee and organizers of Toronto's International Women's Day celebrations began, in the wake of intense criticism, to pursue a more anti-racist organizational structure and politics. Indeed, racist dynamics were identified by feminists of colour as endemic to many white-dominated feminist services and organisations (Findlay, 1993, p. 208).

White feminist activism during this time was increasingly directed towards gaining recognition and resources from the state. As Christina Gabriel (1996) has noted about this period, the province's responses to women of colour were “ad hoc” because this group could not be inserted neatly into either “race relations” or “women’s policies” frameworks (p. 190). Carmencita Hernandez, an activist who later served on a College of Midwives advisory board observed, “there was no policy regarding visible minority women. As women we were not targeted by policies and programs of the OWD [Ontario Women's Directorate]; as visible minorities, we were lumped together with men by the Race Relations Directorate” (Hernandez, 1988, p. 159). A 1984 Royal Commission on Equality in Employment had identified four groups - women, visible minorities, Native people and disabled persons - who had historically suffered discrimination and disadvantage and numerous policies ensued which addressed issues relating to the groups as defined by the Commission. These target groups having been identified, provincial bureaucracies like the Ontario Women's Directorate and the
Race Relations Directorate were both conceptually and structurally unable to deal with those whose subjectivities emerged at the intersection of identity categories.

In such a political climate, the legalization of midwifery was viewed as a “women’s issue” and its successful implementation as a benefit to all women. Rarely does the TFIMO report refer to social identities which complicate the category of “woman.” “Immigrant women,” largely an inferiorizing social category (Ng, 1988), is invoked only in passing and only in terms of the “neediness” of those referenced by that term. Even the advocacy group Women Working with Immigrant Women claimed in their submission to the TFIMO that “women from different cultures” needed midwifery care because of their aversion to male physicians, thus reinscribing such women as subjects entrapped in gender-segregated patriarchal cultures (TFIMO, 1987, p. 259). Moreover, the remedy which was promoted for this situation was care by women who were motivated by cross-race female empathy and who were, therefore, unimplicated in individual or systemic racism. What is absent from the report, except in a statistical accounting of the province’s nurses, is any reference to immigrant women of colour with midwifery training from their previous country of residence or to the barriers that might prevent them from benefiting from the province’s celebrated attention to this “women’s issue.” While white midwives and their supporters used their considerable skills and influence to produce an extraordinary number of submissions to the TFIMO, women of colour, a group with significant investments in the midwifery profession, were almost completely absent from the Task Force report.

**Accounting for immigrant midwives of colour in the TFIMO report**

The TFIMO report showed, inarguably, that immigrant midwives of colour were keenly interested in practising in the province. While in a survey conducted in 1985 through the College of Nurses of Ontario, 4514 Registered Nurses and
Registered Nursing Assistants reported that they had received midwifery training, it was estimated that the actual number of nurses in the province with such training was between 6000 and 7200 (TFIMO, 1987, p. 149). Approximately 35% of those who responded to the survey reported that they completed their midwifery education in the West Indies, India or the Philippines (TFIMO, p. 151). While among the total number of respondents with midwifery training, 621 desired to practise midwifery once legislation was in place, only 110 of these had ever actually practised midwifery prior to coming to Canada. Of these 110, nearly forty percent had practised in the “West Indies or the Philippines” (TFIMO, 1987, p. 151). There is no data that would indicate what portion of those nurses who responded that they had previously practised in the United Kingdom or the “United Kingdom and another country” or who had indicated the category “other” were women of colour. However, among those immigrant midwives of colour interviewed for this study, 7 out of 17 or 41% had studied and/or practised midwifery in the United Kingdom. These data suggest that perhaps half or more of those who had been trained in midwifery and who had practised the profession prior to coming to Canada and who wished to resume practice, were women of colour.

It can be argued as well that estimates of the number of ‘racial minority’ women in the ranks of trained midwives and among those interested in practising the profession are complicated by post-1985 trends in immigration. While immigration to Canada from Europe accounted for 77% of immigrants in 1967, in 1987 only 22% of immigrants were Europeans (Task Force on Access to Professions and Trades in Ontario, 1989, p. 12). In 1987, immigration from South and Central America (including the Caribbean) quadrupled from its 1967 rates (Task Force on Access to Professions and Trades in Ontario, 1989, p. 12). Nearly 40% of Chinese immigrants, who comprise 26% of adults in “visible minority” groups, arrived in the years between 1982 and 1991. The figures are similar for immigrants from the Philippines, although they comprise only 7% of the total ‘visible minority’ group (Statistics Canada, 1999). In addition, it is
important to note that one third of all Filipinas, as well as one third of all Black women, work as health care professionals (Boyd, 1992, p. 303) suggesting that recent immigrant women from the South may be more likely to have training as health care workers, including midwifery training.\(^{43}\)

The 110 women, probably half or more of whom were women of colour who had previously practised midwifery and wished to do so again, must be considered carefully here. The data in fact indicate significant confluences between nurses with midwifery training and those engaged in re-emergent midwifery. According the TFIMO report, these women had, almost uniformly, performed the entire range of midwifery functions named in the survey. In addition, they had practised in a variety of settings and a notably high proportion (71.3%) had conducted home births (p. 343). The Report also showed that while this group envisioned midwifery as a nursing specialty with independent status, they were not wedded to the idea of nursing training as a prerequisite for hospital privileges for midwives in Ontario (p. 382). While responses specific to the 110 nurses who were also experienced midwives and who wished to practise are not available, statistics for the cohort of all 621 of those who wished to practise (with and without experience) showed that nearly half supported the right of non-nurse midwives to practise in the province both in and out of hospitals and an overwhelming majority supported the right of all qualified midwives to conduct home births -- positions not supported by their own provincial nursing organizations (p. 382).

\(^{43}\) Despite this demographic profile of Ontario, Task Force members saw fit to survey in detail only European and American midwifery systems, visiting England, Scotland and Wales, as well as Denmark and the Netherlands. In the U.S., members visited numerous midwifery practice sites including those staffed by nurse midwives and empirically trained midwives (TFIMO, 1987, p. 39). Indeed, no midwifery sites in either the Caribbean or the Philippines, the previous locations of midwifery practice for nearly half of those with training outside Canada, were visited during the Task Force’s investigations. While the Report claims to have reviewed material about midwifery in other countries, these are not named.
The data collected for the TFIMO report offered the only knowledge available at the time about the skills and aspirations of immigrant midwives of colour. These statistics, as well as data presented in Chapter Six below about the philosophies and skills of foreign-trained midwives of colour, belie alarmist claims such as those made subsequently by the members of the Midwifery Task Force of Ontario who, it can be argued, entirely misread the TFIMO report. In a quote which resonates with racist discourses of immigrant invasion and usurpation, the civilized mission of midwifery is seen as being overrun by the uncivilized:

"It is important to remember when we consider ongoing challenge testing that according to the 1987 survey in the Report of the Task Force on the Implementation of Midwifery in Ontario, there are approximately 4000 foreign-trained midwives working as nurses in Ontario. Of these approximately 600 would be interested in practising midwifery in Ontario. These are overwhelming numbers in comparison to the 50 or 60 practising midwives in Ontario today. There are concerns throughout Ontario that the soul of midwifery could be jeopardized by such a large influx of foreign-trained midwives with a different philosophy of continuity of care, choice of birthplace, and informed choice, who would shape or alter the approach of midwifery care simply as a result of their numbers. (Matthews & Thatcher, 1992, p. 21)"

While the TFIMO report proved otherwise, the conceptualization of foreign-trained midwives as philosophically opposed to the Ontario model of midwifery care infused the entire project of integrating midwifery into the health care system. Midwifery activists, and policy makers who supported them, held firmly to the argument that foreign-trained midwives would endanger the project. Such an assertion served as well to delineate the boundary between midwifery "turf" and that occupied by nurses. A member of the Interim Regulatory Council

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44 These arguments were being launched in response to an acrimonious debate in the midwifery community over the proposed nature of the Midwifery Education Program. Some midwives who remained opposed to regulation fought to retain the apprenticeship model and the right to continue midwifery training outside of a formal midwifery education system. The authors of this quote spoke on behalf of the MTFO, a group historically aligned with the state-sponsored midwifery apparatus. (Bourgeault, 1996, p. 155).
on Midwifery (IRCM), the first institutional precursor to the College of Midwives, commented:

[T]he issue of preserving the full model of care wasn’t designed with any conscious intent to exclude anybody, as much as it was designed with conscious intent to protect ourselves against the College of Nurses who initially wouldn’t have wanted a home birth model. [...] The foreign-trained midwife thing for the IRCM...wasn’t a matter of “foreign”, it wasn’t a matter of “foreign” at all. It was people who didn’t have the home birth experience. Because without the people having had that home birth experience in the program we couldn’t protect home birth and that was really, really important to the model itself. (Interview No. 25)

Despite documentation demonstrating the wide scope of their former practice and indications of some degree of philosophical congruence between the Ontario midwifery movement and those nurses with midwifery training from abroad, the TFIMO Report painted foreign-trained practitioners as effectively obsolete. It took pains to emphasize one aspect of what the College of Nurses of Ontario survey had reported: that the training of those who wished to practise after legislation had been obtained, for the most part, before 1970, and was, therefore, “outdated” (p. 148). However, for those working as labour and delivery nurses, temporal distance from midwifery training and practice did not necessarily signal an absence of midwifery skills. Indeed, to claim so is to deny any confluence between obstetrical nursing knowledge and that related to midwifery, a claim which cannot logically be substantiated. My research with immigrant midwives of colour who worked as labour and delivery nurses demonstrates that their midwifery qualifications distinguished them in the hospital setting as especially skilled, and even prompted doctors to allow them to manage deliveries alone in some institutions. However, in the end, the report concluded, “foreign-trained midwives” were likely to be required to repeat their basic midwifery education (p. 346).
The designation of foreign-trained midwives' knowledge as obsolete clearly impacted negatively on both white women and women of colour. But for the latter, it replicated a racist legacy of the inferiorization of the credentials of nurses of colour in Canada (Calliste, 1993) and became yet another roadblock in a system structured in ways which limit their occupational mobility in the health care system. Immigrant midwives of colour were unlikely in this period to have seen the necessity to make a special case with the Task Force for their integration into practice in the province. While, as my research has shown, many were unaware of the impending legislation, those who were, may have believed that their nursing organizations would protect their interests. Regrettably, they did not testify on their own behalf before the Task Force for the Implementation of Midwifery in Ontario and their interests went unrepresented for the entire formative period of the midwifery profession in the province. But the TFIMO Report did not formulate insuperable barriers for foreign-trained midwives. It recommended the initiation of a Midwifery Integration Program as “a means for the best qualified midwives, maternal/child nurses, and others to integrate into the regulated profession of midwifery” (p. 153). It outlined a straightforward procedure in which anyone with 12 months of residency in Ontario as a citizen or permanent resident, English proficiency as well as “educational preparation or significant experience in midwifery, maternal/infant nursing or medicine” (p. 152) could undergo examinations leading to Ontario certification. The government-appointed bodies that were charged with the implementation of midwifery, and which were controlled largely by white midwifery practitioners, would reformulate these earlier policies in ways which worked to exclude women of colour from practice in the province. How this occurred and which purposes were served by the exclusions will be explored below.
The Interim Regulatory Council on Midwifery, the Curriculum Development Committee and the Midwifery Integration Project 1989-1993

On May 19, 1989, 13 members were appointed by Order-in-Council to serve on an Interim Regulatory Council on Midwifery which would formulate policy leading to regulation (Ontario Interim Regulatory Council on Midwifery, 1990, p. 1). The members included health care professionals and consumers. The IRCM was chaired by lawyer Mary Eberts who had chaired the TFIMO. The Task Force Report had indicated that midwives could not be appointed to any governing council until they were legally registered in the province. However, it had recommended the appointment of a committee which would “provide liaison and advice” to the Council (p. 21). Stipulated to constitute that committee were “students in the Midwifery Integration Program and foreign-trained midwives waiting to present their credentials for recognition” (p. 21). However, the Liaison Committee was selected and directed by the Association of Ontario Midwives and was composed of the organization’s most politically involved members (Bourgeault, 1996, p. 85). Remunerated on a per diem basis by the province, the Liaison Committee members functioned in a capacity almost identical to that of the Council’s official members. 45 The second group stipulated by the TFIMO report, foreign-trained midwives, never received representation on the Committee.

With one exception, the IRCM and the midwives’ Liaison Committee were a white and highly privileged group (Ford, 1992, p 1). And while there was awareness of this fact, it did not seem to prompt much introspection nor did it diminish their sense of being on a pioneering mission. Indeed, Council members found participation in the widely celebrated process a heady experience and one in which their own participation constituted a sort of heroism. One Council member interviewed told me:

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45 Bourgeault (1996) reports that while that funding for six Liaison Committee members was provided by the Council, nine midwives shared the disbursement (p. 85).
There was so much, um, sort of, you know “the world is watching you” kind of that surrounded all those early days at the IRCM and the release of the (TFIMO) midwifery report (which) all led to this kind of “oh my God, can you believe it, we’ve actually done it.” And I think that a lot of us got very blinded by that attention and status that went with that. (Interview No. 27)

However “blinded” Council members might have been, they were not entirely unaware of their own homogeneity. Such awareness, however, in no way blunted their desire to retain their seats on the Council and the attendant power to enact policy for the new profession. As one member told me:

[T]here was talking right from the beginning [...] that there was this awareness that it was not a representative group. That not only were we more or less, with the exception of Murray Enkin, in a certain age range, all white, all of a certain educational level...I mean it was appalling how homogeneous a group we were. Um and so that got raised, but it was...there was never anybody really uh...willing to take a strong stand [...] No one ever said “I’ll come off the committee if you’ll put a woman of colour in my place.” (Interview No. 27)

The only Council member who did not fit the profile described above was Jesse Russell. Russell, a Metis woman from Thunder Bay, had worked as a policy analyst on Aboriginal women's issues, providing services to the Ontario Women's Directorate (Ontario Interim Regulatory Council on Midwifery, 1991b, p. 3). One Council member interviewed described Russell as “the only voice that brought a different community perspective around the table” (Interview No. 27). “Russell," claimed the same Council member, “never felt like she belonged.” Russell’s only committee appointment on the Council was to the Equity Committee, a body that was not mandated by the final HPLR report but which had been formed at her urging (OIRCM, 1993, p. 10). Russell’s participation on the IRCM was focused unwaveringly on the relationship of Aboriginal women to the impending regulation of midwifery in the province and she exercised considerable influence, as will be shown below, in bringing to the table the contentious and uncomfortable issue of jurisdiction over Aboriginal midwifery.
One Council member indicated that it was the political pressure of Aboriginal groups that forced the Council to acquiesce, ultimately, to the exemption of Aboriginal midwives from the legislation.

The Curriculum Development Committee (CDC) and the Midwifery Integration Planning Project (MIPP), two groups which functioned separately from, but concurrently with the IRCM, enacted policies that took significant exclusionary turns. The CDC, formed in 1989, was empowered by the provincial government to develop a midwifery curriculum and to propose options for a site for a midwifery education program. In addition, the CDC was to recommend a program for the integration of those with prior midwifery experience. While the CDC's decisions would have a significant impact on foreign-trained midwives who expressed an interest in practising, the impact was more profoundly felt by women of colour as has been argued above. None, however, were appointed to the Committee and no organizations representing the interests of immigrant women of colour were among those who offered submissions. Like the TFIMO, the CDC referenced only midwifery data from Europe. However, it diverged from the TFIMO in reformulating its recommendations regarding foreign-trained midwives so as to effectively exclude them from participation in an integration program intended to incorporate those with midwifery expertise into the newly legalized profession.

The CDC retained the TFIMO policy of baccalaureate-preparation as the educational standard for midwifery practice but abandoned its recommendation that a 12-18 month diploma stream be available for nurses with university-level training. This decision had exclusionary consequences for foreign-trained midwives across the board. Baccalaureate preparation for nurses and midwives is exceedingly rare worldwide. Indeed, while "visible minority" immigrant women

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46 Two white midwives who were working at the Povungnituk birth centre in Northern Ontario did make a submission to the CDC (CDC, 1990, p. 51). The centre serves Inuit women in the north.
are more likely to be university-trained than those born in Canada (15% vs. 10%) (Statistics Canada, 1995, p. 58), this statistic may not represent the educational attainments of nurses in this group, many of whom received their training in countries where, as in Canada, baccalaureate preparation for nursing has, until only recently, not been the norm. In the period under discussion, approximately 14% of Canadian nurses held baccalaureate nursing degrees (Sedivy-Glasgow, 1992, p. 28). However, some statistics indicate that less than one half of one percent of all foreign-trained nurses with formal midwifery education were university educated (TFIMO, 1987, p. 331). Having been eliminated from the program which would integrate practising midwives into the health care system, most foreign-trained midwives would have to augment or repeat their prior education to gain entrance to practice.\footnote{This policy may have stemmed from the overwhelming preference on the part of hospitals for midwives to be baccalaureate-prepared (Bourgeault, 1996, p. 135).} The discriminatory nature of the baccalaureate requirement can be viewed as particularly grievous given the fact that the CDC and the MIPP did not require applicants to the Michener Pre-registration project, which integrated currently practising midwives into the health care system, to have or complete a baccalaureate credential (Schatz, 1992). How the baccalaureate equivalency has constituted a roadblock on the major route to practice available for immigrant midwives of colour - the College of Midwives of Ontario's Prior Learning and Experience Assessment program - will be discussed in Chapter 6.

A second CDC recommendation had a more direct exclusionary impact on immigrant midwives. While the TFIMO had designated that the integration process be open to “the best qualified midwives, maternal/child nurses, and others” (TFIMO, 1987, p. 153), the CDC report recommended that “an integration program be developed as quickly as possible to meet the needs of those midwifery practitioners with current experience in Ontario” (CDC, 1990, p. 12). Members of this group, identified not as “foreign-trained midwives” as in the
TFIMO report but as "midwives without Ontario experience,"⁴⁸ were to apply to
the future College of Midwives to have their credentials assessed (CDC, 1990, p.
38). Five years would pass before this was a possibility.

Appointed in October 1990, the Midwifery Integration Planning Project
took up where the CDC had left off. Identical in its racial homogeneity to its
predecessor, the MIPP's mandate was to formulate the procedure by which
practising midwives would be assessed and licensed in the province. In their
third meeting, MIPP members recommended that in order to be eligible for the
integration project, candidates must have practised two years out of the previous
six in Ontario (MIPP, 1990, p. 2). While the requirement succeeded in keeping
out and raising the ire of some apprentice, newly-practising and rural midwives,
immigrant midwives of colour were the least likely to have had Ontario
experience and therefore, despite other qualifications, the least likely to qualify
for the planned integration program and for immediate access to practice. This
decision and the exclusionary effects which it activated are of singular
importance to the story of racist exclusion that this thesis recounts. Indeed, the
Ontario practice requirement firmly inscribed a normative national/racial identity
onto professional midwifery and delayed for years the entry of women of colour
into the profession.

Midwives of colour, as I have argued above, were less likely to be located
within the social geography of the nearly monoracial Ontario midwifery
community. As a consequence, they were also less likely to establish
apprenticeships which could link them to the social networks where midwifery
was in demand and where clientele were likely to pay fees that could sustain a
midwife in full-time practice. Some midwives of colour did, however, deliver

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⁴⁸ This change in terminology represents an important discursive shift. I remember being
corrected in 1995 by one midwifery activist when I used the term "foreign-trained" in as
much as the "foreign" designation was seen to be a form of "othering." The apparent
contradiction of a discursive shift to a less exclusionary terminology in the absence of
inclusionary practices that would give "foreign-trained" midwives access to practice
seemed obvious to me at the time.
babies within immigrant communities but the low incomes of their clientele kept their practices small. One white midwife related in an interview how she had, in the early 1990s, struck a partnership with a midwife who had immigrated from a Latin American country. The fees that they were paid by their working-class Latin American immigrant clientele were often well below the going rate of 600.00 CDN and therefore both continued to work part-time - a situation which prevented them from accumulating the number of births necessary to be considered for the Michener program.

As Sherene Razack (1999) has argued, immigrant people of colour in white settler societies are always already construed as a threat to the racial order. Even when legally allowed to dwell within such societies, they are subject to surveillance and their “goodness” is the counterpoint invoked to highlight the “badness” of undocumented immigrants. Under these circumstances, it is not surprising that immigrant people of colour become hyper-vigilant about not transgressing the law. Immigrant midwives of colour are no exception. Prior to legalization, while anxious to work in their profession, these women feared legal prosecution and deportation if they were to practise in the legal limbo which characterized that period (Burtch, 1994). Stories of deportation of immigrants of colour and their construction as criminals are daily fare in the Canadian press. And even documented immigrants, argues Sherene Razack (1999), speaking of her own experience, “can still be confused with the unruly mob and suspected of treason at worst, of failing to conform to respectable codes of behaviour at best” (p. 171). Midwives of colour related that they strictly avoided using their clinical

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skills even when requested to attend (out of hospital) births of friends and relatives. As one Indo-Caribbean midwife put it:

You're coming from Third World Countries, from war-torn countries, whatever or you're just coming because you think the grass is greener here. Can you imagine coming to this country and working as a midwife illegally? We so want to do things the right way. I don't think they [midwifery officials] envision what it means to come here as an immigrant do something illegally. (Interview No. 8)

An Afro-Caribbean midwife told me: "I didn't want to jeopardize my status to become a midwife because I wanted to be a Canadian" (Interview No. 6).

**IRCM members' explanatory schemata of exclusion**

Two out of the three IRCM members interviewed for this study admitted that the midwifery integration process had been a racially exclusionary one. And while only one interviewee demonstrated significant remorse about this, the two used similar explanatory strategies to rationalize the exclusions. There were, in effect, three discursive devices that enabled the IRCM members quoted above and many others to rationalize and ultimately acquiesce to the racist exclusion that they observed. These include: the "heroic tale" of midwifery, "white solidarity," and "inoculation." The first and, I believe, most indispensable of these, is the interviewees' participation in what has already been identified as the "heroic tale" of the re-emergence of midwifery. Central to the heroic narrative offered by midwifery activists was the claim that exclusionary strategies that led to the legalization of midwifery were justified both because of the anticipated benefits to women and because midwifery's (largely medical) adversaries were extraordinary powerful (Davidson, 1997). Recounting her own moral struggles with the exclusions that she observed, one IRCM member told me:
And the more I met women who it affected, the more I realized that there was something wrong with it and the more disillusioned I became. It was a constant struggle in my mind and not just me, there were other community members on the IRCM who felt very similar to me. There was a constant feeling of “you know why you’ve done it this way” [...] and this will go down in history as being an absolutely remarkable coup for the women’s health movement and the childbirth movement in this country...But there are pieces of that that probably should have been reexamined along the way. Now the argument for why they weren’t reexamined [...] was always that there were these other forces that were powerful, that were gonna get us if we weren’t careful, if we didn’t show solidarity and unity amongst ourselves that we wouldn’t...it was always held before us like a carrot. (Interview No. 27)

Utilizing, as did the speaker above, what I call the “forces of evil” excuse - an unmistakable “race to innocence” (Fellows & Razack, 1998) strategy in which the claim to oppressed status is used to deflect knowledge of one’s own dominant positioning - another IRCM member rationalized exclusionary practice thus:

I mean it happened that there weren’t people with different skin colours doing this. And the problem was protection of the model and vulnerability of the model. You have no idea what kind of beating we took from the medical profession in those years and how vulnerable we were to getting absolutely killed. [...] If we weren’t careful in registering, in the pre-registration process and we exposed the professions to inadequacies of practice that left us vulnerable to vultures just waiting to kill or waiting to pick up the spoils. (Interview No. 25)

If the “heroic tale” constituted the theory which rationalized exclusion in the pre-integration period, then white racial solidarity was the practice through which it materialized. While appointments to the IRCM had been made by health minister Elinor Caplan, many of the recommendations had come from midwives and midwifery activists (Bourgeault, 1996, p. 83). Some women who had been appointed had themselves been midwifery consumers and they were zealously loyal to the midwives who attended their births. As well, the liaison committee members were all prominent midwives. Solidarity in this case had a number of
complex dimensions. IRCM members interviewed indicated that they were reluctant to abandon allegiance to those with whom they shared both politics and the significant personal event of childbirth. Said one member, "We were supporters, they knew we loved them and that we'd back them. Some of them had delivered our babies" (Interview No. 27).

In the IRCM and elsewhere, intense interpersonal links, formed under conditions of ideological commonality and struggle among women whose class backgrounds and racial identities were extraordinarily congruent, rendered any critique of white racial privilege unthinkable, if not traitorous, to the midwifery cause. I would argue that the solidarity expressed here is a form of what Christine Sleeter (1996) calls "white racial bonding" - a set of "interactions that have the purpose of affirming a common stance on race-related issues, legitimating particular interpretations of oppressed groups, and drawing we-they boundaries" (p. 261). Such interactions, Sleeter posits, invite white people to signal their solidarity with the dominant racial group. To refuse to participate in these rituals, she argues, is to risk losing the approval and friendship of one's peers (p. 263). However, breaking the ranks of white sisterhood also posed the risk of losing one's self. In psychoanalytic terms, argues Carol Schick (1998), "[t]he desire is to see oneself...as good...with the fantasies covering over or forgetting parts of the narrative that do not coincide" (p. 115). A profoundly anxiety-provoking event, coming to grips with exclusion would have meant an end to these women's sense of themselves as benevolent and unimplicated in relations of domination, notions foundational to their participation in midwifery-related work. Finally, while it may be difficult to envision this "solidarity" as a de facto consolidation of white privilege and not merely as loyalty to a cause, in the case at hand, these two effects are conflated inasmuch as forms of racist exclusion have been foundational in the reemergence of midwifery in the province. Indeed, it is precisely this kind of envisioning that is required if white women are to cease reproducing relations of domination.
Managing difference: The IRCM Equity Committee

A third device used by IRCM members interviewed to rationalize exclusion, and one which very effectively "inoculated" the midwifery project against charges of discriminatory practice, was the foregrounding of the accomplishments of the IRCM's Equity Committee. In a provocative essay in which she argues that French social and literary critic Roland Barthes was "one of the first white Western critical theorists to develop an analytical apparatus for theorizing white consciousness in a postempire world" (p. 88), Chéla Sandoval (1997) outlines several figures of Barthes' "rhetoric of supremacy" which "shape and inhabit not only the most obedient and deserving citizen/subject, but also even the most rebellious agent of social change" (p. 88). The first of these that Barthes posited was "the inoculation." In this process, "modest doses of dissimilarity" are introduced, providing the subject's consciousness with a cautious exposure to forms of difference which can be "taken in, tamed and domesticated" (Sandoval, 1997, p. 89). Having ingested the serum of difference, the subject becomes immune to difference's more virulent strains and to their threat to the very tissue of subjecthood - itself contingent on the difference which it seeks to deflect. This process is very much in evidence in official midwifery publications and in other materials written by midwifery supporters which touted the establishment of an Equity Committee as evidence of Ontario midwifery's commitment to anti-oppression politics. Indeed, this commitment was characterized as being without parallel among regulated health professionals in the province (Ford, 1991, 1993; OIRCM, 1991a, 1992a, 1992b, 1993; Shroff, 1997). Before returning to this point, I will summarize the work of the Equity Committee.

In January of 1990 the IRCM was presented with a mandate for an Equity Committee which was to "ensure that the proposed College of Midwives is responsive to different groups who are interested in midwifery as a profession or as a service...focusing on varied language and cultural groups, disadvantaged
women and women in institutions" (IRCM, 1990, p. 4). The Committee, which had been proposed by Jesse Russell and which included her as well as three other IRCM members, was not mandated by the provincial government and was something of an aberration among other professions which had undergone the Health Professions Legislation Review process.

Between 1990 and 1993 the Committee conducted a series of consultations across the province intended to elicit input from marginalized groups about access to midwifery care and practice. The groups included Aboriginal women, women with disabilities, immigrant and refugee women, and Mennonite, teen, and lesbian women. However, the Committee focused the bulk of its attention on the concerns expressed by various First Nations communities with the pending midwifery legislation. At least half the pages of the Committee's published "Equity Reports" were devoted to consultations done in Northern and Northwestern Ontario, the Akwesasne First Nations Reserve in Eastern Ontario, and the Six Nations Reserve near Brantford, Ontario. It is entirely logical that the Committee's focus should have been directed at Aboriginal women's childbearing, given Jesse Russell's intent focus on the issue and her position as initiator of the Committee (Equity Committee of the IRCM, 1992, p. 2). Russell's initiatives, as well as political organizing among Aboriginal people, brought pressure upon both the IRCM and the Ministry of Health to exempt Aboriginal midwives from regulation under the pending Registered Health Professions Act.

First Nations midwifery and Ontario midwives: Tracking exemption and redemption

By September 1990, the Ontario Native Women's Association had adopted a resolution at its annual assembly calling for "steps to insure that the needs and concerns of Aboriginal women are brought to the attention of the provincial government regarding midwifery" (IRCM, 1991, p. 3). In a letter dated
May 7, 1991 to then Health Minister Frances Lankin, deputy grand chief of the Nishnawbe-Aski nation, James Morris, stated: "It is important that regulations and legislation do not obstruct existing traditional midwifery practices within the Native communities and their desires to revitalize any midwifery practices in the future." Lankin received another letter soon after from Equay Wuk, the Native group representing Nishnawbe women from the 28 communities within Northwestern Ontario (Terry & Calm Wind, 1994), expressing concern that the legislation would not benefit Aboriginal women in the north. However, the strongest statement on the impact of midwifery legislation on Aboriginal communities came in August 1991 from the Ontario Native Women's Association. "It is obviously evident," read the statement, that the social issues and conditions in Native Communities... are the result of Natives not being in the control of their affairs [...] Again it seems that the same mistakes are reoccurring with the midwifery issue. In the report that was prepared by the task force [TFIMO], it is clear that once again, government agencies are assuming control of issues that clearly affect Native people and Native communities. The task force has only suggested that Native people... will receive special treatments such as flexible admission policies. This clearly is not enough. Native people ultimately have to be in control [of] their own affairs to improve the social issues. [...] It would be counterproductive to continue with any strategies which involve Natives and Native communities without the involvement of Native people. (Ontario Native Women's Association, 1991, p. 8)

Equay Wuk and Nishnawbe-Aski Nation also submitted a brief to the Ontario Ministry of Health with recommendations for the protection of Aboriginal midwives and again any obstruction of their practices by legislation, regulation or education policies related to Ontario midwifery (Equay Wuk Women's Group and Nishnawbe-Aski Nation, 1991, p. 8). The overwhelming impulse among Native organizations was to gain exemption for Aboriginal midwives and

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51 Letter to Health Minister Frances Lankin, from Sara Melvin on behalf of Equay Wuk, Native women's organisation, May 10, 1991.
traditional Native healers from the pending Registered Health Professions Act. Indeed, given the anticipated impact of the RHPA, exemption was the very condition upon which Aboriginal midwifery and other forms of traditional healing might be protected and expanded (Couchie & Nabigon, 1997). On October 30, 1991, representatives from the Ministry of Health met with Native groups and an agreement was reached which would exempt Aboriginal midwives and healers from the Act. Members of the IRCM were not invited to attend the meeting.

Following both the enactment of an exemption clause and vigorous statements from Native communities asserting Aboriginal control over midwifery, the Equity Committee continued to visit and collect information in at least five other Native communities.\(^5^2\)

Despite the time, resources and attention devoted to Aboriginal issues through these consultations, their impact on Aboriginal women's access to midwifery practice through the mechanisms created by the legislative process was minimal. Indeed, in July of 1993, less than six months before final proclamation of the Midwifery Act, the Ontario Native Women's Association declared that:

The current university programme offering a Bachelor of Midwifery degree lacks a cultural component in its curriculum design specific to Aboriginal needs. It is our belief that ineffective and inefficient consultation with Aboriginal communities and organizations has been made in the early stages of curriculum design to allow for a cultural component.

A report on the admission process (to the Pre-registration program)...has indicated that out of a total of 149 applicants, 2 were Aboriginal women. Of the 80 successful candidates, one was Aboriginal. The accepted Aboriginal candidate does not reside in

\(^5^2\) These trips included visits to a Native Friendship Centre in Timmins and community meetings in Moose Factory, Moosonee and Attawapiskat on the James Bay Coast between March 29 and April 2, 1992; a visit to the Akwesasne First Nation near Cornwall, Ontario in June of 1992, a visit to Manitoulin Island in July, 1992; and a visit to the Six Nations Reserve near Brantford, Ontario in December of 1992 (IRCM, 1992b; IRCM, 1992c; IRCM, 1992d).
the province of Ontario. The reasons for this inequity remain questionable, however, there may be some connection to the fact that the admissions committee was comprised largely of foreign midwives unfamiliar with Canadian history and the position of Aboriginal peoples.

In any effect, the inequity generated within the Michener Institute program has been interpreted as grossly inadequate, given that Aboriginal peoples have the highest birth rates per capita in comparison to caucasian women or women of other ethnic minority groups. (Thomas, 1993, p. 27)

Indeed, these issues were flagged as far back as 1991. At an Equity Committee consultation with Native residents of Sioux Lookout conducted that year, participants asked the committee to curtail their presentation on the IRCM so that they might present their own issues. "Natives," one of the speakers told the Committee, "are always put in the position of having to respond to and deal with legislation that already exists." Those present called for two seats for northern Native women on midwifery bodies and a subcommittee of Native people to address Native concerns and suggested that Native women should be conducting consultations about the way midwifery would be implemented in Northern communities (IRCM, 1991, p.10). Indeed, Native people used the consultations as a forum to express opinions on a variety of reproductive health issues and to send a strong message of displeasure to the provincial government about a legislative process that seemed to circumvent other policies relating to Aboriginal self-government. For the Native communities involved in the consultations, the Equity Committee provided a fortuitous opportunity to amplify a burgeoning political protest.

Canada's attempts to westernize the childbirth practices of First Nations peoples are paradigmatic of the cultural violence enacted through the imposition of Western birthing practices on Native populations (O'Neil & Kaufert, 1990, 1995; Thomas, 1993). Such colonial interventions produced a loss of local knowledges and autonomy and disrupted complex social links. Indeed, I see this issue as one of vital concern and do not in any way mean, through the critique at
hand, to diminish its importance. However, inasmuch as the IRCM, the MIPP and the CDC do not appear to have enacted policies which fostered Native women's participation in midwifery, and Native organizations seemed to want to disentangle their communities entirely from the web of midwifery legislation which had been cast unilaterally upon them, how are we to understand the Equity Committee's devoting the vast majority of its admittedly scarce resources to Aboriginal issues even after the Aboriginal exemption clause had been achieved?

There are, I believe, a number of ways to answer this query. To begin with, as Carol Schick (1998) has observed in another context, it is safer for white groups making claims to multicultural sensitivity to promote the equality of those who offer no imminent threat to their dominance than to champion those whose threat is more immediate (p. 243). In distinct contrast to numerically significant, urban-dwelling immigrant midwives of colour, the few Aboriginal midwives practising in geographical locations outside of major Ontario cities where midwifery activity was centred, hardly threatened to overtake the midwifery movement. Indeed, they often pursued parallel, rather than competing, routes to midwifery practice, routes which constituted only a minimal threat to the Ontario midwifery project. Aboriginal people were also seen to be docile political partners. Explained one IRCM member, in the past political experience of some IRCM members, coalition with Aboriginal people was "not...as volatile as some of the alliances that have been made with groups around race" (Interview No. 27). Unlike in other recent feminist cross-race initiatives, the Equity Committee's motives and benevolence seemed unlikely to be challenged by Native groups defending Aboriginal midwifery.

The concern with Aboriginal issues can, indeed, be viewed as a benevolent venture, but as Barbara Heron (1999) argues, the performance of benevolent acts for the racialized Other is never simply good or bad but, in fact, represents a "complex mixture of relations and effects" (p. 88). Such acts confer
a moral status on the those who perform them. Indeed, Heron argues, the performance of these acts is key to the construction of the white female bourgeois figure who constantly requires "moral superiority, a self-image as a saviour and self-satisfaction through favourable (to us) comparison with Others" (p. 88). Midwifery's championing of Aboriginal concerns could only be construed as a moral and anti-racist venture through a disavowal of the uneven relations of power between white midwives and Native communities. This was accomplished in two ways: (1) through the idealization of Aboriginal people, a strategy which purports to invert oppressive constructs but which succeeds only in reproducing the binary categories of "Indian" and "White" within the Canadian nation (Légère, 1995, p. 356), and (2) through the promulgation of a set of "redemption discourses" in which white midwifery activists imagined themselves (and not Aboriginal people) as the saviours of Aboriginal midwifery. Indeed, I will argue that the ameliorative effects of Ontario midwifery's concern with Aboriginal peoples are minor when compared to what such a concern yielded in terms of producing politically efficacious subjectivities for midwives and those involved in midwifery implementation.

Any unravelling of the complex relationship between Aboriginal peoples and Ontario midwifery as it was represented by the Interim Regulatory Council on Midwifery must begin with Jesse Russell, a Metis woman and the only racialized minority person to serve on that body. Russell's dual positioning as both idealized "other" and feminist activist rendered her claims of inequity and exclusion difficult for Council members to dismiss. Indeed, she was the very embodiment of a subaltern group whose idealisation had been an important discursive strategy in the reemergence of midwifery in North America. If, as some activists argued, midwives across time and space were the heroines of a drama in which "female healers champion the natural, resist technology and are instinctively in sympathy with the childbearing woman" (Treichler, 1990, p. 118), then participation in the enactment of midwifery legislation which stood to endanger indigenous Canadian
childbearing practices threatened to unsettle the ontological ground upon which the midwifery movement's identity had been built.

I will begin by reiterating what has been stated earlier in this chapter - that the North American childbirth reform movement has long idealized indigenous birth practitioners imagined to possess access to uncorrupted female bodily knowledge (Nestel, 1995). This idealization typifies the process of "eating the Other" described by bell hooks (1992), in which "a contemporary longing for the 'primitive' is expressed by projection onto the Other of a sense of plenty, bounty, a field of dreams" (p. 25). That this process was at work here is confirmed by the Equity Committee member who related, in this astonishing passage, what can only be described as a perfect paradigm of not only eating a particularly delectable "other" but disgorging her as well for voyeuristic display:

I mean there was a kind of momentum that got started early on and the momentum was around this incredible, extremely selfish on our parts, but this incredible cultural phenomenon which is how birth is handled in Aboriginal communities, or was handled, that some of us were just learning about for the first time. And we were awe-struck and we were amazed and we were disgusted, one - that it was being lost and two, - you know our ancestors had contributed to its loss all of those things, and that's where the guilt comes in. And I think that we were, we kind of rolled with that momentum and we were having the opportunity to visit these, to have these incredible experiences. So that's when I say it was selfish. We were having these incredible cultural opportunities that every Canadian should have the experience of and we rolled with it. We talked about it, we made briefs to the Aboriginal Commission on it. We brought people back with us and had smudge ceremonies at our meeting, it was a really a big kind of "happening". There wasn't anything equivalent from any of the other communities we talked to. (Interview No. 27)

Stuart Hall (1996) also suggests the Freudian antecedents to the concept of "eating the Other," suggesting that the process of identification requires that the Other upon whom a given identity is contingent must be assimilated into the self. Hall quotes Freud from *Mourning and Melancholia* on identification: "It behaves like a derivative of the first oral phase of organization of the libido in which the object that we long for is assimilated by eating and in that way annihilated as such (Freud 1921/1991, quoted in Hall [1996], p. 3)."
The responsibility of white settlers for the destruction of Aboriginal peoples gets a brief acknowledgement but the genocidal past is seemingly redressed and attendant guilt assuaged through the speaker’s reverential consumption of Aboriginality, a move that anthropologist Renato Rosaldo (1989) has dubbed “imperialist nostalgia” (p. 108). Left unexamined are the contemporary relations of domination that construct the very encounter in which Equity Committee members were engaged. Cultural theorist Philip J. Deloria (1998) argues that countercultural movements of the late twentieth century have had a particular affinity for "Indianness," seeing identification with Aboriginal peoples as a way of moving their white identities "away from Americanness altogether to leap outside national boundaries, gesture at repudiating the nation, and offer what seemed a clear-eyed political critique" (p. 161). The gesture seen here is one of repudiation of white IRCM members' implication in a racialized order in a belief that it could be willed away through practices of identification. However, as Leslie Roman (1997) argues, such practices are linked to a set of "redemption discourses" which may have certain limited counterhegemonic effects but which serve to reinscribe the identities of both dominant and subordinate subjects.

Some IRCM members believed that it was the Equity Committee that rescued traditional Aboriginal midwifery from threatened suppression under the pending Midwifery Act. In their presentation to the Royal Commission on Aboriginal People in November of 1992, Committee members Anne Rochon Ford and Vicki Van Wagner proclaimed that as "a result of the information we have brought back from communities we have visited, the Ontario government has noted the importance of a more equitable approach to any health professions

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54 See also Ward Churchill's (1992) analysis of New Age academics' attempts to appropriate First Nations religions and cultures. Churchill aptly argues that while “the New Age can hardly be accused rationally of performing the conquest of the Americas, and its adherents go to great lengths in expressing their dismay at the methods used therein, they have clearly inherited what their ancestors gained by conquest, both in terms of resources and in terms of relative power (p. 210).
legislative changes which will have an impact on Aboriginal people" (Equity Committee, 1992, p. 4). An IRCM member whom I interviewed reiterated this position succinctly in our interview. In response to my prodding about whether she thought the Equity Committee's emphasis on Aboriginal issues was justified, the member responded:

I mean if we did nothing else successful we did the Aboriginal stuff. That came out of the Equity Committee. We literally turned that legislation on its head literally three days before it went in for third reading. They stopped the whole process and revised the legislation around Aboriginal issues because we had done that. That's one of the constructive things toward equity that we achieved. (Interview No. 25)

The midwifery movement's foregrounding of Aboriginal issues achieved two related, but slightly different effects. The first of these was the creation of the inoculatory device described above. If midwifery activists can be seen as having rescued Aboriginal midwifery from extinction, then there exists exculpatory evidence against possible charges of racist exclusion of non-Aboriginal "others". But this strategy was useful not just in deflecting criticism from the outside, it also helped liberal-thinking IRCM members to resolve the contradiction that indelibly marked the re-emergence of midwifery: that the disqualification of racialized minority midwives helped secure the access of a small number of white women to the lucrative, newly-legalized profession. It might be argued that Aboriginal midwifery was the site for a symbolic resolution of this troubling contradiction. This process is quite evident in the following quote, where an IRCM's members discursive strategy of simultaneously acknowledging exclusion and recuperating innocence is deployed: "we didn't learn enough and we didn't do it well enough and I agree with you in that respect. But then, we were just absolutely boggling every bloody mind in the health professions world at the time with how unbelievably progressive and audacious we were" (Interview No. 25).
"Immigrant and Refugee Women" in the Equity Reports

While white midwives had been inferiorized by other health professionals and had been practising in a quasi-legal manner in the province, they had long employed sophisticated discursive repertoires to promote the midwifery movement in the press and other public fora. However, pending legislation had given them direct access to what Teun van Dijk (1993b) calls "the means of production of public opinion" (p. 45). The widely circulated and referenced Equity Reports were foundational to securing midwifery's respectability. As was demonstrated above, one discursive strategy employed by midwifery activists was to construct themselves as the saviours of Aboriginal people. And while far less attention was paid in the Equity Reports to "immigrant and refugee women" than to Native peoples, the scant 11 pages devoted to this overdetermined group are no less instructive in demonstrating how this form of white representation works. As Richard Dyer (1997) has argued, it is not just the deployment of stereotypes which achieves racial differentiation; this effect is achieved as well through "narrative structural positions, rhetorical tropes and habits of perception" (p. 12). In the case of the Equity Committee's "Midwifery and Immigrant and Refugee Women" report (IRCM, 1993), the narrative structure positions "immigrant and refugee women" as needy and white midwives who practise "culturally sensitive midwifery" as those capable of remedying their need. The report, through its very title, draws on a recognizable rhetorical trope which has come to signify "women of colour, women from Third World countries, women who do not speak English well and women who occupy lower positions in the occupational hierarchy" (Ng & Estable, 1987, p. 29). The report, in fact, reinscribes this trope and the racialization process by focusing on issues of victimization, including: linguistic and cultural barriers to adequate obstetrical care, the negative obstetrical experiences of women who had undergone "female
circumcision," and the difficulties faced by political refugees in dealing with authority figures.

By the admission of one Equity Committee member, participation by women of colour in the consultations upon which the report is based was scant. Unlike their consultations with Aboriginal people, for which the Equity committee travelled to reserves and Native community agencies, the Committee's meetings with women of colour required that these women come to them, a strategy that appears to have been less than efficacious. As one Committee member put it, "Turn-outs were almost always poor. There was poor reception on the other end of the line in a lot of cases and we didn't have the 'ins' that we needed. We weren't getting in and we weren't being welcomed" (Interview No. 27). In fact, this member admitted, Committee members did not aggressively solicit input from women of colour and some of this avoidance was due to their wish to avoid "women's politics à la Toronto...1980s" (Interview No. 27), i.e. the vigorous challenge that had been mounted by women of colour to the racism of feminist organizations in the city.

Indeed, the reports were based, to some degree, on consultations that were individual and informal, and not specifically tied to the Equity Committee's activities. Some of what went into making the Equity Reports, specifically around immigrant women, admitted a committee member,

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55 In a recent article, Inderpal Grewal and Caren Kaplan (1996) critique the use of terms such as “female genital mutilation,” “excision,” and “female circumcision” employed by feminist campaigns in the West to end the practice in Africa of surgically removing all or part of women’s external genitalia. Such terminology, they argue, "is attached to a history of colonialism, linked to Enlightenment concepts of individuality and bodily integrity, medicalized notions of ‘cleanliness’ and ‘health,’ sexualized notions of the primacy of ‘clitoral orgasm’ and cultural organizations of pleasure" (p. 10) Referencing Isabelle Gunning’s (1992) important work on the imperial effects of Western feminist interventions into these practices, Grewal and Kaplan suggest the use of the term “genital surgeries” as one which avoids terminology that is either “ethnocentric and judgemental” or “misleadingly benign” (p. 10).
was sort of mixed up or tied in with personal consultations we had with individuals or with two or three women who (another Committee member) might have gone out with or I went out with or discussed, you know, in a break in a conference, all of that kind of stuff would have fed the things that are in there. (Interview No. 27)

However, the majority of those who ended up consulting with the Equity Committee were midwives of colour, and contrary to what is represented in the reports, it appears that it was not victimization that they wanted to discuss. As one Equity Committee member told me:

Who actually ended up coming to most of the gatherings were foreign-trained midwives [...] and all they wanted to talk about was access to training. And they had, you know, every reason in the world to be there and every reason in the world to be angry. You know here they had an opportunity to get some of the people who were involved in making the legislation and get our ear, and we were caught because it wasn't what we were supposed to be doing. (Interview No. 27)

In fact, these women came to the Equity Committee with a truth claim that challenged the dominant epistemology in which women of colour were understood to be the needy recipients of midwifery care, and not as its potential providers. What they lacked was the power to circulate such a challenge. Indeed the challenge was dangerous enough to elicit a potent response, and the competing discourses were neatly reconciled by those who had easy access to public discourse - the IRCM. As Jane Flax (1993) has noted, power produces "the appearance of a neutral resolution" by eliding truth claims which threaten to fragment a given discourse (p. 40). Marginalization and silencing are some of the discursive practices that make such elisions possible. While the report specifies that the Committee met with women who had "practised as midwives in their countries of origin and were anxious to practise here," this issue, claimed the report, was not mandated to the Equity Committee but was "in the jurisdiction of
that equity was in no way achieved through this route is the subject of the remainder of this thesis.

Indeed, in suppressing the access to practice issues raised by immigrant midwives of colour, the report enacts significant epistemic violence. Not only are the voices of immigrant midwives of colour introduced and then suppressed in the Report through a bureaucratic sleight of hand, this elision is rendered normal through a reliance on racist discourses. Denied any competing formulation about their identities and in the absence of any listener positioned to receive their insurgent messages, "immigrant and refugee women" are effectively muted (Spivak, 1988). Indeed they remain discursively constructed as a powerless and needy population while Ontario midwives are produced as those white bourgeois female subjects capable of saving them. Within this economy of meaning, immigrant women of colour who are autonomous, competent and sophisticated practitioners of midwifery are not just silenced, they are rendered unimaginable -- virtual non-subjects. Indeed, this is a construct of some value for those struggling to integrate midwifery into the health care system. As I argue in Chapter Five, popular perceptions of midwifery as a primitive and discredited form of feminized care threatened the midwifery movement's struggle to foreground a new and respectable "professional midwife," configured as modern, university-educated, feminist and therefore, in all likelihood, white. The presence in the province of thousands of trained midwives from Third World countries threatened that construction. Indeed, it made the confirmation of respectable bourgeois subjectivities a matter of some urgency for those who supported the professionalization project.

56 The admission that this issue was raised during the consultations is curiously excised from the most public document relating to the Equity Committee's meetings with "immigrant and refugee women," an article entitled "Midwifery Care for Immigrant and Refugee Women in Ontario" published in 1994 in the journal Canadian Woman Studies (Equity Committee of the Interim Regulatory Council on Midwifery, 1994).
The IRCM’s Equity Committee was a contradictory project and while the intentions of those who participated in it were to disrupt various forms of privilege, its actual effects guaranteed that privilege remained intact. While claiming to pursue equitable treatment within the re-emergence of midwifery, the Equity Committee reports actually reinscribed marginalized identities and secured dominant ones for white midwives. In fact, it can be argued that the pursuit of equity was not a power-sharing endeavour but actually constituted a project of bourgeosification which very publicly produced white midwives as benevolent and rendered them apparently innocent of racist exclusions.

The Transitional Council of the College of Midwives of Ontario - 1993

The Transitional Council of the College of Midwives of Ontario (TCCMO) was created by Order-in-Council in February 1993 and was the immediate predecessor of the College of Midwives, which would become, with the passage of the Registered Health Professions Act, the regulatory body of the midwifery profession in Ontario (Bourgeault, 1996, p. 87). The TCCMO is of interest here because its composition reflected far more social diversity than had any midwifery organization or government-appointed body which preceded it. Unlike its Liberal predecessor, the newly-elected New Democratic Party government embraced an aggressive equity agenda and proposed appointments to the Transitional Council which reflected representation of very specific constituencies. The five professional members were to include one Aboriginal midwife and one who was “foreign credentialed” and the seven public members would be comprised of, in addition to three IRCM members who were to provide continuity, one Aboriginal member, one disabled woman, one consumer from northern Ontario and one “visible minority” member (IRCM, 1992a, p. 3). The

57The IRCM had actually opposed the appointment of any foreign-trained midwife who would not be eligible for registration upon passage of the Midwifery Act which, as explained above, would have virtually guaranteed that immigrant midwives of colour would receive no representation on the Transitional Council. (Letter dated July 27, 1992 to A.R. Burrows, Director, Professional Relations Branch, Ontario Ministry of Health, from Mary Eberts, Chair of the IRCM).
government exerted its authority in making the appointments. While it acceded to the IRCM's recommendations *vis-à-vis* Aboriginal appointees, it chose to appoint two women of colour - one professional member and one public member - neither of whom had previously been involved with the Ontario midwifery movement.

While the composition of the Transitional Council reflected a more equitable representation of the province's "visible minority" population, there were at least two important reasons why this seemingly improved configuration had only a minor impact on the achievement of equity within the new profession. First, as discussed above, critical decisions had already been made about access of all foreign-trained midwives to the first cadre of practitioners and these guaranteed that immigrant midwives, among them substantial numbers of women of colour, would have a long and complicated route to take in order to practise in the province. The presence of racialized minority women on the Transitional Council did not undo these important policy decisions. Second, unlike the IRCM, which had the arguably exciting task of imagining a new profession into being, the Transitional Council had the far more tedious task of writing the College's regulations and policies. Those Transitional Council members who had had no prior experience on midwifery bodies found themselves at a disadvantage in relation to this work; the majority of these new members without such experience were "visible minority" or Aboriginal appointments. One IRCM member interpreted the situation thus:

Because we were now dealing with technicalities and regulation and things of that nature, new consumer members, and I remember hearing this from people within a few months of its operation, were left in the dust. I mean as wonderful as their diversity and their contribution was, they didn't have a hope in hell of competing with the technical knowledge and in the technical tasks that were demanded of the Transitional Council. (Interview No. 25)

However, as I will demonstrate in Chapter Six, in addition to the disadvantage conferred upon them by lack of exposure to the midwifery politics that preceded
the appointments, racialized minority women who served on midwifery-related councils and boards between 1993 and 1995, experienced significant marginalization and numerous forms of overt and covert racism.

**Prior Learning Assessment and access to midwifery practice for immigrant midwives of colour**

*Enchanted by the tantalizing image of Canada in various countries, professionals eagerly give up their jobs to emigrate to Canada. Often, they are granted residence visas based on a point scoring system that recognizes academic qualifications, professional standing as well as financial and social status. Consequently, these professionals emigrate believing that jobs abound in their various fields and that their professional expertise will be optimized and appreciated. Once in Canada, their rosy expectations quickly prove to be illusions: they face tedious and expensive processes of credentials assessment and licensing as well as barriers to employment. All too soon, the initial optimism and enthusiasm give way to disillusionment.*

Margaret Azuh (1998)
*Foreign-trained professionals: facilitating their contribution to the Canadian economy.*

As has been discussed above, the Task Force on Access to Professions and Trades in Ontario publicly identified exclusionary practices in the licensing procedures of professions in the province. Long delays in gaining access to language and training programs, lack of financial support during re-training, and difficulties in qualifying for language programs were some of the barriers to professional practice the report had cited (TFAPT, 1989, p. xv.) The Task Force concluded that while all immigrants were affected by systemic barriers, the origins of which were "administrative, economic and cultural in origin,"that "minority and ethnic groups" suffered disproportionately (p. 4).
A recent regional study funded by a federal agency, Status of Women Canada, indicates that systemic barriers to professional licensure have not disappeared in the decade since the TFAPT report was published. The research project, which involved over 200 foreign-trained professionals living in Windsor, Ontario, showed that both the length of time and the excessive costs involved in re-credentialing remained significant obstacles to re-entry to professional practice for new immigrants (Azuh, 1998). Eighty-eight percent of those surveyed had to upgrade their skills through professional education courses and more than 30 percent had to begin their training anew (p. 24). Health professionals, by far the largest group surveyed, comprised nearly one quarter of those included in the study.

Despite the bold and thorough recommendations of the Access! Report and the subsequent establishment by the Ministry of Citizenship of an Access to Trades and Professions Unit, barriers to professional practice continue to be a contentious public issue in Ontario. In 1999, a series in the Toronto Star focused attention on the fight of immigrant professionals to obtain professional credentials citing uneven assessment practices, high costs and the dissemination of misleading employment information to potential immigrants as among the barriers to accreditation (Hurst, 1999; Murray, 1999a, 1999b, 1999c).

On the eve of the legalization of midwifery, the Transitional Council needed to establish a process for assessing the training of those midwives who wished to become registered but who had not gained access through the Michener Institute Pre-registration Program. These included both women who had been practising in the province and who had not been admitted to or had failed the Michener program, and those whose credentials were obtained outside of Ontario. A Registration Committee, to whom responsibility for this task had been delegated, published their recommendations on June 28, 1993. The committee consisted of long-time midwifery activist Elizabeth Allemang,
sociologists Hugh and Pat Armstrong and British-trained practising midwife, Freda Seddon.

Using the Access! Report as a point of reference, the Registration Committee recommended that the credentialing process for those with previous midwifery training utilize a Prior Learning Assessment (PLA) model (Alleman, Armstrong, Armstrong, & Seddon 1993, p. 19). The report reiterated the working definition for Prior Learning Assessment which had recently been adopted by the Prior Learning Assessment Secretariat of the Ontario Council of Regents for Colleges of Applied Arts and Technology:

Prior learning assessment is a process using a series of tools, which assist learners to reflect, identify, recognize, articulate and demonstrate past learning in order to have it measured, compared to some standard, and in some way acknowledged by a Credentialing [sic] body.

It is based on the premise that adults acquire skills and knowledge through many means of formal or informal study. For Ontario's Colleges of Applied Arts and Technology, a PLA system evaluates this learning and relates it to courses and programs for the purpose of granting college credit. (Alleman, Armstrong, Armstrong & Seddon 1993, p. 19)

There are a number of reasons that PLA made sense for the new profession. In the absence of a provincial or national credential assessment agency, the fledgling College of Midwives would have had to wait a considerable length of time and expend significant financial resources to develop a system which would rate educational equivalencies from midwifery education programs internationally. In addition to the profoundly difficult task of establishing educational equivalencies, many trained professionals, particularly those who have become refugees or political exiles cannot easily gain access to records and transcripts. PLA seemed the most expedient and equitable process given limited resources. In addition, the re-emergent profession had relied on apprenticeship and non-institutional learning as its primary training model for
many years and it needed not only to validate this educational model, but to acknowledge the expertise of those practising midwives who were not grandparented into practice but who still sought registration. And while the process appeared equitable, it compelled women with many years of midwifery training and practice to undergo a long, arduous and expensive re-assessment process.

Today, the Prior Learning and Experience Assessment program of the College of Midwives of Ontario is held up as the gold standard of equitable professional accreditation programs for foreign-trained professionals. In the *Toronto Star* series cited above, the College is credited with allowing foreign-trained midwives to have their skills assessed through Objective Structured Clinical Examinations (OSCE), a process which the article claimed led to the accreditation of 23 out of 27 applicants and which the author sees as far more liberal than the restrictive policies applied to foreign-trained physicians in the province (Hurst, 1999, p. A8). However, the numbers the article cites are deceiving. They in no way reflect the extraordinary rate of attrition from the PLEA process nor do they (although the series largely focuses on the experiences of racialized minority professionals) reveal whether the process has been an equitable one for women of colour.

The Community Advisory Committee to the PLA

Around the time of legalization, there was mounting evidence that immigrant midwives of colour comprised a considerable proportion of those who would seek to become registered through the Prior Learning Assessment program. By May, 1994, 48% of the 900 requests for information about registration received by the College of Midwives of Ontario had come from women with midwifery training from the Philippines (25.1%), Jamaica (3.4%), Nigeria (3.4%), Pakistan (2.9%), India (2.4%), Hong Kong (1.9%), Iran (1.9%), Ghana (1.4%), China (1.4%), Guyana (1%), and Somalia (1%) (College of
Midwives, 1994a, p. 3). As has been argued above, the cohort of British trained midwives, who made up 30% of those seeking information, likely included a substantial percentage of women of colour. Having publicly embraced an equity agenda, the Transitional Council needed to find a forum where this numerically significant group could be seen to have an impact on the PLA process.

In September 1993, the Transitional Council convened a Community Advisory Committee to the Prior Learning Assessment project. Of the twenty-two attendees, seven were women of colour. Indeed women of colour formed a distinct minority in relation to white women at every meeting of the Committee. Carmencita Hernandez, a well-known community activist and founder of the Coalition of Visible Minority Women, spoke about the excitement that the PLA had generated among immigrant midwives in the province who hoped to practise their profession. She proposed that Filipino women, whose inquiries to the Transitional Council had comprised the largest percentage of total calls, were willing to assist in developing a portfolio course and in collecting oral histories on the nature of midwifery practice in the Philippines. Hernandez proposed that the Committee needed to find ways to insure that the early cohort of PLA graduates would include significant numbers of racialized minority women. Her concerns were echoed by Betty Wu-Lawrence, a public health nurse active in the Chinese-Canadian Nurses Association, who had been appointed to the Transitional Council.

58 The remaining 22% were from Eastern and Western Europe, Australia and jurisdictions that were not identified.

59 In February 1995 I represented the Toronto Birth Centre at a meeting of the Community Advisory Committee of the PLA. Women of colour were outnumbered by white women, many of whom, unlike myself, were not representing community groups but rather were directly affiliated with the College of Midwives. Scrupulously scripted and choreographed, a dazzling display of white dominance in action, the atmosphere guaranteed that only the most aggressive unscheduled speakers managed to question the policy decisions being presented.
Indeed, Filipino midwives took an exceedingly pro-active stance in relationship to the Prior Learning Assessment process. In November of 1993, the National Council of Canadian Filipino Associations invited trained Filipino midwives to a discussion of midwifery regulation with members of the Transitional Council. Eighteen out of the twenty Philippines-trained midwives who had contacted the Council's offices about accreditation in Ontario attended the meeting ("Regulating midwifery," 1993). In a strategy session following the meeting, those attending articulated the barriers to practice that they felt would impede the entrance of Filipino midwives to the midwifery profession. First, the group acknowledged that a significant percentage of credentialed midwives worked as nannies and that for this group, taking time off work for training was simply impossible. They also recognized that the proposed cost of 2500.00 CDN was well beyond the means of many of the women represented in the group. In addition, the status of some midwives as live-in caregivers guaranteed at least a two-year gap in practice, a deficit which would put them at a disadvantage in the accreditation process which promised advanced standing to those with recent practice experience. The group proposed the formation of an organization whose goals would include lobbying for equitable access to the profession, looking for funding for training and professional review sessions, and initiating a bursary fund for those seeking registration (National Council of Canadian-Filipino Organizations, 1994, p. 10).

The organization which emerged from the strategy session was the Association of Philippine Midwives. One of the group's stated purposes was to "liaise with similar organizations and with the College of Midwives of Ontario" (National Council of Filipino-Canadian Associations, 1994, p. 8). In the summer of 1994 the group presented a formal proposal to the College of Midwives in which they outlined a plan to organize a series of workshops which would

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60 Minutes of the Community Advisory Committee to the Prior Learning Assessment of the Transitional Council of the College of Midwives of Ontario, September 21, 1993.
"heighten awareness among foreign-trained midwives in the immigrant and racial minority communities on the history of the practice of Midwifery in Ontario," and "provide support and/or networking capabilities to foreign-trained midwives."  

The project organizers proposed a budget of 6500.00 CDN and pledged a community contribution of 3000.00 CDN. Funding, however, was denied to the group.  

One woman who helped to formulate the funding proposal expressed her disappointment with the College of Midwives' failure to support the effort:  

But I was really hopeful that the women, the regulatory body, would be more open and acceptable. Just like you think there might be solidarity in terms of women. And also in terms of issues related to women...I felt that it was not maximized. They had the power to do something. 3500 dollars is no big amount (Interview No. 30).

Clearly discourses of female unity across other axes of difference - the midwifery project's stock in trade - had underpinned Filipino midwives' understanding of the movement for legalization and had created expectations of solidarity that were to go unfulfilled. Indeed, the woman quoted above, a participant in the Transitional Council/College of Midwives' Community Advisory Council on the PLA, felt that she and others had had no influence on policy, partially because of their outsider position and because their primary loyalty was, unsurprisingly, not to the midwifery movement but to the achievement of employment equity for Filipino midwives. She explained the constraints on her participation thus: "I know it's difficult to influence policy unless you're inside, right? And unless you know the steps to go about it." "My goal," emphasized this interview subject, "wasn't for them" (Interview No. 30).

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62 Registration Committee of the College of Midwives Minutes September 23, 1994
One of the policy areas which immigrant midwives involved in the CAC did attempt to influence was that of language testing. The Task Force on Access to Professions and Trades in Ontario had flagged language testing as a key barrier. "Emphasis on training in general fluency rather than on occupation-specific proficiency development" argued the report, had made it difficult for some professionals to achieve accreditation (TAPTFO, 1989, p. xv). At their 1993 meeting with Transitional Council members, Filipino midwives echoed the TFAPT Report in flagging the inequity of the TOEFL (Test of English as a Foreign Language) exam, used to measure English language skills ("Regulating midwifery," 1993). The Transitional Council's response was to develop a profession-specific language exam which was piloted in June of 1994. The College's decision to offer no exemptions from the language exam, even for native English speakers, was conveyed to the Community Advisory Committee by CMO Council member Brenda Hyatali at their June 20, 1994 meeting. Objections were raised by several women of colour at the September 20, 1994 meeting and at the next meeting on November 1, 1994. Narinder Kainth, representing the Scarborough Grace Birthing Centre, expressed her own opposition and stated that there had not been support for the policy on the CAC. PLA coordinator Diane Pudas dismissed the issue, claiming that no objections had been raised when the decision had been announced in June. Both the interviews conducted for this study and statistics about participation in the PLA process demonstrate that language testing has been a significant roadblock to both midwives who are native English speakers and those for whom English is a second or third language. This will be discussed in greater detail below and in Chapter Six.

The implementation by the CMO of a major policy which was clearly opposed by immigrant women serving on the CAC certainly bespeaks the token nature of this advisory group. And while their opinions may not have been heeded, the support of immigrant women of colour became an important

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63 Minutes of the Community Advisory Committee to the PLA, November 1, 1994.
resource in the College's bid to win funding from the Access to Professions and Trades Demonstration Project Fund for the next phase of PLA - the "Multifaceted Assessment" of midwifery skills. PLA project coordinator Diane Pudas had sent a memo in April 1994 in which she informed Registration Committee members that the Access to Professions and Trades Branch had, in a conversation with her, emphasized their equity mandate. Therefore, she concluded, "It would appear to be to our advantage to solicit co-sponsorship from community groups that have members that wish to apply to the CMO for registration." "The needs of immigrant women to access the profession of midwifery," claimed the College of Midwives' successful funding proposal, "coincide with Ontario's need for accessible midwifery care" (CMO, 1994a, p. 3). Groups such as the Caribbean midwives group, the Filipino Midwives Association, the Chinese Canadian Nurses Association, and the Coalition of Visible Minority Women wrote enthusiastic letters of support. However, like the Equity Committee initiative, consultations with marginalized groups produced benefit for the midwifery project but seemed to produce little in the way of access to the profession for immigrant midwives of colour.

The Prior Learning Assessment project was launched in October 1994 with three public orientation sessions which had been widely advertised across the province. While nearly 1000 women had inquired about access to practice, only 337 actually attended these sessions, which cost participants ten dollars each. The orientation was considered the first step in the PLA process and introduced potential applicants to the multi-tiered process. The first major requirement was a two-part profession-specific language exam, after the successful completion of which the candidate was to submit a four-part portfolio which included a clinical practice equivalency portfolio, an autobiographical portfolio, a baccalaureate equivalency portfolio and a core competency portfolio. For admission to the PLA, midwives needed to be either graduates of a recognized midwifery program or registered to practise in another jurisdiction and have a minimum clinical experience of attendance at a minimum of 40 births, 20
of which must have been as primary midwife (i.e., assuming sole responsibility for the parturient woman in the intrapartum period). Alternately, applicants were to have attended 40 births as a primary midwife or at least 30 as a primary midwife and 20 as an assistant to the primary midwife (CMO, 1994b).

The admission criteria were clearly designed to include both those Ontario midwives who had not graduated from the Michener program, as well as midwives trained outside of Canada in institutional midwifery education programs. Nearly fifty percent of those who applied to the first cycle of PLA were from the latter category. The first cycle of the Prior Learning Assessment process had a rather dramatic rate of attrition. As was mentioned above only 337 of the thousand women who expressed interest in the process actually attended the first orientation. Of these, 165 submitted applications to the College. Only 126 of this group took the first language examination late in 1994. Nearly half of the applicants failed that exam and only 63 went on to take the second half. Fifty-six of these submitted portfolios to the College and 51 went on to undergo the Multifaceted assessment process. Candidates whose baccalaureate credentials were considered outdated (older than ten years for sciences, older than fifteen years for social sciences) were required to sit “challenge” exams or re-enroll in equivalent courses and most candidates were required to enroll in a course entitled "Midwifery in Ontario" that had not been part of the original PLA plan. Initially scheduled to grant eligibility to successful candidates in the summer of 1995, the first PLA cycle took nearly four years. And while 27 were eligible, only 17 of the original 165 applicants were registered as of May 1998. In October 1997, 40 women, included 11 returning candidates from cycle one, embarked on a slightly modified second PLEA cycle. And while half of cycle one candidates

64 The CMO's Prior Learning Assessment project was renamed Prior Learning and Experience Assessment (PLEA) in December, 1996.
were white women who had practised previous to legislation in Ontario, only 2% of cycle two candidates fit that description.  

By May 1998, the percentage of women of colour among registered midwives in the province bore little resemblance to that of those originally expressing interest to practise. As was noted in Chapter Three, in December 1994 there was just one registered midwife of colour out of the 68 who had completed the Michener Institute Program. By 1998, out of 126 registered midwives, 12 were women of colour and one was an Aboriginal woman and an additional 19 women of colour were scheduled to complete the Prior Learning and Experience Assessment program (Holiday Tyson, personal communication, July 9, 1998). As has already been noted, by July 2000 approximately 19 women out of 180 registered midwives were identified as women of colour or Aboriginal women but not all had succeeded in securing employment in the province. Only about half of these women entered midwifery practice through the Prior Learning and Experience Assessment route.

**Language proficiency and cost: Two barriers to participation**

I would like to focus briefly here on two of the most salient barriers to equitable access in the Prior Learning Assessment process - language exams and cost. In both the first and second cycles of the Prior Learning Assessment process, more than half of those who submitted applications failed the program's first step, the profession-specific language exam. Given that the a very large percentage of applicants were from countries in the South where English is not the dominant language, it is highly likely that the bulk of those who failed the

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65 The figures in this paragraph and in the one below are based on my interview on March 11, 1998 with CMO Registrar Robin Kilpatrick and PLEA Coordinator Jill Moriarty, as well as on personal communication from College of Midwives official Holliday Tyson, dated July 9, 1998.
language exam were women of colour.\textsuperscript{66} And while the confidentiality of the College of Midwives' exam precludes any detailed analysis of possible cultural bias or other exclusionary functions of the exam, those interviewed, among them native English speakers, raised troubling questions about the level of English skills required to pass the exam, technical aspects of the exam such the speed of the audio tape,\textsuperscript{67} and about why the ability to interpret highly local sociocultural expressions seemed to be part of the assessment process.\textsuperscript{68} Some midwives interviewed even questioned the language assessment procedures by pointing out that in a province as multicultural as Ontario, no concomitant process evaluates "Canadian" midwives' competency in any of the non-dominant languages spoken in Ontario. One interviewee, a native English speaker and longtime resident of Canada, explained her own struggles with the taped part of the exam, while simultaneously anticipating the difficulties someone less skilled than she might experience in the interpretation of dominant linguistic and cultural signs. Naming the speaker on the tape as "Canadian," this midwife emphasizes the culture-bound nature of the exam content, neatly unmasking dominance masquerading as invisibility:

The second [part] was this Canadian person talking fast on a tape ... and at the end they'll ask you "is this woman happy or sad"? Well, no not really like that, but what did you understand? What were they saying? It was too fast. I passed the test but it was too fast. So

\textsuperscript{66} The unwillingness of the College of Midwives to release statistics about participation in the Prior Learning Assessment process broken down by participants' country of origin makes any estimates of the racial composition of those who failed the English exam impossible to report.

\textsuperscript{67} Four out of eight PLA candidates interviewed, three of them native English speakers, mentioned the fast speaking pace of the person speaking on the audiotaped portion of the English exam. An exam based purely on a written response to taped speech, would, I believe, preclude the use of communicative strategies that are normally used in everyday life such as asking people to repeat what they are saying, use of body language, etc. Any testing that precludes the assessment of such communicative strategies may lack validity (Viete, 1998).

\textsuperscript{68} One informant told me that the tape she heard included the phrase "broad as the side of a barn" an expression she determined to be largely North American in context.
I'm sure that people not familiar with this Canadian accent are going to miss the under thing. And it's a psychological question where you have to decide what does it really say. (Interview No. 13)

Key midwifery spokespeople and activists have communicated to the public that the "culturally sensitive practice of midwifery" is fundamental to the profession's philosophy (Equity Committee of the IRCM, 1994, p. 86). The need to provide educational programs and labour support for birthing women in their native languages has been touted as a foundational element of such culturally sensitive care (Equity Committee of the IRCM, 1994, p. 86). However, the College of Midwives' practices around language bespeak a different reality. By narrowing, rather than expanding the linguistic resources of the province's midwives, exclusion related to language actually reflects what Ella Shohat and Robert Stam (1994) have defined as "linguistic non-reciprocity" (p. 193): the demand that subordinate groups speak the dominant language but that no reciprocal requirement to acquire communicative resources is imposed on dominant linguistic groups. Moreover, exclusionary language exams and high failure rates reinscribe foreign-trained professionals as lacking competencies seen as fundamental to "Canadianness." As Eve Haque (1999) points out, focusing on language competency "establishes the cultural lack in the immigrant, thus making it impossible to consider any other framework that might locate the lack elsewhere, for example, the lack being in defining the Canadian nation state as only bilingual and only in two European languages, no less" (p. 5).

Policies which privilege dominant language groups are part of larger disciplinary practices which serve to differentiate not only between those who belong in the nation's most prosperous and prestigious occupational groups and those who do not, but between those who belong in the nation and those who do not (Tollefson, 1991). The College of Midwives' profession-specific language exam, while attempting to avoid the inequity identified in more generic tests of English competency, did, in fact, serve a gatekeeping function that dovetailed with other strategies, such as those outlined in Chapter Two, which create race
and gender-related labour segmentation in Canadian society. Curiously, requiring English language testing not only for non-native speakers of English but for native speakers as well - a policy formulated by the College of Midwives to avoid charges of discrimination - served to remind native English-speaking midwives of colour from former English colonies of their outsider status in the profession and the nation. Many of those interviewed expressed anger about being made to spend hundreds of dollars on the examinations when they had been raised and educated and had worked for years in the English language. The impact of this policy on these women's experience of the PLA process will be explored in greater depth in Chapter Six.

In metropolitan locations where, as Homi Bhabha (1994) argues, "colonials, postcolonials, migrants and minorities" challenge through their very speech the "imagined community" of a culturally unitary homeland, non-native speakers of English continue to be regulated by the monopoly that dominant linguistic groups hold over work and cultural life. Even in the polyglot transnational metropolis, linguistic competency in the dominant language poses as a "natural" requirement for citizenship and its economic and social rewards and is rarely recognized as tool for domination and exclusion. Indeed, as Dell Hymes (1996) has observed, the dominant intellectual response to diversity in Western societies has been "to seek an original unity" while the dominant practical response has been "to impose unity in the form of the hegemony of one language and standard" (p. 28). In the case of midwifery, the languages of postcolonial subjects both disprove the unity of the nation and present an audible disruption to the claims to respectability of a profession labouring to overturn a century of inferiorizing narratives about midwives, some of which have relied on racist and xenophobic discourses.

69 As has been noted above, the bi-lingual (French/English) standard in Canada deflects criticism from charges of linguistic dominance. As Eve Haque (1999) observes, this strategy allows Canada to "tell a story of itself as a pluralist and tolerant society where there are no systemic inequities, but rather equal opportunity for all linguistically competent individuals" (p. 5).
One strategy for interrupting this dynamic would be to recognize the critical value of communicative skills in languages other than English and to reward, rather than punish, those who possess them. A secondary strategy would involve the provision of supportive educational settings for acquiring the dominant linguistic and sociocultural knowledge necessary for economic survival. In her article on equitable assessment of the oral English of foreign-trained teachers of English in Australia, Rosemary Viete (1998) has argued that the ability to communicate in a given language and to function successfully in the sociocultural context in which that language is embedded can only be assessed fairly if the person examined has been provided, prior to the examination, with significant support in gaining such competency. With the exception of one notably unsuccessful attempt at this - the establishment of a collaborative mentorship program for midwives with Chinese language skills - a program of support has not been offered to foreign-trained midwives in Ontario.\(^70\) And as a result, I would argue, the language exams have reproduced employment inequality in the province by barring the way of those otherwise competent midwives who fail the English language exams.

The other significant exclusionary policy which I will consider here is the cost of completing the Prior Learning Assessment process. While course fees, text books, childcare, room and board, and stipends were freely provided to those practising midwives who participated in the Michener Institute's midwifery integration project, the Prior Learning Assessment process has been run entirely

\(^70\) The Toronto East Cultural Mentorship Initiative was a collaborative project undertaken by the Chinese Canadian Nurses Association of Ontario, the City of Toronto Department of Public Health, Toronto East General Hospital and Riverdale Community Midwives. Designed to pursue "linguistically/culturally appropriate care... for women who seek out midwives as their preferred caregivers during childbirth" as well as "to provide resource assistance for the ESL candidates" who apply to the PLA program, in Toronto's eastern areas, the Initiative provided bursaries to two candidates in the PLA program (Shroff, 1997, p. 252). While financial aid had been given to candidates, other forms of support were never forthcoming. Neither of the candidates funded by the project are currently working as midwives.
on a cost-recovery basis. The cost to participants for cycle one was 2400.00 CDN for all aspects of assessment by the College of Midwives. If the candidate was deemed to be lacking baccalaureate credits, she had to write a challenge exam or pursue the more lengthy and expensive process of completing a university-level course. Like those who attended the Michener Institute program, PLA candidates incurred child care and travel expenses and experienced loss of income when attending full-time courses such as "Midwifery in Ontario." They also incurred costs for obtaining, copying, notarizing and transporting documentation of their professional lives and educations. Given my own interview data, as well as recent statistical information on inequitable earning patterns between European and non-European immigrants (Lian & Ralph, 1996; Orenstein, 1996), I would argue that exceedingly high recertification costs worked to keep immigrant midwives of colour from participating in the College of Midwives Prior Learning, and Prior Learning and Experience Assessment programs.

The second cycle of the Prior Learning Assessment began in Spring 1997 and, as noted, was renamed "Prior Learning and Experience Assessment" (PLEA). This cycle cost candidates over 600.00 CDN more than did its predecessor. For those who were able sit the baccalaureate challenge exams, the cost of challenging all five university-level courses was 775.00 CDN. For those who actually needed to enroll in and pass the requisite baccalaureate courses, the tuition costs were often as high as 700.00 CDN per course. One candidate, who was close to finishing at the time of our interview, estimated that the cost of her recertification in a profession in which she already had training and in which she had successfully practised was close to 8,000.00 CDN (Interview No. 7). And while many needed extra assistance to make their way through the maze of portfolio preparation and other challenges, few of those interviewed could afford to pay the 100.00 CDN (per course) fee for a series of five one-day preparatory seminars designed by the College to introduce candidates to the prior learning assessment process.
Cost creates racist exclusion when income is inequitably distributed among racialized groups in society. Analyses of data from the 1991 Census indicate that while there are significant differences among groups and within groups, overall, non-European ethno-racial groups in the Metropolitan Toronto area had mean incomes which were between 6,000.00 CDN and 12,000.00 CDN below the city-wide mean annual employment income of 31,300.00 CDN (Omstein, 1996, pp. 8-9). A recently published Canada-wide study which controlled for multiple variables including: gender, age, age squared, marital status, province of residence, metropolitan versus non-metropolitan area of residence, geographic mobility in the past five years, period of immigration, knowledge of official languages, occupational level, industrial sector, weeks worked and weeks worked squared, and full versus part-time weeks work, concluded that wage inequity along racial lines was present at every educational and occupational level (Lian & Ralph, 1998). The findings are worth quoting here at length:

Among Europeans, whether from the north, east or south of Europe, most ethnic groups have approximately the same income levels as their British counterparts with similar education. [...] In sharp contrast to the situation for Europeans, adjusted earnings of visible minorities were much lower than for the British at most educational levels. Compared to their British counterparts, out of the 10 educational categories, most visible minority groups earned less than their British counterparts in the majority of categories. Moreover, in many of the educational categories, visible minorities earned significantly less than their British counterparts [...] From high school to doctorate there is clear evidence of lower earning amongst visible minorities compared to their British counterparts at the same educational level. Thus all visible minorities earned less than the British at the high school graduate level, at the level of Bachelors degree holder, Master's degree holder and, with the exception of Arabs, at the level of doctorate degree holder. Likewise, all visible minorities who held degrees in medicine earned less than their British counterparts, as did all but the Blacks among those who held a university certificate above bachelor's but below master's level. Moreover, in the majority of
cases, these differences were either significant or highly significant. In sum, it is clear from these findings that educational achievement at any level fails to protect persons of visible minority background from being disadvantaged in terms of the income they receive. (Lian & Ralph, 1998, p. 474)

Analyses of the 1996 Canadian census also show significant discrepancies between the earnings of recent immigrant women of colour and recent white female immigrants, with women of colour earning on average 16,300.00 CDN and white women earning 20,100 CDN (MacKinnon, 1999, p. B1). In Toronto, where the vast majority of people of colour in the province reside, not only do recent immigrant women of colour earn lower salaries, 21% of such women in the 25-44 age category are unemployed as opposed to 6% of their white counterparts (Badets & Howatson-Leo, 1999). In the absence of provincial subsidies for the PLA/PLEA process, and given the lack of provision for loans or bursaries for those undergoing it, high recertification costs pose an unfair barrier to those whose incomes fall below the national mean because of systemic racism.

**Bureaucracy and systemic racism**

Administrative delays and errors have been endemic to both the first and second cycles of the PLA/PLEA, and play a role, I believe, in producing exclusionary outcomes. Eight out of ten immigrant midwives of colour interviewed who participated in the PLA/PLEA described being frustrated with the College's delayed or non-existent response to requests for information and/or the curt manner or short time frame in which payment for various parts of the process was requested. One woman reported that after inquiring for over a year about the status of her application - which included irreplaceable original documents retrieved from her politically volatile homeland - she was informed that it had been lost. She did not reapply (Interview No. 9). Many of these women described the tenacity required to actually gain access to information
about participating in the process. One woman explained that when she phoned the College, she inevitably got an answering machine. "I left my message, left my message, left my message, nobody returned my call" (Interview No. 3). Another woman who had asked to be alerted when the first PLA process started, but who never was, placed regular, insistent phone calls to the College about the process' second phase. Despite having given the College her name and mailing address several times, no information arrived. In the course of yet another telephone inquiry, she was asked to give her name and address yet again, after which letters began to arrive with information. After a year of frustrating contacts with the College, this immigrant midwife of colour felt that,

The whole process ...I just find is just very...is a process I feel is there to discourage people. It's one that is there to weigh you down. [...] There are a lot of things that could be done differently to make the process run a lot smoother, which, if they claim to be as professional, as on-the-ball and as fair as they say they want to make it... It's not a fair process at all, I don't believe. I just don't feel it to be a fair process. (Interview No. 7)

The College explained away the mistakes by claiming that there was inadequate staffing and by using the "heroic myth" of midwifery's reemergence to deflect blame. One immigrant midwife of colour remembers being told that "they were just three [staff] and the huge things that they did, and 'til now [midwives had] sacrificed their own personal life to reach this" (Interview No. 9). Another applicant was told that "resources are limited and we have to put them towards the midwives and the PLEA candidates" (Interview No. 7). These practices must be regarded as neither random nor benign. The allocation of inadequate resources to the PLA/PLEA process must, I believe, be seen as indicative of the low priority assigned either by the College of Midwives or the province or both to the incorporation into the profession of previously practising midwives, many of whom, as has been repeatedly argued, were women of colour. Midwifery representatives had successfully negotiated ample, if not lavish resources for the integration of practising midwives through the Michener Institute program, but
their negotiating skills had obviously not been employed to create the conditions by which foreign-trained midwives could re-enter the profession for which they had been trained.

The bureaucratic incompetence and administrative unresponsiveness detailed above represent particularly cogent examples of institutional racism. Inasmuch as race-related discrimination is a documented feature of the Canadian workplace, these practices may indeed have been interpreted by candidates of colour as racism. A 1985 study conducted by the Urban Alliance on Race Relations and the Toronto Social Planning Council found significant evidence of discrimination by employers against researchers posing as job seekers using non-European names and/or speaking with non-dominant accents (Henry & Ginzberg, 1985). While white Canadian researchers were told in response to telephone inquiries that jobs were already filled in only 13% of cases, white immigrants were told this in 31% of cases, Black West Indians were told jobs were closed in 36% of cases and Indo-Pakistani researchers were told this in nearly 44% of cases (p. 5). While there may be many explanations for the high rate of attrition from the Prior Learning Assessment process of trained midwives, it is possible that some were deterred by the College's constant deferrals and bureaucratic bungles. While perhaps not intentionally racist, these occurrences, I would argue, may have produced racist effects when experienced by racialized "others," whose encounters with white gatekeepers have reinforced the message that access to the nation's rewards are not theirs for the taking.

**Conclusion**

This chapter has documented the numerous ways that Ontario midwifery has been maintained as a white space, despite the presence in the province of scores of trained midwives of colour. Fundamental to practices of racist exclusion has been the understanding that midwifery is a project formulated to address gender oppression and that women are positioned in a uniformly subordinate way, rather than in a hierarchical fashion in the social matrix. Such an
understanding has rendered race a largely irrelevant consideration in the formulation of policies and in everyday practices related to midwifery's reemergence. Many structural factors, including the threat of professional or legal reprisals, created conditions in which women of colour may have feared practising in the quasi-legal atmosphere that characterized the early years of midwifery's consolidation as an alternative health care practice. However, there existed ample evidence during midwifery's formative period that women of colour with midwifery skills and philosophies of care congruent with local practices wished fervently to practise their profession. Uninspired attempts at inclusion did nothing to increase women of colour's participation in the movement and later served to reinscribe marginalized women's identities while simultaneously producing white midwives as benevolent. Government-appointed bodies remained shockingly unrepresentative of the large number of midwives of colour in the province and enacted numerous policies which created roadblocks to the entry of midwives of colour to professional practice. Seeing their project as one which addressed the "universal needs of women" allowed white midwives and their supporters to rationalize exclusionary measures, all the while consolidating white solidarity in the profession and leaving intact a history of racist exclusion in the health care field and reinforcing racial segmentation in a province significantly populated by people of colour. As I will discuss in the next chapter, the same unexamined belief in universal sisterhood propelled Ontario midwives to travel to Third World sites and border spaces where significant material and discursive rewards were made available to them through access to the bodies of subaltern mothers.
Chapter Four

Midwifery Tourism: Third World women and the production of professional status for midwives in Ontario

With all tourist sites, commerce depends on the construction of a desirable Other - often one that titillates as well as appeals - capable of attracting outsiders. This construction can create inequitable interactions between local and traveler that actually serve to reinforce disparity while being represented as mutually beneficial. In these international interactions...the flow from center to periphery, from here to there, is virtually unidirectional...The disparity of interactions can be charted in this flow: when "they" come "here," we educate them; when "we" go "there," they service us.

Ryan Bishop and Lillian Robinson (1998)
Night market: Sexual cultures and the Thai economic miracle

Introduction

In the course of conducting this research, I discovered that a significant number of Ontario midwives had acquired training and experience in "Third World" maternity clinics. Many, but not all, travelled in order to garner the requisite quota of births for participation in the Michener Institute project designed to integrate practising midwives into the health care system. Whether birth numbers were required or not, the experience obtained in these clinics enhanced the midwives' professional status, enabling them to claim first-hand knowledge of the birth practices of Third World women, a commodity which was valued highly both in the medical and the alternative birth communities. This practice continues today, as aspiring midwives, midwifery students and practising midwives continue to seek expertise in these sites. It seemed profoundly ironic to me that while immigrant midwives of colour were largely unable to use their professional expertise in Ontario, practice experience acquired in the Third World enabled white Ontario midwives to qualify for registration in the province. Indeed, that Ontario midwives
derived substantial material benefits from their encounters with Third World women seemed to confirm recent scholarly claims that, both 19th and 20th century feminist projects in the West have been contingent upon global conditions of imperialism and racial dominance (Burton, 1994; Chaudhuri & Strobel, 1992; Grewal, 1996; Mohanty, 1991; Pierson & Chaudhuri, 1999; Pratt, 1992; Ware, 1992). This chapter then, looks at some of the transnational processes which have made birthing women's bodies in the Third World available for the educational consumption and material advantage of First World women. Below I will describe the global conditions which make this travel possible and analyze some of the travelogues I have gathered from "midwifery tourists." These travelogues recount violence and benevolence, as well as innocence and complicity, but, above all, they demonstrate how feminist projects which rely on unexamined notions of "global sisterhood" actually reproduce unequal relations of power between women.

**Crossing the border for midwifery experience**

While some Ontario midwives had acquired formal midwifery credentials abroad, most had learned the profession through intensive self-study and apprenticeship. However, opportunities to gain and exercise a broad spectrum of clinical skills were rather limited in the period prior to proclamation of midwifery legislation. Barred from practising in hospitals, midwives could employ their full expertise only at home births. The 26 midwives who were practising in Toronto, for example, attended, between 1983 and 1988, the home births of 1001 women, which meant that in a period critical to the establishment of midwifery's credibility, a Toronto midwife had, on average, complete professional responsibility for fewer than 8 births per year71 (Tyson, 1991). Obtaining clinical experience became a

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71 It must be stressed that this number is merely an average. In fact, some midwives attended 30 or 40 births per year in this period while others attended relatively few. Also, owing to family responsibilities, travel, or study, midwives would often withdraw from practice for an extended period, during which other practitioners would take on larger case loads (personal communication Christine Sternberg RM, May, 2000).
matter of some import for women who wished to devote their professional lives to the practice of midwifery.

For midwives practising in the legal limbo which characterized the pre-legislation period, obtaining wider clinical experience was crucial to gaining public confidence in the viability of midwifery care and to stemming physician opposition to the burgeoning practice. Such experience took on even greater significance with the advent of legislation when it became a basic requirement for licensure. As was noted in Chapter Three, in 1986 the Ontario government accepted a Health Professions Legislation Review's recommendation that midwifery become a regulated profession and appointed a provincial task force to develop implementation strategies. The Task Force for the Implementation of Midwifery made clear in its recommendations that attendance at a substantial number of births would be required of currently-practising midwives seeking to be grandparented into practice in the province.

Responding to the need for its members to acquire maximum clinical experience in the minimum time possible, the midwives' professional organization - the Association of Ontario Midwives - scrambled to find clinical sites where midwives could gain experience. Lacking institutional midwifery credentials, most Ontario midwives had no access to American or European clinical settings where midwifery was the standard of care. And while some midwives found placements in rural areas in the Philippines and in Guatemala, Haiti or Jamaica, the vast majority of those who travelled enrolled as interns at independent midwifery clinics on the U.S./Mexico border, a geopolitical space where, in Norma Alarcon's (1996) words, "the third world rubs against the first" (p. 45). For a fee, Ontario midwives could receive didactic training and attend Mexican women who, for a variety of reasons which will be discussed below, crossed to the U.S. to deliver their babies. An Ontario midwife who spent time at one such clinic in the late 1970s was able to name more than 20 colleagues who had also done so in the years prior to legislation. For these women, Canadian nationality and white skin served as
passports to unmolested border crossing and instant authority in the border spaces made available to them through this "midwifery tourism."  

**Travel and the female subject of modernity**

As postcolonial theorist Lata Mani (1998) has observed, colonized space has frequently served as a "theater of social experimentation" wherein Europeans have sought to critique and reconfigure the social relations of "home" (p.3). In the previous two centuries, European women's ventures into such space have allowed them to claim social identities unavailable to them under Western patriarchies. This area of inquiry has been a fruitful one, with feminist/postcolonial historians and theorists crafting a burgeoning "cultural retrospection of empire" (Ware, 1992, p. 229) aimed at untangling European women's role in the establishment and consolidation of imperial rule. In colonized locales, Western women were frequently able to act outside of the restrictive gender roles available at home because cross-gender bonds of race in the colonies were far more important to the maintenance of colonial hierarchies than was upholding the gendered social organization of the metropole.

As has been argued, scholarship which explores the historical relationship between feminism and imperialism can be useful in understanding contemporary social relations because the contours of the imperial world and the very categories and spatial boundaries that it created and policed continue to hold sway. (Razack, 1998a). In a recent study, Barbara Heron (1999) has demonstrated how white Canadian women who participate in overseas development work are able to enjoy a "release from the strictured constructions of white femininity" (p. 186) within largely masculinist development projects. "Faced with the numerically overwhelming physical presence of the Other," Heron explains, "[the] response of whiteness seems to entail extending a degree of insider status and white power

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72 I am grateful to Margot Francis for suggesting this term.
relations to women development workers albeit in gender specific ways" (p.186). Heron's interview subjects emerge from their development experiences with a "new narrative of self" (p.189) reflecting a subjectivity which approximates that of the modern bourgeois subject: free, unfettered, and able to act in the world in ways unrestrained by hierarchical gender norms. Like that achieved by their historical counterparts, this contemporary feminist re-coding of the self accomplished by development workers and other white female travellers, such as Ontario midwives, requires (and subsequently reproduces) the colonial context.

**Why "midwifery tourism"?**

"Tourism" rather than "travel" best characterizes the process by which white women from Ontario engaged in encounters with providers and consumers of birthing care on the U.S./Mexico border. The term "travel," as Inderpal Grewal (1996) has noted, implies a "universal form of mobility" (p.2) and consequently elides contemporary forms of population movement which are inherently coercive: the results of war, inter-ethnic conflict, forced migration, and the movement of people seeking reprieve from the decimation of social and economic structures wrought by policies of structural adjustment. "Tourism," on the other hand, connotes a largely voluntary form of travel available to those whose citizenship status and financial resources permit them access to locations and populations deemed desirable.

While an appetite for the exotic has long fueled the modernist tourism enterprise, some of its newest forms claim to offer the tourist something more morally uplifting than the pursuit of pleasure through the consumption of difference. In a context of widespread anxiety in the West around social degeneracy and planetary decline, initiatives such as eco-tourism and cultural tourism promise the Western tourist access to those spaces not-as-yet destroyed by capitalism's excesses. Indigenous cultures are fantasized in this schema as the repositories of health and wholeness and both land and people, represented via a "revitalized
primitivist stereotype," became seductable objects for tourist consumption (Jacobs, 1996, p.142). Constrained as an inherently ethical and mutually beneficial engagement with the "other," these forms of tourism promise a fundamental transformation of self in which the tourist's implication within neo-colonial relations of power are rendered moot. What cultural tourists seek, argues Griselda Pollock, is to "refuse the space and time of their own cultural deaths while inflicting it on everyone else" (Pollock, 1994, p.72).

"When the past is displaced, often to another location," explains Caren Kaplan (1996), "the modern subject must travel to it" (p.35). It is to this "anachronistic space" (McClintock, 1995, p.130), a place which exists in the real world but which lacks synchronicity with modernity's teleological march, that cultural tourists are drawn. And while the broad outlines of cultural tourism's appeal have been traced above, midwifery tourism is driven by a desire for a very specific "other": the Third World mother, mythologized widely within natural childbirth discourse as possessing innate feminine birthing knowledge as yet uncorrupted by Western medical practices. From American anthropologist Margaret Mead in the 1940s, to British childbirth reformer Sheila Kitzinger in the 1990s, primitive subjects have been deployed to decry the impaired childbearing capacities of women in the West (Mead, 1967; Kitzinger, 1992).

Indigenous Latin American women have been awarded a particularly revered status in natural childbirth iconography. Bridget Jordan's (1983) Birth in Four Cultures, a scholarly ethnography of childbearing "with the assistance family and friends" (p.40) among Maya Indians in Yucatan, Mexico, a book once impossible to find, is currently in its fourth printing, having been used widely, by the author's admission, "in the ongoing enterprise of changing the American way of birth" (Jordan, 1997, p.1). For many years, Birth, a medical journal devoted to the reform of clinical maternity care practices, has featured Latin American birth art, from reproductions of Mixtec genealogical-historical manuscripts to a contemporary painting entitled "Homage to the Mothers of Latin America." In Canada, the image
of a Nicaraguan partera (midwife) is emblazoned on a poster promoting the Association of Ontario Midwives, and a film produced in 1979 in a Brazilian hospital is enthusiastically screened for more than twenty years, proof that childbearing women in the West have lost the innate ability to birth naturally, while those in the Third World, frozen in time, have retained it. 73 Indigenous Latin American childbearing women can be constructed as particularly authentic through links to iconographic figures such as Quiché Indian activist Rigoberta Menchu as well as through popular representations of the forest-dwelling suppliers of raw materials to The Body Shop who are touted as having access to the secrets of natural health through substances unknown in the West.

Midwifery tourism is a material practice involving travel from one place to another, the exchange of money, the performance of medical acts and the issuance of certificates of completion. However, its materiality is inextricably interwoven with, indeed produced by, discursive constructs. A discourse of authenticity makes the Third World woman a desirable object of engagement because she is a "full representative of...her tradition" (Spivak, 1999, p. 60). However, it is the discourse of global sisterhood that allows midwifery tourists to defer any implication in the North/South relations of global inequality. As one midwife told me about her experience on the U.S./Mexico border,

There was something that went beyond borders, in terms of midwifery care and terms of caring for each other as women. It was such a common bond that it didn't matter who you were at that point [...] I felt you were just 'with woman' and all you had to be was a woman to make that happen. (Interview No. 21)

73 The film, Birth in the Squatting Position, was produced in 1979 by two Brazilian physicians, Moyses and Claudio Paciornik in their hospital in Curitiba, Brazil. In an article in the Summer 1982 issue of the journal Birth: Issues in Perinatal Care and Education, the Paciorniks published an article which elaborated on the film, Entitled "Rooming-in: Lessons Learned from the Forest Indians of Brazil." The article describes how the patients in their hospital follow the example of "our teachers, the Indian women out of the woods" (p. 16).
Framed within discourses of borderlessness and benevolence, midwifery tourism allowed Canadian women to produce themselves as respectable professionals while rationalizing both the specific relations of violence experienced in the border clinics and the global violence which produces the geopolitical spaces in which those clinics have thrived.

The U.S./Mexico Border as transnational space

The U.S./Mexico border is a space characterized by histories of colonial conquest, dramatic demographic shifts and aggressive economic incursions by multinational corporations. In the words of Chicana theorist Gloria Anzaldúa, the border is a "1,950 mile open wound" (Anzaldúa, 1987, p.2). The proliferation since 1965 of scores of maquiladoras, or export-processing factories, which are largely U.S.- or Japanese-owned, has dramatically altered the population of Northern Mexico, drawing steadily northward residents of central and southern Mexican states to border regions such as Matamoros/Reynoso, Ciudad Juarez/El Paso, Calexico/Mexicali and San Diego/Tijuana. Factories employ Mexican workers at low wages - typically the peso equivalent of between forty and fifty U.S. dollars per month - which are inadequate to support an individual worker, much less an entire family (Salzinger, 1997). The largest concentration of maquila workers in Mexico is to be found in Ciudad Juarez, which borders El Paso, Texas. These workers, Debbie Nathan (1999) explains, put in "forty-eight hour weeks soldering electronics boards, plugging wires into car dashboards, binding surgical gowns and sorting millions of cosmetics discount coupons mailed by North Americans to P.O. boxes in El Paso" ( p. 27). In the Matamoros/Reynoso maquiladoras, the organization of work has been described as "reminiscent of 19th century U.S. sweatshops...Tayloristic and authoritarian, with detailed division of labor, repetitive simple tasks and piecework wages" (Moure-Eraso, 1997, p. 597). Mexican labour from this border space makes possible the consumption of low cost consumer goods and other commodities which contribute to the high standard of living in the West.
As elsewhere in the globalized economy, employment in the maquiladoras has a distinctly gendered dimension. The proliferation of export processing plants in Free Trade Zones around the globe has created unprecedented employment opportunities for women who are considered to be a dexterous and docile, apolitical and endlessly replaceable workforce. While as recently as a decade ago, 75-85% of Juarez's maquiladora workers were women, this number has been reduced in recent years to around 50% of the total workforce. Not only has increasing militancy by female workers rendered their employment less desirable to the managers of export-processing plants, but the devaluation of the peso has reduced the cost of labour, making maquila production even more profitable for transnational corporations, and the recruitment of male labour a practical necessity. For the young women who do enter the maquiladora workforce, hiring is conditional on a negative pregnancy test and pregnant workers can be summarily dismissed. Employee turnover is exceedingly high and most workers have less than one year's seniority on the job (Salzinger, 1997, p. 16). For women displaced to the north of Mexico, but unable to sustain employment in maquiladoras, domestic labour across the border in the U.S. offers a viable employment option. In El Paso, at least 15-20,000 homes hire domestic help and the majority of these workers are women from Ciudad Juarez who are employed as both daily maids and live-in household workers (Mills, 1991). At both the personal and the global level, Third World women's labour translates into First World privilege.

Undocumented Mexican migrants are increasingly the targets of border surveillance and the objects of a strengthening discourse in the U.S. about the drain on the public purse (Kearney, 1991). Unwanted as citizens, Mexican residents and migrants are indispensable as transnational consumers. Border cities like El Paso are economically dependent on Mexican shoppers who spend 22 billion dollars a year in U.S. border cities, generating some 400,000 jobs and paying 1.7 billion dollars in taxes (Brown, 1997, p. 105). By some estimates, nearly 6000 medical service jobs in El Paso are underwritten by Mexican nationals willing to pay
for medical services, including prenatal, intrapartum and postpartum care delivered by direct-entry midwives in out-of-hospital birth centres on the U.S./Mexico border (Brown, 1997, p. 108).

White midwives and Mexican women are at the nexus of several transnational processes. Displaced to the North by the promise of employment in export processing plants and largely impoverished, Mexican women who become pregnant require cheap and competent perinatal care. Poor or inaccessible services on the Mexican side of the border and tightened controls over services to undocumented migrants on the U.S. side of the border (coupled with fears of deportation if they seek care in state-funded institutions), prompt some Mexican women to deliver their babies in out-of-hospital clinics run by predominantly Anglo, direct-entry midwives. More than a cheap or convenient individual solution, giving birth in the U.S. is fundamentally an act of resistance which challenges arbitrary border delineations and creates a transnational Hispanic community through children's U.S. citizenship (Rodriguez, 1996, p. 21). A widespread practice, cross-border childbirth has gained the attention of public health researchers hoping to improve maternal-infant health status on both sides of the border. At least two studies have shown that approximately ten percent of border-dwelling Mexican women cross into the U.S. to deliver their babies, frequently without having received prenatal care there (Guendelman & Jasis, 1991, p. 10). While some of these women give birth with nurse-midwives in church-funded Catholic maternity homes, many receive care from direct-entry midwives (Boyer, 1992). While only .3% of all births in the U.S. (approximately 12,000 births) are attended by lay or direct-entry midwives, 75% of these are conducted in birth centres located on the U.S./Mexico border and the majority involve Mexican or Mexican-American women as clients (Rooks, 1997, p. 153). "The great demand for this service," boasts one clinic's promotional pamphlet for potential students, has resulted in El Paso being "the heart of midwifery in the United States."74

Border clinics and tourist schemes

While there is little in the way of historical documentation about the midwifery border clinics, their founding is largely contemporaneous with the installation by transnational capitalist enterprise of export-processing industries in the north of Mexico (McCallum, 1979). While numerous alternative midwifery training schemes have arisen in North America since the early 1970s, most direct-entry midwifery training has been based on attendance at home births which, according to available statistics, did not, in the last decade, exceed .7% of total births in the U.S. (Rooks, 1997, p. 150). Border clinics have, for the last twenty years, been a significant training site for those unwilling or unable to pursue long and expensive apprenticeships in the few available programs. The clinics have been popular because they enable direct-entry midwifery students to attend large numbers of births within a relatively short time frame. More recently, self-study programs have offered direct-entry midwifery students short-term "externships," primarily to impoverished Jamaican hospitals, but also to American-run birth clinics in the Philippines and Guatemala where students can garner the requisite number of births to acquire the designation "Certified Professional Midwife" granted by the independent Midwifery Education Accreditation Council (Rooks, 1997, p. 268). Both the border clinics and the travel schemes are contingent on transnational processes which make Third World women's bodies available for First World women's educational and professional needs.

Seven practising and non-practising white midwives or midwifery students interviewed for this thesis participated in midwifery tourism between 1978 and 1997. The women provided rich data on their experiences in a number of settings,

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75 In an undated program brochure, postmarked in 1997, The Maternidad La Luz clinic in El Paso, Texas, for example, promises that students will attend approximately 25-35 births in a three month "quarter," nearly enough to fulfill the requirement (depending on the student's role at the birth) for attendance at the 40 births required to sit the North American Registry of Midwives qualifying examination.
including four U.S./Mexico border midwifery clinics. Interview subjects also
provided access to clinics' promotional literature and other materials. In addition,
internet research has yielded information about travel schemes to Jamaican
hospitals (advertising materials specifically target Canadians) as well as to
independent birth clinics in Guatemala, India, and the Philippines. The training
programs last from eight days (a hospital stint in Jamaica) to fifteen months (a
missionary midwifery training program in the Philippines). Costs vary from 1850.00
US for the shortest trip to more than 12,000.00 US for the training program in the
Philippines, with a popular three-month internship at one Texas midwifery clinic,
costing 3750.00 US. Internships at the border clinics typically involve
didactic/academic training in the form of classroom education and immediate
hands-on experience. Most border clinics do not require previous midwifery
experience and yet students can expect to attend 25-35 births in a three month
period. The Jamaican trips offer a much higher volume of births to the prospective
student, who, according to one information letter, can expect to deliver between two
and five babies per shift and assist at another four to six even if she has had no
previous training.\(^{76}\)

Promotional materials for the clinics/trips utilize an unmistakably touristic
framing to render the sites exotic and desirable. Topographies which have been
ravaged by the incursions of transnational corporations are rendered whole and
unblemished. The following description of El Paso in a clinic brochure is offered
from a border where the poorest residents on both sides find themselves "breathing
the same particulates from open fires, smoke stack emissions, automobile
exhausts, burning tires, road dust, and construction sites and sucking water from
the same briny depleting aquifers beneath a surface polluted by raw sewage,
pesticides and toxic wastes" (Ortega, 1991, p.2):

\(^{76}\)"Jamaica Clinical Trip Information Sheet," International School of Midwifery, Miami Beach,
Fla. 1997.
El Paso is situated in the Chihuahuan desert in the western corner of Texas, on the Texas, New Mexico and Mexico borders. It is very hot and dry in the summer with balmy mild winters; sometimes it even snows. The city is bisected by the Franklin Mountains, which is at the tail end of the Rocky Mountain chain. This creates a diverse scenery, including spectacular sunrises and sunsets and beautiful mountain views.  

In a place where both space and identity are subject to frequent and often violent contestation, human interaction too is discursively costumed in the garb of contented coexistence:

The term "bilingual and "biculultural" come to life in practically every day-to-day activity in El Paso. With a combined population of over two million, El Paso and its sister city of Cd. Juarez are the largest cities on the U.S./Mexican border. The constant interaction between the two cities adds up to over a million border crossings per month over the four bridges which connect the U.S. and Mexico.  

More than geography, however, is reimagined by the narratological strategy which is used to promote and sustain midwifery tourism. Indeed what is most successfully recoded is the relational positioning of the "tourists" and the "natives." Here, cautious comparisons can be made between midwifery tourism and another form of tourism in which transnational movements and racialized and gendered processes of representation collude: the sex tourism industry in Asia. Ample care must surely be exercised in such a comparison. While, as will be described below, brutal treatment of Mexican women was witnessed by Canadian midwives in the border clinics, sex tourism exposes the women who are its objects to far more grievous forms of sustained violence, including physical assault, HIV/AIDS infection and involuntary confinement (Seabrook, 1996). What links these two forms of tourism, however, is that in both cases, Third World women's bodies are viewed as a natural resource and "customers lured by an appealing conflation of natural, 

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78 Ibid.
social and cultural forces are themselves represented as inherently desirable" (Bishop & Robinson, 1998, p. 10).

As Ryan Bishop and Lillian Robinson (1998) have demonstrated in the case of the heterosexual sex trade in Thailand, the conditions of globalization which thrust women into prostitution are thoroughly obscured through Thai women's representation in tourist literature as naturally desirous of sexual commerce with white men, a representation which also serves to explain the low cost and easy availability of these women for paid sexual encounters. The identical discursive dynamic can be viewed in the midwifery tourism pamphlet quoted above. Having rendered neutral the harsh environmental and social realities of the border, indeed having performed a magical disappearance of the entire neocolonial system, promoters of midwifery tourism are free to argue that Mexican mothers freely choose midwifery care in the clinics because it is an "affordable and desirable alternative" and not because it is a survival strategy in an environment that offers few options. As in sex tourism discourse, midwifery tourism's key selling points are the availability of abundant desiring and desirable bodies and promises of pleasure for the consumer. A letter accompanying a brochure for potential interns guarantees in proto-pornographic language access to "a lot of beautiful Mexican Mamas" and promises that the intern can "expect to palpate and listen to more bellies than you ever thought possible....But most of all you can expect to have fun!".

Although they position themselves as the generous benefactors of women eager and grateful for contact, midwifery tourists, like sex tourists, reap rewards well beyond those gained by those who service them. Western (male) heterosexual sex tourists return to a privileged existence, their white masculinities secured through sex with brown women. Midwifery tourists, on the other hand, come home

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79 Ibid.

endowed with an enhanced respectability that allows them to claim a relatively lofty slot in a race and gender segmented workforce. Those who enable these rewards, however, merely survive. This unequal exchange is at the heart of transnational logic. "Whether the gift is worth the price for which the receiver has to pay," Trinh T. Minh-Ha has commented, "is a long term question which not every gift giver asks" (Trinh, 1991, p. 22). To do so, I argue, would unveil the reigning "mystique of reciprocity" (Bishop & Ryan, 1998, p. 126) revealing that these tourists' innocence is no more than an illusion.

Narrating the innocent tourist

The discursive enticements to midwifery tourism promise a fair exchange, an act of benevolence and a moral project, all of which secure the traveller's innocence rather than reveal her collusion with the violent effects of globalization. However, encounters in the border clinics threaten to undo this. Indeed innocence is fundamental to midwifery subjecthood in Ontario where it is narrated through the heroic tale already identified in this thesis, wherein a dedicated group of women endured both legal jeopardy and personal sacrifice to create "not just another profession, but a tool to gain community-based woman-defined care" (Van Wagner, 1988a, p. 117). Some of the challenges which threaten the univocal timbre of this narrative have been recounted here, but it is the "forgetting" of those processes that allows the tale to be told and which enables midwives to assume a subjecthood that is unassailably moral and unproblematically unitary. If, as Teresa de Lauretis (1984) has argued, subjectivity is not a "fixed point of departure or arrival from which one then interacts with the world" (p. 159), but is produced instead through our social interactions and our shifting positionalities within those interactions, then it cannot be the case that experience is something that individuals "have." Rather, experience is the grounds upon which our very subjecthood is articulated. It is how midwives rationalize their contradictory experiences in the border clinics in order to preserve their status as innocent subjects that I now turn.
Subjectivities, as I have noted, are produced in relationship, however they require technologies of articulation to render them intelligible and serviceable. Narrative is one such technology. Narratological structuring imposes a coherency on the unruly strands of a story by discarding those threads which threaten to disturb the desired pattern of the weave. But the sequencing of this weave, as Hayden White (1981) has pointed out, always assumes a moral ordering. How then do midwifery tourists, through the stories they tell about their experiences in the border clinics, reclaim a moral self by reordering the threads of a narrative which includes participation in forms of care which are at best antithetical to an articulated Ontario midwifery philosophy of female benevolence and of multicultural sensitivity and, at worst, unmistakably violent?

A common thread running through the midwives' narratives of their border experiences is the language barrier between themselves and the Spanish-speaking women they attended. In the promotional materials for one border clinic "a thorough understanding of English" is required for admission but only a basic understanding of Spanish is deemed necessary. This, despite the fact that 85% of the clientele are unilingual Spanish speakers. In a second clinic, Spanish is "recommended but not required." Much of the communication between Ontario midwives and Spanish-speaking women in the clinics is effected through non-verbal forms of communication which, for the tourist, can be yet another exotic attraction "to be felt internally, recognized and enjoyed as a private and intensified 'object'" (Curtis & Pajaczkowska, 1994, p. 207). Ontario midwives interviewed were convinced of the authenticity of their interpretations of the communication conducted through non-verbal cues and improper Spanish usage, and, as demonstrated below, communication gaps are most frequently construed as benign. I suggest that such a construction resolves the contradiction inherent in Ontario midwives' providing care under inferior communicative conditions when education and counseling,

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shared decision making, and informed choice are the hallmarks of midwifery care in the province (College of Midwives of Ontario, 1994).

Ineffective communication between Spanish-speaking women and their Anglo/Canadian caregivers as a humorous event is a theme repeated again and again in the interview narratives. "They're amazing people actually," remarked one veteran midwife, referring to the women she cared for, "they're so warm in terms of being accepting, especially of students who speak poor Spanish. They used to laugh at me all the time" (Interview No. 21). Another midwife told me:

I would make a lot of those Mexican ladies laugh their heads off all night long listening to me attempt to speak Spanish, it was really good to help them open up [achieve cervical dilation]. They thought it was really funny. (Interview No. 18)

In this quote, communication barriers are not just amusing, they are therapeutic as well. Another midwife found it "hilarious" to be working in an environment that was Spanish-speaking when she spoke only a rudimentary form of the language (Interview No. 24).

Whether care in a border clinic is benevolent and humane (as it frequently is) or tinged by violence (as in the experiences described by some of those interviewed), the relationship between Mexican women and white midwives is always already embedded in a transnational and local racial hierarchy. For Mexican women using the border clinics, compliance and laughter might represent a spontaneous display of mirth, but such behaviour might also symbolize an indispensable survival strategy learned in a hostile border space. Cross-cultural communication, argues Ophelia Schute (1998), is often received in fragments, and it is frequently the most important part of the message that is discarded because its accurate reception would require "the radical decentring of the dominant Anglophone speaking subject" (p. 53). In at least one study of Latina women's childbearing experience in the U.S., laughter was not the response the researchers
encountered when women relayed the impact of language on their maternity care. Rather, Carolyn Sargent and Grace Bascope (1997) report that during interviews with Spanish-speaking women in a Texas hospital after childbirth "several women cried upon realizing that the interviewer spoke Spanish, expressing their desperation to find someone with whom they could communicate" (p. 193).

Two of the women interviewed described witnessing events in the border clinics which transformed their experience from a demonstration of their dedication to the profession to a test of their moral and physical resolve to gain midwifery experience. The women are clear about their objections to what they witnessed but still attempt to resolve the contradictions between the unnerving realities of the border internships and their own benevolent self-conceptions. Their strategies range from, in one case illustrated below, constructing a subtle narrative which distinguishes the witnessing student from the guilty perpetrators of the violence, to constructing a blanket rationale in which the repellent elements of the training are justified by the acquisition of valuable midwifery experience.

In the following quote, an Ontario midwife describes her astonishment and disgust at the violent treatment a Mexican woman receives, but quickly elides that violence by recoding herself as a potential victim of the clinics midwives' vicious behavior. In this way, she manages to justify both her self-imposed silence and her continued stay at the clinic:

The hardest part for me was after being there for two weeks, seeing the director kind of say to women [harshly spoken] "get up on the bed" with her knee like this, like tooph, like getting really impatient with this women [shouting] "open your legs, ahh aah ahh!!" And I just thought... what am I doing here? This is awful! I've got to speak to this. So we're sitting around the table afterwards chewing the fat and I just..."you know I feel that it's really important...I don't feel that any woman in labour should ever be treated unkindly." "Oh", says C____, "um hmm." "Oh" says R____ the other intern. Silence. Then they decided they were going to blackball me, kick me out of the program. How dare I critique the program? So, very early on, I
got my threat, you know. And I never ever opened my mouth about anything that I couldn't stand there. (Interview No. 19)

In another incident, an Ontario midwife describes the behavior at a birth of a clinic employee whom she knew to engage in casual prostitution. The speaker emphasizes the clinic midwife's unrespectable status by referencing her as a prostitute and biker and masculinizes her by describing her behaviour in the language of sexual violence and male esprit de corps. As the narrative describes the "prostitute woman" it simultaneously constructs, by contrast, the femininity, innocence, empathic character and bourgeois sensibilities of the speaker, masking her complicity in the violent scene:

You know the "rape" began and the woman in the Harley-Davidson tee shirt, the prostitute woman in the Harley-Davidson tee shirt, put her feet up against the wall and her knee in the woman's belly to push the baby out and the blood flowed and her mother-in-law came with her Kleenex to cry and mop up the blood. It was just awful. There was this sort of camaraderie, this sort of rough camaraderie afterwards, 'oh, did you see her mother-in-law was praying,' gross stuff, gross stuff. (Interview No. 19)

For many of those interviewed, descriptions of their border experiences are infused with a deep sense of ambivalence. One woman returned with a "real sense of experimenting on people" (Interview No. 36). Others described being profoundly disturbed by the lack of respect and absence of choice which characterized the care in which they participated. One woman was particularly disturbed by the transformation of birthing women's bodies into a spectacle where up to ten people would pile into a labour room to observe the final moments of birth. "Sometimes it's kind of like a 'crotch on a plate,'" she told me. "I mean you come in there for ten minutes, I mean what have you seen? Have you seen a birth? No. Have you seen a baby come out? Yes" (Interview No. 36). However ambivalent they felt about their stays in the border clinics and in Third World practice sites, all the women considered their experiences to be invaluable. They were described as "good," "great," and "inspirational." Those who had witnessed the most violent incidents
were adamant that even if they had known beforehand what it would be like, they would still have gone to the clinics.

**The rewards of midwifery tourism**

Ontario midwives and students were unanimous in their recognition of the material and discursive value of the experience. During the early years of the midwifery movement in Ontario, travelling to border clinics increased midwives' credibility not only among peers and clients but among other medical professionals as well. A recent study of the midwifery movement in Ontario notes that the 

rewards and actual leadership status was [sic] given in the early days in the Movement in Ontario to those who had very early begun learning about birth through 'life experience' the traditional way midwives used to learn. Third World experience was especially held in high esteem. (Daviss, 1999, p. 107)

One woman who had apprenticed with physicians in the 1970s talked about the importance of her lengthy stay at a border clinic:

The significance was that I was considered by the doctors that I worked with when I came back as someone now who had experience, a lot of experience. And most doctors...just absolutely assumed that I had my equipment...(and that) I would catch the baby at birth. So it gave me a certain kind of ability, expertise, understanding. I learned a lot, I thought a lot. I dealt with stuff down there. Postpartum hemorrhage that was unbelievable that I'd never dealt with here (Interview No. 19).

Indeed, access to complicated maternity cases was key in conferring a degree of medical expertise and credibility that would have been impossible to acquire in Ontario where midwives managed only medically uncomplicated births. In an oddly contradictory way, the clinic experiences allowed Ontario midwives to claim both medical and midwifery authenticity through their experience with Third World women, whose birthing capacities are ambivalently marked as both natural
and pathological in the descriptions. Border experience even served as a tool for convincing hostile Canadian physicians of midwives' professional skill. Venturing into what must have been exceedingly hostile territory, pro-midwifery Toronto physician Brian Goldman published a 1988 article on home birth in the Canadian Medical Association Journal in which the border experience of the midwife described and her exposure to abnormal birth are used as evidence of her competency (Goldman, 1998). More recently, the border clinic experience allowed one aspiring midwife "to see a lot of things that I wouldn't see here because of numbers. I mean I saw a prolapsed cord, I saw babies going, I saw a lot of hemorrhages, this and that" (Interview No. 31). For another midwife, Third World women provide a constantly renewable source of expertise: "And what I find...I've always done is I go back to developing countries to refresh my skills on doing breeches and twins and some of these complicated cases here" (Interview No. 17).

Conclusion

Midwifery tourism is a particularly transparent example of how First World feminists make use of imperial subject positions in their struggle for localized forms of gender justice and how identity is made in and through space. And while midwifery legislation did not directly compel midwives to travel abroad for experience, the conditions for its implementation made midwifery tourism a necessary strategy for some white women seeking to become registered midwives in the province. The enticements and incentives which make these travels desirable and the rationalizations which render them benevolent demonstrate the numerous ways in which white First World subjects, even those with relatively little power in the transnational scheme of things, continue to find racialized others a useful tool in constructing dominant identities. Little, if any reward, however, accrues to the women whose availability as objects of study is predicated on globalizing processes of uneven development. Neither, as I have argued in this thesis, are Third World women recognized outside of the imperial script when they
appear in the West, not as reified objects of a primitivist discourse, but as agents in their own rights (Alexander, 1998).
Chapter Five

"Ambassadors of the Profession:” Identity Regulation and the Construction of Respectable Midwifery

Because there are myths and, in fact, fears about midwives in our society, it is very important not to alienate the audience by reinforcing any of the myths by your appearance or the content of your speech. [...] If you appear to fit right into your audience’s stereotype of a “backwoods hippie” or “starry-eyed earth mother” with “yellow socks and Birkenstock sandals” or a “strident angry militant feminist” or “selfish homebirth fanatic,” then you have defeated the purpose of being there in the first place. [...] It is very important at this time in the history of midwifery that we present a very consistent vision of what a midwife is. This is not the time for individual visions of midwifery—although hopefully the time is coming.

Vicki Van Wagner (1988b)
"How to Speak about Midwifery Issues"

In a sense, the power of normalization imposes homogeneity; but it individualizes by making it possible to measure gaps, to determine levels, to fix specialties and to render the differences useful by fitting them one to another. It is easy to understand how the power of the norm functions within a system of formal equality, since within a homogeneity that is the rule, the norm introduces, as a useful imperative, and as a result of measurement, all the shading of individual differences.

Michel Foucault (1979)
Discipline and Punish

Introduction

In Chapter Three, I described how racist exclusion operated to construct the Ontario midwifery movement, and the bureaucratic structures which superceded it, as normatively white spaces. However, immigrant midwives of colour were not the only women who threatened the creation of a respectable midwifery profession. The midwifery movement harboured its own “others” who, as Vicki Van Wagner demonstrates in the opening epigraph, provoked enough
alarm to require a concerted strategy of repudiation. In order to make rights claims on the state and achieve access to both health care resources and public approval, midwives in Ontario required a significant degree of social and epistemological parity with the professional group paradigmatic of respectability, power, and scientific rationality: physicians (Starr, 1982). Ultimately, midwives needed to attain an ontological positioning in the public imagination as scientific/rational readers of women's reproductive lives (Murphy-Lawless, 1998). Veteran midwives who threatened this positioning by virtue of their immoderate spirituality, femininity, or emotionality found themselves pushed to the margins of the midwifery movement. Indeed, a new norm - in the form of the neutral, liberal humanist subject - was rapidly occluding the figure of excess that had come to be associated with the revival of midwifery in North America. While unruly veteran practitioners were being contained, the production of rational/respectable midwives was being consolidated in the provincial Midwifery Education Programme (MEP), where subjects were disciplined, identities policed, and norms inscribed. This chapter, then, will trace the installation of a normative midwifery subject and the bending towards this norm of midwives and midwifery students. This normative subject, I will argue, represents a standard to which not all bodies can be shaped.

**Disciplinarity and the respectable midwifery subject**

In *Discipline and Punish*, Michel Foucault traces the development of those disciplinary mechanisms which, in an age of putative equality, introduced "insuperable asymmetries and excluding reciprocities" (Foucault, 1979, p. 198). Such mechanisms, he argues, secured the dominance of the bourgeoisie through non-juridical means. Foucault reasons that in modernity, exclusion cannot be understood to function through a "massive binary division between one set of people and the other." Rather, he claims, it is achieved through "multiple separations, individualizing distributions, an organization in depth of surveillance and control, and an intensification and a ramification of power"
(Foucault, 1979, p. 198). Juxtaposing the figure of the leper with that of the plague victim, Foucault describes two separate, but not unrelated, means of differentiation: the construction of the "pure community" and the production of the "disciplined society" (p. 199).

Contagion and potential social disintegration are directly controlled through the creation of spaces of exclusion or "pure communities" which rely on frankly binary divisions such as "mad/sane; dangerous/ harmless," and in the case of the leper, curable/incurable (Foucault, 1979, p. 199). The production, in this manner, of the normatively white space of midwifery was the subject of the previous chapter. Disciplinary power, on the other hand, transforms individuals, making them knowable in relation to a range of behaviours anchored at the poles of "good" and "bad," and ranking them in ways which delineate the gaps between individual behaviour and an established norm (Foucault, 1979, p. 180). Disciplinarity, as Foucault notes, operates as a dual system of "gratification - punishment" (p. 180), rewarding adherence to the established norm more often than punishing the individual for his/her transgressions. Punishment in such a regime consists of comparison and differentiation in relation to adherence to a rule which is "made to function as a minimal threshold, as an average to be respected or as an optimum towards which one must move" (p. 183). This process was famously evoked by Foucault through the device of Bentham's panopticon, the penal architectural structure which rendered the prisoner visible to scrutiny at all times but which made it impossible for him to know whether he was, at any given moment, actually being watched. In time, he would begin to watch himself, policing his own gestures and movements so as to avoid punishment, and moving, incrementally, towards more socially accepted behaviours (Ransom, 1997). "The perpetual penalty," writes Foucault (1979), "that traverses all points and supervises every instant in the disciplinary institutions, compares, differentiates, hierarchizes, homogenizes, excludes." "In short," Foucault concludes, "it normalizes" (p. 183).
At the heart of this, and all disciplinary projects then, resides the 'normal' individual who serves as a "standard of valuation" for determining who is to be included and who excluded from a given collectivity. This norm, as John S. Ransom (1997) notes, "acts not in a descriptive sense, but in a prescriptive sense, imposing a good-bad distinction on what was at first only a mean distribution of individuals" (p. 52). Such a distinction is candidly drawn by midwifery activist Vicki Van Wagner in the opening epigraph, wherein Ontario midwifery's (white) figures of ill-repute are summoned up against a norm which is invoked in inverse relation to the clutch of disagreeable figures that she sketches. As Edward Said (1993) has argued, cultural identities are never self-referential constructs but form, rather, "contrapuntal ensembles" with their various "opposites, negatives, oppositions" (p. 52). Country/city, material/spiritual, archaic/modern, rational/irrational, disembodied/embodied, public/private are just a few of the binaries alluded to in Van Wagner's quote. Arguably, it is the first partner in each pair which is favored in the moral ordering which constructs the norm lurking behind Van Wagner's admonition. Peeking from the shadows is to be found none other than the liberal humanist subject: abstract, autonomous, independent, unraced and non-sexed (Shildrick, 1997). This subjectivity, as Margaret Shildrick (1997) argues, requires "taking on the ontological status of a man" (p. 147), a man, I would add, who is always already racially (un)marked as white. This is a subjecthood not available to all. Indeed, the valorization of this norm and the bending of midwifery subjects toward it has prevented the midwifery professionalization project from delivering a broader liberatory and democratic vision.

What I wish to explore here, then, is the project of disciplining white midwives (and the few racialized 'others' deemed worthy of inclusion) so as to produce "ambassadors of the profession" (Bourgeault, 1996, p. 129): neutral and rational/scientific subjects whose whiteness and bourgeois character are uncontaminated by the figures of abjection described in the opening epigraph. Some of these figures command wide public recognition and have discernable
antecedents in an archive of stunningly enduring discourses which inscribe the midwife as a "relic of barbarism" (Sullivan & Weitz, 1988, p.11). Others represent more contemporary, although no less publicly recognizable, portraits of debasement. These images and discourses, and their relationship to the disciplinary strategies exercised by some elite midwives over their colleagues and students in the pre- and post-legislation period, will be explored in this chapter.

While it is the case that the struggle between those women who sought merely to decriminalize midwifery and those who sought state-regulation and funding is a defining feature of the re-emergence of midwifery in Ontario (Daviss, 1998), the intent of this chapter is not to adjudicate between the relative merits of decriminalization and those of state-regulation. Rather, my purpose here is to trace how the decision to pursue state-regulation necessitated a particular kind of midwifery subject as well as to map the cultural battles over the construction of the "new midwife." To whom is the new midwifery subjectivity available, and how has midwifery used the modern appeal of "technical-rational rule" (Flax, 1993, p. 42) to exclude its 'others' are some of the questions which are addressed in this chapter.

_The shadow of race in the elimination of the midwife: Representational and historical discontinuities between the United States and Canada_

The archive of images which represents midwifery as an archaic and disreputable profession has enjoyed a remarkable longevity. And while opponents of midwifery in both Canada and the U.S. drew liberally on such negative representations in both recent and past campaigns to impede the practice, they diverged in relationship to their employment of unmistakably racist discourses. Indeed, while racism was central to the elimination of the midwife in the U.S. early in the last century, it has not constituted a significant rhetorical or political strategy in Canadian anti-midwifery discourse. Rather, in their evocation
of the dangerous midwife, opponents of self-regulating midwifery in Canada employed discourses which conflated the obsolete and the feminine. Consequently, a political strategy which sought to contain those midwives who represented female excess became important to midwifery activists in the struggle for legalization.

The evolving public image of the midwife in the West can be understood as a palimpsest upon which has been inscribed a progression of ominous figures including: the witch/midwife portrayed in the infamous Malleus Maleficarum, a 15th century church text which codified the Catholic Church's anxieties over the links between midwifery and sorcery; "Sairey Gamp," the dirty crone of Charles Dickens' 1884 novel Martin Chuzzlewit; the "ignorant" granny-midwife who, until the 1960s, continued to deliver many African-American women in the Southern U.S.; the alternately reviled and revered Third World midwife; and finally, the "starry-eyed" hippie midwife named in this chapter's opening epigraph. Feminist scholars have, in recent years, launched historiographic challenges to these negative discourses, offering richly complex analyses of midwifery's decline. Popular writers as well have attempted to reconstruct the midwife as a transhistorical/global female folk hero. Such efforts, however, have not entirely succeeded in overturning this sedimented archive of disparaging representations. While a thorough examination of the historically- and geographically-specific processes which have produced these images is beyond the scope of this chapter, it can be argued that the demise

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of the traditional midwife in the West and her replacement with the physician, or the physician-supervised nurse-midwife, is coterminous with the decline in traditional anthropomorphic epistemologies and the ascendancy of science in Europe (Papps & Olssen, 1997). Such a development must be understood not as an abrupt shift from "superstition and magic to objective scientific knowledge" (McNay, 1994, p. 5), but seen rather, as Lois McNay argues, as a "series of abrupt and arbitrary paradigm breaks" (p.5). While dotted with innumerable pockets of resistance, the overall effect of such breaks was that women and non-European others were deemed atavistic repositories of outmoded knowledge while white European men were seen as the "bearers of modernity" (Papps & Olssen, 1997, p. 52).

In the U.S. context, an escalation of anti-midwifery sentiment can be traced to the turn of the last century when medical education became standardized and a burgeoning belief in the efficacy of scientific medicine was taking hold among white, middle-class Americans (Amey, 1982). Both non-specialist physicians and members of the growing obstetric profession in the U.S. viewed midwifery as an impediment to their professional, economic and political advancement. Having already become the accoucheur of choice for nearly all white middle-class women in America, the physician still faced competition from immigrant and native-born midwives who continued to deliver the babies of many immigrant and poor urban and rural women (Wertz & Wertz, 1989). Nearly 86% of Italian-American births were reported by midwives in 1908 (Litoff, 1978, p. 27) and a 1924 study revealed that 86% of Minnesota midwives were foreign-born and that they served communities where the majority of residents were immigrants (Borst, 1995, p. 44). And, while by 1935 the percentage of women attended by midwives had dropped to 12.5% from 50% in 1900, nearly 80% of those midwives who continued to practise were African-American traditional midwives working in the rural Southern U.S. (Rooks, 1997, p. 30) who would, for a variety of reasons, not be completely eliminated until the 1960s.85 Unfounded suspicions that midwives contributed to

85 For discussions of the disciplining and ultimate elimination of the Black southern midwife see Susie, D.A. (1988). In the way of our grandmothers: A cultural view of twentieth century midwifery in Florida. Athens, GA: University of Georgia Press, and
increasing maternal and infant mortality rates\textsuperscript{86} were also deeply intertwined, in both Canada and the U.S., with the concern with "race degeneration" which arose in response to the influx of immigrants and the high casualty rates of World War I. It is not surprising then, that anti-midwifery discourse in the early 20\textsuperscript{th} century U.S. relied heavily on racist and xenophobic themes to discredit the midwife.

However, U.S. anti-midwifery discourse of the early 20\textsuperscript{th} century was, in fact, superimposed (in palimpsestic fashion) upon an amalgam of older discourses in which the degenerate female figure of "Sairy Gamp," the unkempt, unruly and inebriated proletarian nurse in Charles Dickens' (1944 [1884] \textit{Martin Chuzzlewit} figured prominently and from which the "witch/midwife" could occasionally be glimpsed. Some physician monographs of the time targeted "the typical, old, gin-fingerling, guzzling midwife with her pockets full of forcing drops, her mouth full of snuff, her fingers foul of dirt and her brains full of arrogance and superstition" (Sullivan & Weitz, 1988, p. 11). However, like Joseph B. DeLee, the most prominent obstetrician of his day and an activist in the movement to eliminate midwives, some physicians employed particularly misogynist forms of racism and xenophobia in their rhetoric. A popular article written by DeLee in 1926 featured depictions and disparaging descriptions of three midwives: an Italian woman, a Southern black woman and an Irish woman, all dressed in dark garb and portrayed against an ominously dim background. It carried the following descriptions:

A typical Italian midwife practising in one of our cities. They bring with them filthy customs and practices...[A] granny of the far South. Ignorant and superstitious, a survival of the magic doctors of the West Coast of Africa...Surely it might have been this woman of Irish-American parentage who is quoted as having said: "I am too

\textsuperscript{86} In fact, as Judith Rooks (1997) demonstrates, wherever the practice of midwifery began to decline in the U.S., maternal and infant mortality could be seen to increase.
old to clean, too weak to wash, too blind to sew; but, thank God, I can still put my neighbours to bed.' (Susie, 1988, p. 5)

Such images have enjoyed an extraordinary longevity. Indeed, well after midwifery had been virtually eliminated in the United States and Canada, the figure of the degenerate midwife continued to be used by journalists and physicians to trumpet the triumph of obstetrics over the risks of childbirth, and the victory of science over superstition in the lying-in chamber. As late as 1960, the Ladies Home Journal castigated the "unsanitary crone" and celebrated the "long medical struggle against the horrors of much old-fashioned midwifery" (quoted in Miller, 1997, p. 71).

I would like to suggest here that the shadow of race falls differently on the Canadian and American histories of the elimination of the midwife in the 19th and 20th centuries. While the campaign to eliminate the midwife in the U.S. was conspicuously organized around the figures of the immigrant and black granny midwife at the turn of the century, racialized minority women who practised midwifery in Canada were left largely unmolested by the state until well into the 20th century. Aboriginal midwifery is a case in point. While medical missionaries made early incursions aimed at dismantling Aboriginal childbearing systems, it was only in the 1940s and 1950s that the Medical Services Branch of Health and Welfare Canada instituted coercive tactics forcing Aboriginal people to abandon indigenous health practices such as traditional midwifery (Thomas, 1993). There is also evidence that Japanese-Canadian women relied on Japanese-trained community midwives and Chinese-Canadian women on Chinese midwives until at least the 1930s and possibly beyond.87 Indeed, the role of midwives during the internment of

87 In her history of midwifery in Canada, published as an appendix to the Report of the Task Force on the Implementation of Midwifery, Jutta Mason (1987) quotes from a privately published monograph, M. Miyazaki's My Sixty Years in Canada, for which no date is given. From the context it can be understood that Mayazaki was a physician who practised in Vancouver in the 1930's. In a footnote, Mason quotes Mayazaki as saying that "most Japanese people depended on Japanese midwives...from Japan but who had no license to practice in B.C. [...] Mrs. Watanabe was operating a rooming house so that Japanese women from the West Coast and country used to come to Vancouver a week before the expected date and stayed at her rooming house where Mrs. Watanabe delivered the baby and took care of the mother and baby." 'I was called,' noted Watanabe, 'whenever these women had difficult cases'" (p. 228).
Japanese-Canadians during World War II is yet to be explored. Such evidence is tantalizingly scant and certainly in need of exploration.

The demise of the midwife in Canada can be loosely understood as the purging of female expertise in childbirth and its replacement by a scientific model of childbirth management (which included important technological innovations such as anesthesia, Cesarean section and aseptic technique) propounded by and practised almost exclusively by men. Much historical literature focuses on this process in relation to Ontario, where, by the middle of the last century the institution of "social childbirth," in which female relatives, friends, neighbours, and a community midwife attended the labouring women, had been replaced by hospital-based childbirth managed by physicians (Mason, 1987; Biggs, 1990; Oppenheimer, 1990). As in the U.S., the elimination of the midwife came on the heels of the consolidation of medical "regulars" and the enactment of legislation which prevented unlicensed practitioners from performing medical acts (Biggs, 1990). While there exists a debate among Canadian historians as to whether the disappearance of midwifery is primarily attributable to physician opposition and a concerted campaign of eradication, or whether demographic, geographic, and technological factors played an equally or more important role in midwifery's demise, what is certain is that

Also, in his recent autobiography, Chinese-Canadian writer Wayson Choy (1999) reports that a midwife, Mrs. Eng Dick, attended his birth on April 20, 1939 in Vancouver, British Columbia.


89 There were some minor, but not uninteresting, exceptions to the trend towards hospitalization and physician-managed births. Childbirth with midwives continued, for example, well into the 1960s in outport Newfoundland communities (Benoit, 1991). While she offers only scant empirical evidence of this practice, Mason (1987) also suggests that midwife-attended births in Alberta Mennonite communities persisted well into the 20th century.
midwives largely ceased to practise by early in the last century. In Ontario for example, by 1897, the overwhelming majority of births were managed by physicians, and by 1938, most women were giving birth in hospitals (Oppenheimer, 1990, p. 56).

Strident opposition to midwifery, however, did develop early in the last century in response to a scheme initiated by the National Council of Women for addressing the lack of trained childbirth assistants for rural women (Buckley, 1979; Boutilier, 1994). The scheme intended to provide midwifery training to local women, augmented by instruction in "first aid, simple nursing and 'household economy and sanitation'" (Mason, 1987, p. 210). Both physicians and trained nurses expressed intractable resistance to the scheme. While physicians did not wish to endanger their professional dominance over birth, newly professionalized nurses, having put to rest the Sairy Gamp legacy, were equally unwilling for nursing labour to be associated in any way with domestic work. Both physicians and nurses employed rhetoric which associated midwives with "dirt, ignorance and danger" in their efforts to prevent the training or importation of midwives (Boutilier, 1994, p. 34). United in their opposition and mindful of whom they wished to build the nation, physicians and nurses feared that schemes to import British midwives would allow "[O]ld country people who know nothing of Our conditions to dictate a solution of our problems by dumping on to Our prairies people they wish to get rid of" (MacKenzie [1917] quoted in Buckley, 1979, p. 143). Indeed, opponents of midwifery registered a figure of abjection that was hopelessly female, proletarian, and old-world and one which was mired in an atavistic form of domestic empirical knowledge far removed from science's promise to deliver women from the perils and indignities of childbirth. In the late 19th and early 20th centuries she was precisely the figure against whom professional nurses marked their respectability and physicians their scientific rationality and consequent entitlement to manage the bodies of women.

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While Canadian physicians were largely unconcerned with midwifery for much of the 20th century, negative images still surfaced and began, in the 1970s, to appear with increasing frequency, for example, in the Canadian Medical Association Journal (CMAJ) (Winkup, 1998). In 1970, at the very moment that the counterculture/feminist midwifery revival was making its debut, a book review was published in the CMAJ which claimed that "the term (midwife) has a stigma attached to it. It conjures up a picture of an old, unhygienic, unscientific granny, delivering babies in the backwoods, relying heavily on superstition and magic elixirs" (Fuhrer [1970], quoted in Winkup, 1998, p. 54). As Winkup (1998) has shown in her review of CMAJ articles relating to midwifery which appeared between 1967 and 1997, much physician rhetoric deemed midwifery to be "medically obsolescent" (p. 70) and physician opposition to home birth was frequently voiced. Ontario physicians were also opposed to home birth but not to the legalization of midwives. Their stance diverged from that of the Canadian Medical Association which published its official position opposing the licensing of midwives in 1987, a year after the Ontario Ministry of Health announced its intention to regulate midwives and the year that the landmark Report of the Task Force on the Implementation of Midwifery in Ontario was published. Indeed, responses to the Association's position in the pages of the CMAJ frequently evoked midwifery as an outdated practice. For those seeking to discredit midwives, the confluences between older negative representations of midwifery and the emergent "counterculture" empirical midwives could be logically posited. Indeed, these confluences were to be problematic for the midwifery movement. Those midwives who viewed the forgotten "neighbour-midwife" not as a skeleton in midwifery's closet but as an ideal to be emulated, and for whom midwifery practice was part of the achievement of a holistic pastoral ideal and not a professionalization project, would find themselves struggling for credibility, respect and ultimately, the right to continue to practise.
New midwifery identities, old midwifery images: The bourgeois imperative emerges

Beginning in the 1970s a vigorous counternarrative to the obstetrical saga of maternal safety and satisfaction began to arise in the U.S., Canada and Great Britain.\(^\text{91}\) Empirical midwifery and home birth, virtually eliminated in the first half of the century, were enjoying a revival among some North American white women. British midwives, who had not been eliminated in the 20\(^{th}\) century but had come under medical regulation, began to challenge the increasing medicalization of their profession with the establishment in 1976 of the Association for Radical Midwives (Weitz, 1987), and U.S. nurse-midwifery,\(^\text{92}\) which had somehow managed to survive the century, saw a doubling of its clientele (Rooks, 1997). While part of an overall undermining of medical authority, the anti-obstetrical movements had their own unique trajectory. The popular childbirth reform movement, as I have already noted, reflected a curious convergence of ideologies ranging from the cultural left's critiques of the fragmentation of modern life and its separation from nature, to the feminist health movement's advocacy of medical self-help and women's right to reproductive choice, to the gender traditionalism and heteronormativity of breastfeeding.


\(^{92}\) In the past, nurse-midwives did train and practise in Canada but worked mostly in rural areas and in the North. The University of Alberta School of Nursing began training nurse-midwives for rural areas and public health work in 1944, and in 1967 Dalhousie University initiated a program which included an internship in the Canadian north. Memorial University in Newfoundland also began a program in 1978 (Mason, 1987). Prior to legislation in each province, Ontario, Alberta and British Columbia instituted experimental nurse-midwife programs in tertiary care hospitals (Harvey, Kaufman, & Rice, 1995). Despite these initiatives, nurse-midwifery has not been embraced in Canada, where direct-entry midwifery has been adopted in all the provinces in which legislation has been effected.
advocates, the La Leche League, to religious fundamentalist refusal of state intervention into the childbearing process. All of these elements are in evidence in the Ontario midwifery movement, where "counterculture" midwives and supporters exerted a powerful influence in the years prior to legislation. However, this vision of midwifery was not to survive the political struggles of the ensuing decade. Those who sought to preserve "unregulated organic midwifery...which is grounded on spiritual and humanitarian premises and grows naturally from group conscience" (Monk, 1995, p. 7) - the "backwoods hippies," "starry-eyed earth mothers" and "strident home birth fanatics" of this chapter's opening epigraph - found themselves embattled within a movement whose claims to legitimacy were increasingly grounded not only in the authoritative discourses of science, but in claims to a general social normativity.

"Counterculture" influences in the re-emergence of midwifery

In one of several pre-legislation monographs in which she argued that state-regulation was wholly antithetical to the spirit of community-based midwifery in Ontario, historian and midwifery supporter Jutta Mason (1989) described seeing photographs of midwife Judi Pustil delivering her first child in 1979:

The pictures were taken in a summer meadow beside a stream near Powassan; about a half a dozen friends stood or sat in the grass beside Judi. One of them held an open book. Judi told us - amid much laughter - that they were all so 'green' concerning birth that when the baby's head started to show, all wrinkled, everyone thought it was a bum and they hastily looked up the section on breech birth. (p. 5)

Pustil's birth story is one that arose frequently in the interviews that I conducted with veteran white midwives. While it has been supplanted by the "heroic tale" of

93 See also Mason, J. (1990). The trouble with licensing midwives. Ottawa: CRIAW/ICREF.
midwifery identified in the previous chapter, it serves, for some midwives, as the mythological origin story of midwifery in Ontario. Constrained neither by doctors and patriarchal medicine, as in the hospital, nor by the expertise of empirically-trained and occasionally medically-trained home-birth midwives, who already appear in Mason's 1989 monograph as instruments of the state in the surveillance of pregnant women's bodies, Pustil's outdoor birth is presided over by none other than Mother Nature herself. Pustil's uneventful birth and those of other women attended by "untrained workers," argued Mason, contributed to the growing store of "exemplary birth statistics" achieved not only through the efforts of lay midwives, but attributable as well to the counterculture approach to pregnancy, birth and child care. A clear refutation of the claims of obstetrical and other medical practitioners that medicalization had reduced the risks of childbirth, these statistics, argued Mason, reflected not luck, but "the genius of the alternative birth culture: the joy, the neighbourly connections we revived, the crazy quilt of diets, chants, politics, sleeping-in-one bed: all of it, not one element, not even mainly midwives" (p. 6). Even Vicki Van Wagner, who was to be instrumental in the implementation of both midwifery legislation and university-based education for midwives still clung, in 1982, to the belief that professional expertise was not at the heart of community midwifery in Ontario. "Part of our struggle", explained Van Wagner, "has been to recognize that our support as women and mothers, not particularly as experts, can help women in pregnancy and labour" (Van Wagner quoted in Mason, 1988, p. 3).

While Ontario childbirth reformers did indeed reflect the divergent ideologies apparent in the rest of the North American movement, much pro-midwifery literature in the years prior to the province's decision in 1985 to legalize midwifery echoed Mason's "countercultural" views. The pages of Re-Birth, a "quarterly newspaper about choices in childbirth," which was published by midwifery supporters for several years in the mid-1980s, were filled, for example, with ads for natural foods stores and cloth diapers, as well as critical reviews of the medical policies of the province's hospitals, "miraculous" home birth stories,
suggestions for herbal remedies, and directions for "natural family planning."
Indeed, the anti-medical stance of much of the paper's editorial copy is
unmistakable.

Among the many cross-border influences was the extraordinary success
of Tennessee midwife, Ina May Gaskin's 1975 book, Spiritual Midwifery. Gaskin,
an empirically-trained midwife wrote about birth on "The Farm," a rural commune
in Summertown, Tennessee that she had founded in 1971 with her husband
Stephen and several hundred followers who joined them in pursuit of the "hippie
pastorale - a life of minimal technology...self-determination and the happy
coexistence of human life with nature" (Umansky, 1996, p. 54). A combination
"how-to" guide for midwives, and personal narratives which emphasized the
spiritual elements of the childbirth experience, the book sold over half a million
copies in the U.S. and Canada over the course of twenty years (Rooks, 1997, p.
61). A stunning demonstration of the evident safety of home birth for healthy,
well-nourished women, the book also accomplished a unique, perhaps
unprecedented, recuperation of the language of birth from the hands of medical
experts. Uterine contractions in labour were neologized as "rushes" and re-cast
as exhilarating and sensual rather than painful and frightening bodily sensations.
The euphoric language of the psychedelic drug culture and references to openly
sexual behavior also figured prominently in the book's "amazing birth tales":

Well, I got behind Judith and leaned her head on my chest and kind
of cradled her and rubbed and kissed her and did stuff to turn her
on again. [...] And shortly she was rushing all kinds of pretty rushes
and color changes. She changed colors in waves usually starting in
heavy pink at her head and moving down in about an eight-inch
wide wave followed by a gold and a white, the pink one being very

94 "The Farm's" record of maternal and infant safety has been studied by public health
scholars who examined the outcomes of 1707 pregnancies of women delivered at the
commune between 1971 and 1989, concluding that for low-risk women, home birth with
lay midwives was not necessarily less safe than hospital birth with physicians (Durand,
physically visible and the other being more like shining light around her. (Gaskin, 1978, p.193)

In touch with midwives in the province, Gaskin herself saw the holistic birth culture in Ontario as imperilled by the move to legislation. Addressing followers in Toronto in 1989, she warned that professionalization would "cut off opportunities to learn from every unique woman" and block access to "women's collective knowledge" (Monk, 1994, p. 9).

Gaskin's book introduced counterculture midwifery and the figure of the "hippie" midwife to hundreds of thousands of readers. And while *Spiritual Midwifery* is not an overtly anti-medical text, it powerfully re-claims and re-names obstetrical knowledge, peels away its scientific skin, and harnesses it firmly to non-rationalist thought and feminine essentialism. Those who wished to, could easily have argued that the continuities between the hippie midwife and her disreputable predecessors were practically seamless. So close was the confluence, that in her 1985 tribute to the virtues of Canada's emerging midwives, *Midwifery is Catching*, Eleanor Barrington felt compelled to account for Gaskin's "spiritual midwife." "[A] source of much honest confusion," wrote Barrington, "[t]he spiritual midwife works with birth as part of the ebb and flow of life, acknowledging the forces beyond the physical process. But she is not a witch doctor who merely voices incantations when action is required" (p. 16).

Untrained, superstitious and even racialized in Barrington's reference to the witch doctor, the hippie midwife constituted another inscription upon the midwifery palimpsest and yet another disagreeable subjectivity against which midwifery respectability in Ontario would have to be crafted.

Indeed, in the years just prior to the province's decision to legalize midwifery, midwives were treated to a timely reminder that older anti-midwifery

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95 Indeed Gaskin is a far more pragmatic, indeed scientific, figure than her popular image conveys, developing in recent years, highly efficacious obstetrical manoeuvres lauded by both physicians and nurse-midwives (Rooks, 1997).
discourses had not been abandoned, that women's projects that sought to defy the authority of scientific medicine would not go unchallenged, and that midwives' apparent epistemological marginality left them vulnerable to public attack. In his 1982 book, *A History of Women's Bodies*, Canadian historian Edward Shorter launched a powerful salvo against "[e]ngagé scholars in the women's movement who see the midwives of the past as a great boon to womankind" (p. 35).

Shorter's openly-stated and immensely curious intent in the book is to demonstrate that contrary to feminist critiques, modern medicine actually enabled the emergence of feminism by improving women's health. "Traditional women's culture," claims Shorter, did not represent a pre-modern utopia, but was actually the source of much women's suffering. Indeed, he argues, the elimination of that culture's emblematic figure, the midwife, has been in women's best interest. Only in partnership with men, says Shorter, has women's progress taken place. He devotes an entire chapter of the book to displaying evidence that "golden age" historiography of midwifery is, in fact, a deception and that, from the 16th century onward, "unfavorable opinions about the midwives, [came] from all over Europe and Britain until virtually the beginning of the 20th century" (p. 87). Shorter's accounts of midwifery incompetence are brimming with gruesome detail. "[M]any traditional midwives," he recounts, "seemed to have been conversant with the knives, sharp hooks (crochets) and blunt hooks needed to decapitate the infant or evacuate its cranium" (p. 87). Indeed, he claims, if midwives attended most births in the past, and it is known that many women died in childbirth, then midwives must have been responsible for their deaths (Shorter, 1991, p. 98). This, Shorter claims, is "the most stunning of any indictment of the traditional midwives" (p. 98).

Published in the same year as a high-profile coroner's inquest into a midwife-attended home birth in the Kitchener-Waterloo area in which a baby subsequently died, *A History of Women's Bodies* appeared at a critical time in the

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96 Shorter's book was reissued in 1991 by Basic Books as *Women's Bodies*. 
re-emergence of midwifery in Canada. Shorter's intervention into the debates over the practice is not a frivolous one. Methodologically flawed, but well researched, *A History of Women's Bodies* draws on a vast and obscure cache of historical literature in several languages. Widely reviewed in both the popular and the academic press, the book seemed to prove, as the New York Times reviewer noted, that the "benevolent midwife" was, in fact, largely mythological (Papps & Olssen, p. 57). Its impact did not go unnoticed among midwifery supporters in Ontario who saw the book's publication as a direct threat to the struggle for legitimization. Judging from her references to *A History of Women's Bodies* in an article entitled "Survival tactics for midwives," published in the Spring 1983 edition of *Issue* (Newsletter of the Ontario Association of Midwives), Louise Norman97 clearly regarded Shorter's work as a direct hit:

Edward Shorter and his much publicized new book pompously reaffirms the status quo. In print he gets away with "nobody dies anymore" and on the air "modern feminists want to go back to having their babies in huts." Well we know such statements are hogwash, but again thousands will believe him because he's a scholar and because they have never heard or read anything to the contrary. In the end, public sentiment is the crucial issue [emphasis in the original]. (Norman, 1983, p.7)

Norman correctly locates Shorter's work within a discernible power/knowledge nexus, admitting that the image of midwives as "dirty and primitive" had not been expunged from the public record and that those with little access to public discourse would be hard pressed to create a counternarrative as powerful as the palimpsestic one that Shorter offers. If midwives and their supporters needed a warning that female irrationality would not be tolerated as the basis of a self-regulating, state funded health care profession, Shorter had provided a highly amplified one.

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97 In her 1989 monograph, "The dangers of professionalization," prepared as a discussion paper for the November 22, 1989 meeting of the Association of Ontario Midwives, midwifery critic Jutta Mason conjectures that "Louise Norman" was actually the pen name of midwife Theo Dawson.
Disciplining unruly midwives in the pre-integration period

As outlined in the previous chapter, by the mid-1980s the dominant impulse in the province among members of the Association of Ontario Midwives, their supporters, and many legislators, was towards state regulation of midwifery and its integration into the health care system. As Beth Rushing (1993) has argued, Canadian midwifery worked to establish itself in the health care system by propounding both science and feminism as its key ideological constructs. A standardized midwifery curriculum, delivered at the university level with "an emphasis on immediate and ongoing clinical experience under supervision," was supported by the Association of Ontario Midwives in their third submission to the Health Professions Legislation Review in 1985 (Bourgeault, 1996, p. 132).

Indeed, as Ivy Bourgeault (1996) has pointed out, and as was demonstrated in Chapter Three, these changes were not externally imposed but rather voluntarily embraced by the activist midwives who used their political acumen to rescript Ontario midwifery so as to make it acceptable to both the state and the other health care professions upon whose approval midwifery integration hinged. Tolerance for ideological diversity within midwifery was eroding, and in 1985 began to wear thin, as another coroner's inquest, this time into the death of an infant at a midwife-attended home birth on Toronto Island, made news headlines, bringing midwives under unprecedented public scrutiny. Forced to defend itself on medicine's home turf, the midwifery community employed medical rhetoric and used medical experts in this very public, and ultimately successful struggle to prove its legitimacy. "Throughout the process," explains Ivy Bourgeault (1996), "midwives felt the need to stress their educational background, to dress a certain way to enhance their appearance as professionals, and not to appear to be the 'lunatic fringe' they were originally considered to be" (p. 70).

While I wish to avoid, as I have noted above, entering into the debate for or against state-regulation of midwifery, midwives' reliance on the ideologies of
science and feminism and their disciplining of appearance and demeanour to "professional" norms do raise pressing questions about the effects of the liberal state's granting of increased power to women. "Do these expanding relationships," queries Wendy Brown (1995), "produce only active political subjects or do they also produce regulated, subordinated and disciplined state subjects?" (p. 172). As Brown argues, those who are recognized and granted rights by the state require the "stuff of liberal personhood -- legal, economic or civil personality" (p. 182). I would argue that the midwifery activists' embracing of scientific rationality, bourgeois educational norms and normative female appearance helped secure access to the liberal personhood which rights claims require. Indeed, such a strategy provides evidence that, as Brown fears, gains for women granted by the liberal state have a disciplinary effect, producing some subjects who may be political and active but who are also disciplined into certain modes of political agency and subjectivity. If, in order for women to be constituted as liberal subjects they must "repudiate or transcend the social construction of femaleness" and "enter civil society on socially male terms" (Brown, 1995, p. 183), then those who viewed midwifery neither as primarily a political crusade nor a public profession, but as an extension of their spirituality and of their legitimate social roles as wives, mothers, friends, neighbours, etc., represented something of a political liability. If midwives needed to represent the embodiment of liberal subjectivity in order to be seen as legitimate political agents, then those midwives who fell short of that norm needed either to be bent towards it, or else purged. Such was the process applied to practising midwives prior to and during the grandparenting-in process. It is to the construction of midwifery respectability through disciplinarity that I now turn.

Rural midwives of Eastern Ontario

More than 120 midwives applied to the Michener Institute pre-registration program set up to grandparent-in practising midwives in the months prior to legalization. This number was much higher than the figure of 75 estimated by the
Curriculum Development Committee in their 1990 report. Seventy-two applicants were ultimately admitted to the program and 63 graduated in the Fall of 1993. Some of the nine midwives who were left behind felt that they had received biased treatment at the hands of the foreign midwife-assessors (Bourgeault, 1996). Among those not admitted to the Michener program was a group of approximately 16 women, including nine community midwives and seven birthing centre nurses, who organized themselves into "The Committee for More Midwives." They vigorously lobbied the provincial government and the midwifery bureaucracy for special consideration of their skills and community responsibilities and the creation of a special route of entry to the profession. However, such consideration was not granted and for those left out of the Michener program, there remained only two options: to apply for entry to the baccalaureate-granting Midwifery Education Program or wait for the establishment of the Prior Learning Assessment program where their previous experience could be assessed. The Committee for More Midwives raised troubling questions about how midwifery was being implemented in the province and about who was constituted as a suitable "ambassador of the profession."

Beside my own critique of the race politics of the pre-registration program, other researchers have raised questions about the process by which candidates were chosen for the Michener Institute's program, suggesting that criteria were applied unevenly to program applicants (Monk, 1994; Bourgeault, 1996; Daviss, 1998). One excluded midwife wrote of the transitional period:

those midwives expressing dissent with the dominant discourse are 'hounded' up front. During the transition to regulated midwifery, they are being refused access to impartial assessment and/or registration despite demonstrated professional competence and extremely supportive client communities. (Monk, 1994 p. 17)

At the very least, the process left some apparently competent midwives unable to practise and some areas of the province with no access to midwifery care. While some of the nurse-midwives who had worked in the province's experimental
hospital birth centres failed to gain access because of lack of home birth and primary care experience, the selection process seemed to cull out a large percentage of women from Eastern Ontario, admitting only three out of the 14 of the midwives who had been practising in that region, and none of those from rural districts where midwifery was popular. Indeed while in January of 1994, Toronto and national media trumpeted the triumph of midwifery legislation, news media in Ottawa and Eastern Ontario were far more circumspect. The Ottawa Citizen of January 3, 1994 carried a headline which read "Eastern Ontario faces shortage of midwives" while the Ottawa Sun on the same date proclaimed "Out of a job...angry midwives thrown out of work by new provincial regulations say the rules are flawed and will today demand a review" (quoted in Daviss, 1999, p. 207). In rural Eastern Ontario, the reception for legalized midwifery was even chillier. The Smith's Falls Record News of January 12, 1994 carried a headline which read "Rejection of midwives in Lanark County is a lost labour of love" (quoted in Daviss, 1999, p. 207).

Eastern Ontario midwives and their supporters had posed a threat to midwifery respectability for some time. The October, 1986 Kingston hearings of the Task Force on the Implementation of Midwifery were, according to one midwife, "regarded as one of the places where people 'let their hair down,' where midwives and parents said what they really thought instead of what they were supposed to say to appear 'manageable to the Task Force people'" (Daviss, 1999 p. 170). Their unorthodox views did not go unnoticed by Task Force members who apparently voiced concerns to those midwives who had key roles in the legislative process. One Eastern Ontario midwife recalled being reprimanded soon after the hearings by a board member of the Association of Ontario Midwives after TFIMO chair Allan Schwartz reportedly pronounced that "those midwives up there will never be legalized" (Daviss, 1999, p. 170).

Parts of Eastern Ontario had long been home to those who sought alternative and/or communal lifestyles in which self-sufficiency, including a
reliance on community midwives, was valued. In an undated press release which announced a January 3, 1994 press conference to protest the exclusion, in the wake of the passage of the Midwifery Act, of rural Eastern Ontario midwives from practice, members of the Lanark Midwifery Support Association protested that the state was extending its reach coercively into their lives. They argued that their preference for midwifery care and their decision to live in rural Ontario were part of their quest for personal freedom. "Once again," they alleged, "legislation from an unmandated bureaucracy is interfering, removing our freedom of choice and 'NOT serving the people.'" Their midwives, they claimed, had impeccable safety records and high client satisfaction rates. Indeed, the plight of the region's midwives was supported by local physicians who had written dozens of letters protesting their exclusion from the registration process (Daviss, 1999). Invoking historical forms of midwifery persecution, Lanark County midwifery supporters accused the midwifery establishment of engaging in a "witch-hunt." Indeed, the "backwoods hippie" and "starry-eyed earth mother" appeared to be facing the same fate as their spiritual foremothers. While some were never summarily excluded and others succeeded eventually in becoming registered in the province, those midwives whose inclinations and ideologies resembled those of the Lanark County midwifery supporters faced a less than welcoming environment as midwifery built a state-funded and regulated apparatus in the province.

Non-elite white midwives in the legalization struggle

As outlined in Chapter One, eight white midwives who considered themselves socially, politically or ideologically estranged from midwifery's political elite were interviewed for this project. More the "starry-eyed earth mother," "backwoods hippie" or "selfish homebirth fanatic" than "strident angry

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98 Eastern Ontario has not remained without midwives. The College of Midwives of Ontario's list of midwifery practices dated April 6, 2000, lists six midwifery practices in Eastern Ontario, including one serving Lanark County.
militant feminist," these women, many of whom had played key roles in reviving midwifery practice in the province, identified in the interviews a range of beliefs and behaviours for which they felt marginalized once the midwifery community acceded to the push for professionalization exerted by some of its members. Of the eight, five were legally practising at the time of the interview. Two of these midwives had not succeed in being accepted to the Michener Institute Pre-registration program, but had entered midwifery through the Prior Learning Assessment/Prior Learning and Experience Assessment or Midwifery Education Programs. Of the three midwives interviewed who ultimately completed the Michener program, two, who had active practices for many years and met all of the criteria for admission, reported being scrutinized overzealously in the grandparenting-in process. For one of these women, whose entry to practice was delayed, "it was like going into mourning! I was in a total panic for about two years trying to figure out what had happened and realizing how far my colleagues had gone to get rid of me" (Interview No. 17). Of the three trained, but non-practising midwives interviewed, one tried several times to enter the profession through the Midwifery Education Program but was denied admission each time. The remaining two midwives chose not to pursue registration.

While my purpose in interviewing this group was to be able to theorize their repudiation by the midwifery elite, on several occasions I was treated to a demonstration of one of the key theoretical assertions of this project: that those who are themselves marginalized frequently cling to their own marginalization as a way of refusing implication in systems of domination. Some midwives interviewed, particularly those who had faced barriers to registration, continued to harbour a deep resentment towards midwifery's elite. One woman interviewed referred to the group at the centre of the midwifery implementation bureaucracy in unmistakable masculinist terms, calling them the "gang" and "crew" while another midwife interviewed referred to the elites as "feminazis." These women were eager to talk to me, I felt, because I was engaged in a project which criticized this group. Certainly, this dynamic yielded franker data than that which
might have been collected by a researcher engaged in a less explicitly critical project. However, I was frequently struck (and often made to feel disingenuous) by these women's enthusiasm for my project, which they understood to be an indictment of the elite midwives and vindication of the "good" excluded white midwives whom the elites had wronged. Only a few of those interviewed were willing to see both their subordinate positioning as unruly 'others' and their dominant positioning as white women in midwifery's re-emergence.

While relating their stories of exclusion, some midwives did not fail to express exclusionary/racist sentiments towards immigrant midwives of colour. One woman described to me her reluctance to employ a second midwife of colour in her practice even though the midwife of colour she currently employed was working only casually as a second attendant and not as a registered midwife:

I just got a call from a woman of a certain ethnospecific background who wants to join our practice...but one of my reticenses in letting her come and join the practice is that there's already a second attendant in our community who is fulfilling the role of a second attendant at these births. [There's no room for] both of them, specifically with this ethnospecific group, no! Cause there aren't enough births coming from it. [...] I could take her on anyway and have her doing births with everybody...that's the obvious. But I'm just not sure, we...already have a practice that's pretty diversified. (Interview No. 17)

This sense of being besieged by "too many" women of colour, together with the belief that women of colour are best suited to practising in their "own communities" were freely articulated to me. This midwife clearly saw no problem in expressing these attitudes to another white woman, despite having signed the requisite release form in which the anti-racist intentions of the research were explicitly stated. Such "white talk," argues Alice McIntyre (1997), is based on an assumption of shared racist attitudes between white people and is, not infrequently, a feature of their conversations. Encounters with openly racist expression, as I can testify, are certainly problematic for the white anti-racist
researcher. Indeed, to leave racist expressions unchallenged is to legitimate them, which I most certainly did when I refrained from responding to the midwife's comments. To openly disagree, or to end an interview in which racism is expressed, on the other hand, might restrict the collection of data which provides the basis for a broader analysis of racist processes (Wetherell & Potter, 1992). When such issues arose during the interviews they served as timely reminders that subordinate/dominant are always relational positionings in the social matrix, and as such, are in constant need of historicization.

Motherhood and midwives

The non-elite white midwives interviewed identified several features of their own identities which they felt set them apart from the elites. Many women's commitments to a style of mothering which prescribed close physical and emotional contact (including prolonged breastfeeding) with infants and young children created a discomfort with the disruptions to family life required by the model of 24 hour on-call midwifery practice to which many midwives subscribed. Some of those interviewed also felt marginalized for their mainstream or new-age spiritual beliefs by elite midwives who had demonstrated a sort of hyper-rationalism in their quest for legitimization. Finally, a preference for the modes of dress of the North American hippie subculture of the 1960s and 1970s is often mentioned as a point of contention between the elite midwives and those who felt excluded from the political centre. In fact, the visual dimensions of respectability seem to have played a rather overdetermined role in the re-emergence of midwifery and their significance, as I will argue below, should not be minimized.

Maternal obligations and espousal of a traditional model of mothering set some of those interviewed apart from much of the midwifery leadership that emerged in the pre-legislation period. Many of these women were also older than the emergent leadership and, unlike them, had several children and numerous domestic responsibilities which made participating in both midwifery politics and
midwifery practice nearly impossible (Bourgeault, 1996, p. 46). Indeed for some women, the practice of midwifery alone presented difficult ideological and logistical challenges inasmuch as midwives who believed fervently in full-time motherhood frequently needed to leave their children with friends, relatives or other caretakers. One woman described her ambivalence towards the pre-legislation professionalization trend:

I was still a mother who was at home with her kids and you know sort of struggling to...I wasn't willing to sort of become, I didn't want to be this professional that put her kids in day care and that this was more important to her than being with her kids! I mean that was one other thing, I mean I don't say that they [the midwifery elite] did all that but it was sort of this...what we we're turning into, which is what I see the students doing now who have little babies and shuffle them off. It's not like I never shuffled my kids off; I did. But I also took them around a lot and you know I had my daughter at births when she was a baby and that was one of the biggest and most difficult struggles of being a midwife was also being a mother who was involved. Because I always wanted to have kids and be with them. (Interview No. 20)

Another woman who had medical midwifery training and who contemplated, but decided against, practising in Ontario in the early 1980s, felt that she was judged deficient because of her normative views of the family:

I remember going to...AOM meetings and at one point a midwife who shall remain nameless who I had a very friendly relationship with asked me about whether I was going to have children or not and I sort of said "well, I'd like to have a partner first." And "are you one of those women who has to have a partner to have children?" YES!! [...] That was obviously considered like...I was less of a woman, I guess. I don't know. That I was somehow deficient. That I needed to be supported. [...] I just think that for me, when I chose to parent, I chose to parent. And I wasn't willing to...there are stories of certain midwives whose kids have just been to some degree, abandoned in the process of them furthering their midwifery pursuits. And that's not something I would want to do. I wanted to be available for my kids. [...] I did go back to work when my youngest child entered kindergarten. But I've kept...tried to balance my work, my home work and my "work" work so that the kids get a certain amount of quality time and get somebody home for dinner
every night. [...] And we do, we build our lives around the kids. (Interview No. 22)

Another midwife was harshly critical of the Ontario model of midwifery as unfriendly to families, which she consciously defines, in the quote below, both within and outside of heterosexual parameters:

I heard [a midwifery leader] say [...] "if you're a midwife, it's the absolute centre of your life, nothing comes before it. That's what makes a real midwife." I thought, wait a minute, some of us...that may be true for you, honey, but for some of us, our families come first, our families come first and I'm sure that for a lot of lesbian relationships, especially if they have children, their families come first! [...] I have no choice. I must practise full time. I must practice it to the corporate culture image. Work to the exclusion of all else. Because this is what creates a "real professional" somebody who is willing to sacrifice their family, their fun, their physical health and their mental stability for their corporate performance! These people are adopting models that are being abandoned left, right, and centre by pretty well every other field. (Interview No. 18)

The centering of professional rather than maternal identity, was, as this midwife recognizes, a key strategy in the legalization of midwifery. Those women whose lives and outlooks were defined more by domestic interdependency than by civil autonomy constituted questionable liberal subjects and feeble claimants to state resources. In order to be constituted as liberal subjects, Wendy Brown (1996) reminds us, women must "abstract from their daily lives in the household and repudiate or transcend the social construction of femaleness consequent to this dailiness" (p. 183). Ambivalent or unruly midwives who wished to continue practising midwifery after legislation then found themselves bent, sometimes against their explicit desire, towards this norm of liberal subjecthood. In a cogent example of how disciplinarity works at the micro level, midwife Mary Sharpe described in a 1993 monograph, her midwifery practice group which had "pioneered the renaissance of midwifery care in Ontario." Largely former teachers, who had "many children, had homebirths and breastfed our children until beyond toddlerhood," the group, in the wake of legislation, had to:
get ourselves organized. We understand now that expertise in academia and politics as well as experience and midwifery skill is important in order to 'move ahead' in the current midwifery community. What previously was a matter of philosophical preference is now a matter of power around real decisions that affect our lives. (Sharpe, 1993, p. 10)

**Spirituality**

The 'triumph' of reason over nature has certainly been a defining element of modernity (Goldberg, 1993). "Opacity and obscurity," have, in Theo David Goldberg's elegant phrasing, supposedly given way to "rational transparency and precision... a perspicuity of definition... intelligibility of logical regularity... and to the absolute certainty of rational (self-)determination" (p. 4). Such principles are clearly at work in the scientific/rationality of modern medicine which "though it may start from a specific problem, moves on to extract only what are deemed to be significant features in terms of classifying the particular as an instance of the general" (Shildrick, 1997, p. 119). The non-rational, the particular, and the emotional in relation to health and disease are frequently ignored in this classificatory imperative. Midwifery in Ontario is situated largely within this scientific/rational model of care, but it is not without its subversions, including the insistent foregrounding of female subjectivity. And while midwives have opted for a university-based curriculum, they have also used the discourses of science to challenge, through the promotion of "evidence-based care," the opinion-based tenets of "current medical opinion," many of which underpin questionable obstetrical practices (Johnson, 1997, p. 350). However, the hegemonic scientific and rational approach to maternity care does largely dominate the Ontario midwifery model. For some midwives, however, metaphysical and spiritual processes historically played a defining role in their work and in their personal and community identities. Several women explained how these elements, once
valued, were later scorned in the move to professionalization, and how they were urged to suppress or abandon their more public displays of spirituality.

One woman expressed her belief that "there is a connection between midwives, mothers, birth and the universe" that was not being honoured in the move to midwifery professionalization. Indeed, she felt that her faith in such a connection had created an impediment to her becoming registered:

I think that's why I haven't been able to make it so far and if I continue not to be able to make it that is why. I think that the realm of experience and that realm of practice has been a priori dismissed. It does not belong. It does not exist. You must not talk about it. You can pay lip service to such things as dealing with the "whole woman" you know, her physical, social and psychological needs but you can't talk about her spirituality any more because what is that? Well it may mean getting together with a bunch of women and chanting around the fireplace but anything further than that we don't want to talk about. (Interview No. 18)

In an astute analysis of the conflict between the scientific/rational model of childbearing and "spiritual midwifery" she added:

I think the midwives and the folks who bought into this whole thing, they bought into this idea that if you couch things in physical terms and if you couch things in measurable, repeatable, verifiable, you know the mythology of the scientific method, that then they are controllable, they are predictable, they are dealable with and you can avoid any situation that is too scary. [...] When you start to admit that there are forces at work other than the purely physical and that such forces are not subject to human control and prediction then you do threaten that [medical] structure. (Interview No. 18)

Another woman recalled being admonished by elite midwives in the pre-legislation period "not to talk at all on media about spiritual concerns...or the spiritual walk of midwifery" (Interview No. 17). She compared this attitude and the disciplinary atmosphere of Ontario to another province where she had worked as a midwife:
In ----, you don't have elite groups going off and having their retreats. Everybody goes off to have a retreat all together. And we're allowed to light candles and put pictures on the floor about how we see our relationship with the universe at the moment! And we allow ourselves to talk about how we're feeling before we get into the meeting. We're allowed to talk quite freely and it's a different culture (Interview No. 17).

Rituals such as those described above actually became, in the years just prior to legalization, the object of public mockery in the midwifery community. In a recent master's thesis, Ontario midwife Betty-Anne Daviss described how informants in her study remembered an incident when spiritual rituals once common among Ontario midwives were publicly derided:

Holding of hands had long been ruled out and considered inappropriate behaviour among professional midwives in the province. [...] At an AGM of the AOM in 1990, for instance a skit in which some midwives at a meeting pass a rock around a circle was remembered by some interviewees as a way of ridiculing such rituals. It was also considered a subtle means of deterring anyone from suggesting such goings-on in the future. (Daviss, 1999, p. 69)

If, as Jane Flax (1993) posits, science is a "privileged practice within modern knowledge/power systems," (p. 42) it is unimaginable that the struggle to constitute women as rational humanist subjects in the eyes of the state could be won (in the case of midwifery) through claims to a spiritual rather than a rational and scientific epistemology. Consequently, it should not be surprising that the "starry-eyed earth mother," - a figure of spiritual excess - was identified within the midwifery movement as an impediment to public confidence in the new profession and to its acceptance within the scientific community. The disciplining, then, of those who clung to an earlier vision of the midwife - one in which scientific and metaphysical knowledges existed in continual tension with one another - seemed an urgent necessity.
Dress and appearance

"Dress," argue Alexandra Warwick and Dani Cavallaro (1998), "acts as a daily reminder of our dependence on margins and boundaries for the purposes of self-construction" (p. xvi). Wearing the "yellow socks and Birkenstock sandals" cited in the opening epigraph clearly situated a midwife on the wrong side of the respectability/degeneracy divide. Indeed, admonitions about the necessity of presenting a respectable appearance in order to, as one midwife put it, "get away from the image of the hippie midwife, the spiritual midwife, the midwife who doesn't look like a nurse-practitioner" (Interview No. 17) reminded midwives regularly about the counterculture 'other' against whom new midwifery identities needed to be constituted. While I wish to reserve a fuller discussion of the visual dimensions of respectability and the disciplining of the body to the section on the Midwifery Education Program below, it is important to note that several of the women interviewed spoke at length about expectations around appearance which they recalled from the pre-registration period. One midwife, in a quote which recognizes implicitly the role of dress in producing subjectivity through a linking of the individual to a collectivity, remembered a discussion which flagged the drawbacks of conducting an interview with the press in one's home because

the background...would look too 'crunchy granola' so you'd have to dress in a certain way. There was an incredible amount of stuff about image....I don't want to play little games like that, but it's politically very smart of course because then one has a certain image and one can become part of the other group because one has the image of that group. (Interview No. 20)

Another woman related her own comical and largely ineffectual efforts to adopt a more respectable appearance in the years before legalization:

There was a joke along for a while where people would come out of a media event and go 'I looked just like a nurse-midwife!' So I got a perm and I looked like a cross between Shirley Temple and an English judge and I looked more like a hippie! (Interview No. 17)
For these, and other white women in the midwifery movement, presenting a respectable appearance was as easy as changing their wardrobe or hairdo. If the offending markers could be abandoned, then presumably their bodies could fade back into what Judith Butler has called the "taken-for-granted visual field" (Butler, 2000, p. 4) in which able white bodies appear unremarkable. Bodies of colour and disabled bodies can never occupy this default position of invisibility and this raises important questions about who can (literally) be seen as a respectable midwifery subject. This issue will resurface below in the discussion of the production of respectable midwives in the Midwifery Education Program.

"If I get through this program, then I'm going to be myself": Constructing respectable midwives in the Midwifery Education Program

Between 1993 and 1997, 2,475 people applied for admission to approximately 175 spaces in the baccalaureate-granting Midwifery Education Program (MEP) offered in three Ontario universities: Ryerson Polytechnic University in Toronto, Laurentian University in Sudbury, and McMaster University in Hamilton (Stewart & Pong, 1998). Students have been remarkably homogeneous in terms of their demographic characteristics. They are uniformly female; approximately half are married; a large majority have children; their ages ranged, on the average from 28 to 33; they are overwhelmingly native English speakers; and they have increasingly entered the MEP having already earned a postsecondary diploma, with 79% of the 1996 student population bringing with them a previous university degree (Stewart & Pong, 1997, p 14). While statistics have not been collected related to applicants' or students' race and/or ethnicity, one trend that has been documented is a consistent decline in the proportion of midwifery aspirants whose mother tongue was neither English nor French. Applications from this group dropped from 15% in the 1993 cohort to 6.8% in the 1997 cohort (Stewart & Pong, 1998, p. 9). Anecdotal evidence I have collected about every class of MEP participants indicates that the midwifery student body has been overwhelmingly composed of white women.
As was mentioned in the introductory chapter, many of the students who participated, between 1993 and 1998, in the Humber College/Women's College Hospital Multidiscipline Childbirth Educators Program had enrolled in the course in order to maximize their chances of being selected for the Midwifery Education Program. Indeed, sixteen certified childbirth educators (not all from the HC/WCH program) were admitted to the MEP between 1993 and 1996 (Stewart & Pong, 1997, p. 25) indicating that it was a valued credential. With only one out of every 15 applicants being accepted into the MEP, there was vigorous speculation about the qualities and experience being sought by the admissions committees. Women in the childbirth educators program that I taught often discussed this and they eagerly questioned former students who had been accepted to the MEP when they visited the classroom as guest lecturers. Indeed, I read and critiqued many MEP application letters for my students, and they frequently phoned me to tell me how they had fared in the admissions process. Those who had gained coveted interviews spoke of the careful attention they paid to demonstrating a generally normative appearance and to censoring their responses to interviewers' questions so as to communicate neither too radical nor too conservative a political sensibility. While presentation of a highly normative self is likely an efficacious strategy for those seeking to gain admission to prestigious human services professions, and most of us engage in such practices daily, the accounts I was hearing suggested to me that an extraordinary disciplinarity was in evidence within the MEP. Stories from those who were accepted to the program seemed to confirm this and the anger of some students was indeed palpable to me. Expecting a liberal, even liberatory space, a "sort of bubble, a nice happy place" (Interview No. 38), in the words of one woman, they were frustrated and disappointed by what they encountered. Subsequent interviews that I conducted with 11 midwifery students suggested that the normalizing impulse in the MEP, notably in relation to gender, sexuality, ability, spirituality, class and, of course race, have led some students to engage in a rigorous policing of the self. So intensely dissimulating had the experience been for one
student of colour that she told me "when I get through this program, then I'm going to be myself" (Interview No. 41). It was a sentiment frequently articulated by other students. This section will explore these and other dimensions of normativity and their disciplinary effects on students' bodies and behaviours.

Dressing like "Avon ladies": Appearance norms as a microphysics of power

From their position in a genuinely panoptical setting, midwifery students offered narratives which provided a glimpse into the microstrategies of power that Foucault (1979) described in *Discipline and Punish*. Such strategies are not strictly coercive, but work through the setting of norms which are embedded in "ostensibly beneficent and scientific forms of knowledge" (McNay, 1994, p. 95).

The human body is the ultimate target of such strategies and perhaps nowhere is their disciplinary reach more palpable than in their shaping of the way the body is publicly presented. Seen as critical to public acceptance and therefore to midwifery's liberatory agenda of providing more childbearing options for women, the adoption of a normative bodily appearance seems a rational choice rather than an effect of power. However, as Warwick and Cavallaro (1998) argue, dress is a "complex transfer point of power relations" and has an important role in both discipline and transgression. Indeed dress and grooming are sites where gender, race and sexuality are coded, often in and through one another. For midwifery students, messages on how to dress, coif and groom themselves, served as reminders that for the fragile profession, the boundary between respectability and degeneracy was not yet secured and that transgressive appearance had the discursive power to link midwives to any number of socially marginal groups.

I have at least two concerns with this form of disciplinarity: (1) For members of marginalized groups who use clothing or other forms of body decoration as a way of marking identity, a requirement to adopt a "normalized" appearance makes it difficult to connect with other group members, and (2) as I have already argued, defaulting into the taken-for-granted visual field can only be successful for those
not corporeally marked by their difference. If, as one student of colour was told when she began the MEP, the goal was for midwifery students to look like "Avon ladies" - meaning, I presume, an idealized vision of a heterosexual white suburban woman - then normative midwifery subjecthood was not available to those who could never cram themselves into its narrow confines. As the student quoted above went on to note, "If you're a racialized person, this is like you're way out on the edge of acceptability to begin with. It's like Avon ladies don't look like me to begin with" (Interview No. 42).

All the students interviewed referred to a lecture they received in the early part of their midwifery training delineating the bounds of acceptable dress. While no one actually undertook to define what respectable apparel consisted of, they did know what was unacceptable, including: tee shirts, leather jackets, holey jeans, etc., i.e., clothes which were identified with youth or sexual subcultures. A student who had grown up in poverty recalled that the lecture linked dress and respectability indelibly in her mind: "We had to be 'ambassadors of the profession.' I remember this vividly because it was part of the dress code thing and was horrible, a horrible talk" (Interview No. 43). The panoptical effect of such a prescription can be seen in students' constant preoccupation with how they were dressed both in the classroom and in the hospital where scrutiny of doctors and nurses was expected and normative appearance took on greater significance. A woman nearing the end of her program remarked, "we've got to be presentable, basically to these white men who are obstetricians" (Interview No. 42). Another student said that being on call forced her to think about how she dressed at all times. "It's one of my worst fears," she said,

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99Within nursing, another female profession which has struggled to differentiate respectable from degenerate women, the trope of 'proper dress' has a long history. See, for example, McPherson, K. (1996), Bedside matters: The transformation of Canadian nursing, 1900-1990. Toronto: University of Toronto Press. For an analysis of how dress has functioned as a racial signifier in nursing, see Marks, S. (1994), Divided sisterhood: Race, class and gender in the South African nursing profession. New York: St. Martin's Press.
I'm always afraid, like in the back of my mind every morning, if I get paged right now and I got to the hospital is someone going to go "and she's a midwifery student?! She looks like shit. She looks like a hippie!". (Interview No. 33)

For another student, a call from the hospital sent her running to "get my makeup and my perfume on at like three in the morning" (Interview No. 41). For yet another student, the dress code loomed large in her daily decisions about what to wear which were complicated, in turn, by her hesitations, as a lesbian, to adopt a style of dress that might mark her as excessive or invoke a homophobic response from clients:

So, like I won’t wear, I think I did once, at the beginning of the year, I was really nervous about the whole thing...but I won't wear, like I have some really, really ripped up jeans and I'm afraid to wear them to school. I am! I think that like, especially being the lesbian, that makes it worse right? So I don't wear my ripped jeans to school. [...] I do have a sweater that has a big rip in the elbows, it's about ten years old and I love that sweater. I've seen [a midwifery professor] staring at my elbows when I'm wearing it and I'm thinking "what is she thinking??!!" Anyway, so when I have a client visit, I always think "ok, what am I going to wear today?" Cause I'm going to visit a client today. I think like that. I do think that as a student I have to try harder to be more sort of mainstreamy presentable because these women can, for any fucking reason in the world decide not to have me at their birth. (Interview No. 35)

Students were also warned away from forms of self-presentation that were not normatively feminine or that signaled sexual alterity, such as displaying unshaved legs or underarms. For some students, these proscriptions represented the limits of tolerability and became loci of resistance. One student who took particular offense to the dress code was reported to have shaved her head the night before her scheduled appearance as a student representative at a public "midwifery information night." One interviewee believed the student, who was subsequently chastised by an MEP faculty member, had done it to "let everybody know that she was in the program and had no hair, kind of thing" (Interview No. 39). For this student, a lesbian, shaving her head constituted an
act of resistance to the imperative to remain unmarked and therefore respectable. But it also raised a "subcultural flag" (Silverman, 1986, p. 147) which allowed her to signal the existence of that which had been rendered unthinkable: the possibility (however risky) of simultaneously occupying the discursive space of midwife and lesbian.

**Sexuality and reproductive identities in the MEP**

Like the student who shaved her head in protest, students interviewed had a strong sense of which sexual and reproductive identities were considered to be appropriate to "ambassadors of the profession." During the focus group that I conducted with six midwifery students, they spontaneously ranked sexual and reproductive identities, from most to least acceptable, reflecting a strong perception that homosexual and bi-sexual identities were only marginally acceptable within the MEP:

**Interviewee No. 33**: Definitely children, definitely.

**Interviewee No. 34**: You see the best...the thing to do is to be married with children. The next best thing to do is to be in a heterosexual relationship with a partner.

**Interviewee No. 33**: And then "used to be in a heterosexual relationship."

**Interviewee No. 34**: Yeah, there's sort of that hierarchy.

**Interviewee No. 41**: Definitely not a chosen single mother for sure

**Interviewee No. 34**: A chosen single mother is the worst, you know. A lesbian partner is ok.

**Interviewee No. 41**: Maybe but...

**Interviewee No. 34**: Single lesbian is...

**Interviewee No. 41**: And to like be someone without children is like "well, you're aspiring to have children, so it's OK." If you said
you didn't know if you wanted to have children, It's like "what the hell are you doing here?"

Interviewee No. 32: There are real ideas about when you should be having your children.

All: Yeah, totally.

Occupying the hybrid space of midwife and lesbian has presented a particular challenge for students who must make daily choices about disclosing aspects of their sexual identities. As it did with other marginalized groups, Ontario midwifery invoked its own respectability by positioning lesbians as available for rescue (from heterosexist medicine) through midwives' provision of sensitive care, including "interpreting lesbian culture to the hospital staff" (Ford, 1992, p. 5). No mention is made of the role of lesbian midwives nor the complications they might face as practitioners in a homophobic medical/social environment. The "lesbian baby-boom" notwithstanding, lesbian midwives face numerous issues when they negotiate their relationship to childbearing from the (heteronormative) categorical space of non-reproducers (Herman, 1996, p. 88). I believe that this topic, beyond the scope of this research, awaits serious exploration. I can only address here the problematic negotiations of identity which lesbian and bi-sexual students in the MEP shared with me and their relation to the bending of midwifery bodies toward normativity.

Eve Kosofsky Sedgwick (1990) has argued that for most gay men and lesbians, silence, intermittently imposed and broken in relation to the discursive context in which it is deployed, continues to be a fundamental feature of social life. "There can be few gay people," Sedgwick maintains, "however courageous and forthright by habit, however fortunate in the support of their immediate communities in whose lives the closet is not a shaping presence" (p. 68). For

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100 The practice of midwifery by lesbians is largely undocumented. I succeeded in finding only two references to or by lesbian midwives: an interview with well known U.S. lesbian midwife Anne Frye (Chester, 1997) and an article entitled "Queer Midwives" published in Issue No. 9, second quarter, 1996, of hip Mama, a parenting 'zine' published in Oakland, California.
four students interviewed here who identified as lesbian or bi-sexual, life as a student midwife involved a concerted closeting in relationship to clients and frequent reminders by other students of the improbability of the subject position "lesbian midwife."

While two of the lesbian students that I spoke with either self-identified as lesbians on the application to the MEP or did so in their interviews, both knew several other lesbian women who had not. One woman hesitated about being "out" in her application but felt that being closeted would prevent her from displaying her organizational experience, much of which had been gained during her years of queer activism: "I hemmed and hawed about that for a couple of years before I applied and decided I had to do it because I don't know how to talk about all my accomplishments without talking about all my queer stuff" (Interview No. 35). She was prepared, however, if denied admission, to submit a subsequent application in which she would conceal her sexuality.

Another lesbian student described the circumscribed nature of being out in the MEP. It was possible for her and others to self-identify privately but they still encountered homophobic comments from colleagues. While acknowledging that there is some measure of tolerance for lesbian students, this student links the closeting of lesbian educators with the impossibility of a public subjectivity in which the identities "lesbian" and "midwife" are intertwined and the creation of an atmosphere in which homophobic comments are voiced with seeming impunity:

[There's a lot of queer people in this program. But not in an out way. Like we acknowledge it on a personal level and in small groups you can also talk about it. It's not completely closeted. But knowing that your professors are queer and never talk about it and knowing that there have been instances in midwifery where people have said "I don't know, like if you can be a lesbian and a midwife." Knowing students who were talking about a program called "Dykes and Tykes" for lesbian mothers and their children and they say "Dykes and Tykes! What's going on? When I had kids it was "Moms and Tots." (Interview No. 41)]
Women also described relationships with clients in which they felt closeting was mandatory. In the quote below, a midwifery student describes an awkward incident with a client:

I was leaving her and at the corner she was saying "do you have a babysitter? If I called you in the middle of the night do you have a babysitter?" I said, "oh no, I don't have a babysitter." She says, "well I was talking to your nanny" and it was a friend of mine who's British! And I said, "well I don't have a nanny." And she said "well but who's going to look after..." I said "well, I don't have a babysitter." She said "well, who'll look after your son?" And I said, "I live with someone and we look after our son together." But I wasn't about to come out, right? Cause I thought "mmm, this woman's a Christian, and she's not somebody I'm going to come out to and I feel fine about that." Like I don't feel like I have to and I don't feel like I'm diminished." (Interview No. 37)

While such encounters are everyday occurrences for gay and lesbian people, and the student quoted above was not personally offended by the client's presumption of her heterosexuality, we must ask to what degree a normative image for the midwifery profession contributes to the student's burden of silence. As I have stated above, the subject position "lesbian midwife," a distinct interruption of the profession's current image, is simply not available within public discourse in Canada.

In the U.S., however, midwife Anne Frye has conducted a decades-long struggle, within the highly heteronormative U.S. direct-entry midwifery movement, to not only create a discursive space for the lesbian midwife but to intervene in everyday assumptions about sexual orientation. Once hers was constituted as an authoritative voice, Frye used her visible presence to change the public discourse and to interrupt the movement's complicitousness in relations of domination:
When people see that the people they work with, and who take care of them at any level—their service people, their medical care providers, their sons and daughters, their aunts and uncles—are the very same people that are lesbians and gays, then it puts it into an entirely different context and makes it harder for lesbians and gays to be the "other weird people."

I work for predominantly heterosexual women—and it is a calling, not a nine-to-five job. So to feel that some of those same women would ostracize or condemn me for who I am is very intense and makes me that much more committed to be out as a lesbian. [...] I chose to come out into the midwifery community after I had made a name for myself with my work as a recognized writer and speaker. Because I thought that with people knowing who I was and then adding to that my being a lesbian would make it harder for them to reject me. And hopefully my coming out would create more safety for other midwives who want to come out. I want to make sure on an organizational level that we don’t support the intrinsic homophobia in our culture. (quoted in Chester, 1997, p. 122)

The issues around closeting are complex, and involve, among other things, the constant struggle to weigh the very real potential consequences (including physical violence) of being out, with the public and private benefits of refusing the closet. Indeed in one recent Canadian study, nearly 12% of those sampled in an urban area said they would refuse to be treated by a gay, lesbian or bisexual physician (Druzin, Shrier, Yacower & Rosognol, quoted in Beagan, 1998, p. 46). The absence of a public discourse in which midwifery identities are multiple seemed to contribute to lesbian and bi-sexual students’ decisions to remain closeted or largely circumspect in their relations with other students, with most clients, and with some midwives who served as their clinical preceptors in the field. What must be acknowledged is how the impulse to create respectable "ambassadors of the profession" has required a complicitous relationship with heterosexual norms.
Class and family normativity

In terms of deportment and access to material resources, students described the tyranny of a middle-class norm in the Midwifery Education Program and their own reticence to be seen to fall outside of its confines. One student described her reluctance to challenge assumptions within the program because she would then be, in her words, "outed" as a poor person:

I have come to this program, this state in my life, with a lot of baggage about not having money, about surviving on welfare. It's not something I openly discuss or talk about. I get upset when people assume we can afford books, we can afford tuition, no one questions. When I have questions about OSAP [Ontario Student Assistance Program], like the next year, we're going to struggle, I don't know how we're going to do it, and I police myself. I haven't called other students to ask how they cope. I haven't talked to my course advisor on how people cope. I've been very reluctant to...I feel I'm outing myself as a poor person. I've survived all my life as a poor person. I've got great survival skills; I could probably share them with other people, but I don't feel like it's understood. I don't feel it's respected. We're told at the beginning, when you were sent your offer of admission, you were told that it was going to be expensive and you couldn't have a job and you had to survive and you had to have a car. And I thought, so basically, I thought we were told "if you're poor, forget about it. You should drop out now." (Interview No. 43)

Another student conceded that when it came to explaining in their MEP applications how they would support themselves during the segments of the program where they were not allowed to have outside jobs, that students "all lie about that. I realize we have more money than some people. We at least can fake it, right?" (Interview No. 35).

"Faking it" for some students involved relying on the advantages conferred by whiteness. For working-class women, whiteness allowed middle-class identities to be performed through a mimicking of bourgeois behaviour and appearance standards. A retreat into the taken-for-granted visual field of
whiteness was available if markers of poverty were concealed or erased. One woman, who clearly grasps how women positioned subordinately in relation to class may use race privilege to gain a "toehold on respectability" (Fellows & Razack, 1998), explained how this process works:

I, as someone who grew up really poor, like we were dirt poor and I have been thinking more about that too. How class fits into my world and how white privilege has been part of my being able to get through fine, like kind of. Like you just kind of meander your way through and you cut your nails, you clean your nails before an interview, you know you put caps on your teeth or something. But, it can be done. (Interview No. 37)

For some of the students, "middle-class" denoted not only access to resources and knowing how to comport and present the self in a respectable manner, it involved being able to claim a family of origin which was free from emotional upheaval of any kind. One student claimed that what she was careful not to disclose in the context of the MEP was

my fucked-up life. Like I feel that everyone in the program comes from or appears to come from this really white middle-class very "family" background. And I have none of that. [...] I hide so many things, like a sibling dying when I was a child and my father dying, in terms of a lot of that stuff. It's like oh my God, I can't be a superwoman and a good professional if I've had this sort of screwed up life (Interview No. 41).

The student quoted above argued cannily in her application questionnaire that because of her unsettled family history she possessed extraordinarily good stress-management skills. While this may or may not have worried the admissions committee, it clearly did not prevent them from offering her a place in the MEP. Another student, however, believed that admitting to a chaotic upbringing may have jeopardized her previous unsuccessful applications and she chose to sanitize her final application which was successful. "By the time I wrote a questionnaire that got me interviewed," she told me, "none of that was in there anymore" (Interview No. 33). Whether or not admissions committees judge
applicants on these bases is immaterial. The simple perception of the norm is adequate to produce a policing of bodies and a rewriting of personal histories which reinscribe economic and emotional normativity as indispensable elements of respectability. In this process, however, the abjected subjects resurface in the figure of the needy 'other' who is available for rescue and whose proximity and recognizable alterity help define the dominant midwifery subject. One student described this process when she recalled an exercise conducted in a workshop which dealt with identities:

You were allowed to create your own categories for identity and somebody had written down "survivors of violence" or something. And tons of people went...maybe fifteen or twenty people out of a group of thirty wrote down, just wrote ticks that they would...that that's where they would place their identity. And yet when we ever do workshops, it's all with the perspective of these "poor women who've been battered by their husbands." "These poor women who are divorced." "These poor women were abused as children." "These poor women"...and there's never any mention that somehow that might have been your experience (Interview No. 34).

In general, it is the universalizable subject who is desirable within the MEP. One student, a woman who identifies as working class, recalled that in her first application she spoke from her specific class identity and generally from a situated place as a marginalized person. Deeming such an approach inefficacious, she adopted a different strategy in the following year's application:

The next year that I applied, instead of talking a lot about "this is who I am" and "this is why I have this experience," and "I very personally identify with these issues as well as my professional experience." I very much focused on my professional, you know "I am a professional, I work with these 'other' women." And it was very "the other." [...] My tone was more as a service delivery person and not from my own experience. (Interview No. 43)
Disability

In an environment in which the able body is constructed as normal through its relationship to an environment which accommodates only ableness, disability becomes an "intense, extravagant, and problematic embodiment" (Thomson, 1997, p. 283). Wishing to avoid being viewed as inherently problematic, some students chose to conceal their disabilities in their application questionnaires to the MEP. One woman, who suffers from an emotional disorder, had not disclosed her disability to other MEP students before doing so in the group interview conducted for this dissertation. She had remained silent, she related, "because it's so taboo, first of all, in society. And second of all, it's not seen as a disability issue. It seems like you're screwed up" (Interview No. 41). A second woman, whose disability is intermittently visible depending on its severity at the time, made a conscious decision not to flag her physical limitations on her application. Once admitted to the program, she policed herself constantly to contain any nuance of vulnerability. While she has found the faculty generally supportive, any admission of weakness causes her capability to be questioned:

There have been instances where I have said "I can't do this" or "I want to do this earlier rather than later because I'm in pain" or whatever. And the response is "well are you sure you can be a midwife?" "What are you going to do when you're out there practising?" I'm not in practice right now, I'm in school and writing an exam. That's not the issue. And when I go into placement I always feel extra pressure. I can't be the one at the birth saying "I'm tired" or I can't be the one taking a day off sick. Because If I take a day off sick, I might really be sick! But if I say it, it might be because I'm disabled and therefore I won't be a good midwife. (Interview No. 39)

This student has found her physical capacities questioned unrelentingly and her body constantly an object of interest and comparison. Even her right to reproduce was seen as an appropriate topic for interrogation:
I've had students say to me, how do you know it was ok for you to have kids? Do you know what you DID to the next generation? (in relation to my not being able to conceive instantly and having a disability and who knows what I've passed on to my son) I was sort of floored that it was ok for her to say that. But it was ok. (Interview No. 39)

The one student who has not been able to conceal her disability believes that her admission to the MEP was judged by other students to have been based not on her suitability for the program, but rather on her constitution as an "equity admission." In an environment in which respectability needed constant securing through the normalization of bodies, the presence of the disabled body - unavailable for universalization and normalization - could only be understood to have been included through coercion.

**Spirituality**

While counterculture spirituality was a mark of excess for pre-legislation midwives, for students interviewed, even affiliations with relatively dominant religious institutions appeared to threaten their suitability as midwives. One student, a former member of a religious order, described having the Christian identity she carefully hid for a year and a half in the MEP inadvertently discovered during another student's visit to her home:

B____was at my house and looked at my fridge and went "R____ are you a Christian?!!" [...] I mean we were in the program for a year and a half and "you're a Christian?!, You were a nun?!!" And yeah, I don't know anyone else in the program who's an ex-nun and so that's a big piece, all the religious stuff. I have to be really, really careful about the religious stuff. All the stereotypes that go around Christian...and so to be careful about what you say because of all the stereotypes. [...] I think one piece of that is, I'm not quite sure how to say it, but the things that Christians have done and whatever it is. I mean the stereotypes around their position on homosexuality, on abortion, their position on being judgmental, whatever. [...] That you can't be a feminist and be a
Christian. You can't be a lesbian and be a Christian. You can't be all that sort of stuff, I think is one piece. (Interview No. 34)

While her lived experience confirms that one can simultaneously embrace Christian and feminist beliefs, there is clearly no discursive space in which to occupy these positions simultaneously within the MEP; indeed, her only recourse is to silence. Clearly, the anti-abortion and anti-homosexual doctrines and politics of the Catholic Church and the relative invisibility of oppositional voices within it make it more difficult to forge complex subject positions between Catholic affiliation and other forms of identity. However, it is not just Catholicism which has brought students' rationality and universalizability into question. One woman with strong Protestant affiliations agreed that spirituality was viewed as incompatible with midwifery identity and that she had kept silent about her own affiliations and beliefs. Although she was granted permission, she was still questioned vigorously about her plans to take a course in a divinity school. She was advised by one student not to speak openly about the course:

And it was like, 'I'm not sure exactly why I'm not supposed to say that.' Because it's not related to midwifery? [...] Or because I'll go off and...I don't know...become ordained instead of practising as a midwife? I don't know but this really felt like something I couldn't talk about. (Interview No. 32)

These narratives suggest that midwifery students envisioned a normative midwifery subject and strived to perform normativity in a number of domains. The tyranny of the norm operated in the MEP to discipline students' bodies and produce relatively docile and respectable "ambassadors of the profession." However, I would argue that whatever their positioning at other axes of difference, white students and students of colour are regulated differently by this process. Kate Davy (1995) has succinctly summarized how such regulation works:

Played out in the politics of respectability, whiteness becomes the dynamic that underpins a process of racialization that feeds
privilege to all whites, so to speak, without letting all white people sit at the table. Those middle-class people of color invited to sit at the table are bequeathed a status that is always already only honorary, contingent, itinerant, and temporary. (p. 9)

For those who could, assuming the default position of whiteness in "the taken-for-granted visual field" conferred a certain level of respectability and a modicum of protection from unrelenting scrutiny. Consequently, most lesbian students, who, indisputably, were forced to observe their own codes of silence and were required routinely to engage in soul-numbing performances of heterosexual normativity, could expect a meal, if not a banquet, at the table of whiteness and at least had a critical mass of other lesbian students with whom they could identify. The option to "pass," notes Dana Takagi (1996), is not available to racialized minority people,

we do not think in advance about whether or not to present ourselves as "Asian American," rather that is an identification that is worn by us, whether we like it or not, and which is easily read off of us by others. (p. 247)

Consequently, for racialized minority people, historical discourses of difference arise unrelentingly in the face-to-face encounters with whites that are, for them, the stuff of everyday life. Students of colour, then, found themselves renegotiating their place at the midwifery table on a daily basis.

*Race and marginalization in the Midwifery Education Program: The experiences of students of colour*

Three of the students interviewed self-identified as women of colour and their experiences in the MEP, they reported, had been marked intermittently by overt and covert racist incidents, by a sense of either invisibility or voyeuristic display, and by constant feelings of isolation. While there were certainly positive aspects to their participation in the MEP, and not all students of colour would
offer such narratives, these are the experiences that those I interviewed chose to speak about when I posed the question "How have you policed yourself in the midwifery education program?" The critical relationship between silence and survival was a constant theme for these women. They are silent in order to avoid confrontation during racist incidents, silenced and imperiled because of the absence of a community of equally positioned speakers, and silent within their communities of origin because they are unable to disclose that they are not the "pioneers" within the midwifery program they are thought to be. The double bind of silence was described by one woman thus: "I felt that I was betraying my own community, betraying myself by my silence and still I struggle with that, but I know that I wouldn't have got through if I hadn't been silent" (Interview No. 42).

These students were interviewed at different stages in their programs and had had varying degrees of contact with midwifery preceptors and clients. These factors, I would argue, had an impact on the breadth of their experiences and therefore upon the range and number of instances of racism encountered. Attention must be directed as well to the fact that interview material from one student of colour was collected in the context of a group interview in which the rest of the participants, including myself, were white. While she spoke fairly openly about racism and other matters to this politically sophisticated group (and to me as the avowedly anti-racist researcher and as someone known to her outside of this context), it must be assumed that much was left unsaid. In retrospect, I can see the error in conducting a racially-mixed focus group, even when the participants appear to enjoy a modicum of trust. This is a perfect example of how (even well-intentioned) white women are regulated to overlook the difference that race makes. Because of this methodological limitation, and

101 When in February 1997 I delivered a paper at York University in which I outlined my preliminary analysis of racism in the midwifery movement, two students of colour who were known to me signed comments on a sheet that was circulated among the 100 or so participants. In their comments, they expressed their fervent opposition to my work and questioned why I would seek to undermine the newly established profession's credibility with my allegations.
because she shared interview time with five other women, this woman is perhaps less fully represented here than other students of colour who were interviewed individually. It is their voices, consequently, which dominate this section. The woman who was closest to finishing - only weeks away at the time of our interview - recalled a larger number of overtly racist incidents than did the other two women interviewed. She also spoke frequently about the potential consequences of confronting racism directly when its source was midwifery preceptors who had the power to impede a student's completion of her program. The other two women interviewed had not yet had extended contact with preceptors and clients.

In the narratives of the two students of colour who were interviewed separately, silence as a condition and a consequence of survival appears frequently. In addition, both women use metaphors of death and dying to describe the conditions of speech. For one student, to speak out is "suicide," while the other student longed for a time when she would find the strength to speak freely, otherwise, she lamented, she would become a "walking dead person." That parts of the self have, for these women, been violently excised in the process of becoming a midwife must be acknowledged. I am quoting these students at length because such testimonies have not been part of the public discourse about midwifery, at least not among white people, and so that I might avoid the epistemic violence that would be enacted if I were to uncouple the recounting of the racist incident from the emotional context of its telling:

It would just be suicide for me to really talk about issues that are important to me as a woman of colour and my experience and what I perceive as important to the birthing community who experience things as I do. [...] It was always confirmed to me that I had to be very careful that there was no place for the diversity of experience to be shared. [...] So well, I guess the thing that I've learned in my life is that in order to get through I've got to be silent because if I really speak my mind...and it's not about speaking my mind out of anger and resentment, its out of working for change. [...] It's not just "oh I'm angry at white women because whatever" but that I have a
voice that...and it's presumed or assumed or perceived that my voice or needs are the same as white women's and it's not. [...] I would definitely fear really expressing who I am and the repercussions at this point because...and certainly throughout the program...because I was vulnerable. I had preceptors who were brutal, who put me through hell. So I was just "yes sir, yes ma'am, no ma'am" all the way through. And that was the only way I was going to get through. (Interview No. 42)

Allowed into the universalizing bosom of midwifery, this woman can only be tolerated if she does not name the power which renders her silent. To do so would cause her to be "guilty of that most wretched of native sins - ingratitude" (Razack, 2000, p, 42). The assumption, as she states above, is that she does not have sensibilities which differ in any way from white women's, so the articulation of racist sentiments in her presence is not perceived as injurious:

When you silence yourself then you hear things more because people assume you'll never say anything. And you just hear things more and people say things even more cause they don't see you at all. [...] One of the midwives I was with was talking to a client and they were talking about, I think it was abortion. [...] And the midwife, who was against abortion, actually talked about...well she sort of identified with the woman 'cause she was a Christian too and the woman had said "well, you know I don't believe in it, but I accept the people that I work with and their choices, dah, dah, dah. And then the midwife went on to say "yeah, well I've worked with all sorts of people. I've worked with..." And she...I forget the tone, but it was like the tone too that was major, but she said how she had worked...she had even worked with lesbians. No, she had even worked with a lesbian and that she had even worked with heathens in [a southern continent]. And (laughter) I'm standing right there and I have a name [associated with that continent]. I'm not...I don't associate myself as a Christian although I have some Christian background. Anyway so it goes over her head; she has no idea what she is saying. (Interview No. 42)

Relaying another instance of her invisibility, this woman spoke about an incident with a client:

And there have been clients too that have said things. Like the little cap on the baby's head "oh he, he looks like he's one of the
grand..." I don't know what the leaders are of the Ku Klux Klan. But "one of the grand so and so's of the Ku Klux Klan, doesn't he?" And you know, things like that, and there I am standing right there and they smile at me - they think that I think it's cute too. And I just carry on because I neither have the power in that environment or I don't know what you need to address those things. But it's just like I'm trying to get through this day, you know. (Interview No. 42)

Silencing, as the student quoted below notes, also occurs when one is compelled to speak inauthentically, and is, as she describes poignantly, a soul-destroying imperative. It is only the promise of future independence and credibility that sustains hope:

I'm quite silent, very silent, I don't say a word. And when things come up, even if...yeah like I don't take the opportunity to...like there's a couple of times at the [midwifery] practice that I'm at where it just came up that the way people were talking that I could say something about cultural sensitivity. I try not to go into the whole thing not trusting, 'cause of course there are wonderful surprises wherever you are. But comments like, I've heard at my practice, she mentioned a nurse "it was that Chinese girl and she was awful." She was talking about a nurse. And I thought, like there's just constant things that remind me that people aren't aware of their own racism. They aren't. I don't see an openness and I don't see support. The environment is quietly or passively hostile to women of colour speaking about their experiences. Of course we could speak about our experiences in an apologetic way, in a multicultural, smooth, kind of "sugar on top" way. Of course that would be loved cause that would help midwifery in Ontario feel good about itself. But for women of colour to speak honestly about our direct experiences with other midwives, with the system of midwifery, with the history of midwifery, the way midwives are perceived in other countries, the way women of colour are perceived I just don't see that I can do that. And it's a horrible place to be in, I tell you, it feels like you're in a desert. But I just keep thinking that I'm going to get to a place where I'm going to be able to be...hang on to a strong tree or stand like a strong tree and speak my mind. And I'm going to be, that's what I want to do. That's the only way I can live, otherwise I'm a walking dead person. (Interview No. 43)

As I have noted, one form of silencing involves not having access to communities of discourse where experiences of racism could be openly
discussed and others could be counted on for support in raising issues. One woman claimed, once again employing a "life and death" metaphor, that "it's suicide if you do something, if you speak up in isolation, you'll be brutalized; you're just like a duck" (Interview No. 42). She described how difficult it was to make contact with other women of colour, not only because of their scarcity, but because the heavy work load made extracurricular involvements practically impossible. When she did manage to speak with another woman of colour, she related that

both of us were almost moved to tears that we had never spoken about these things. But when we did it was just so clear to both of us, you know, the oppressiveness of it all and the contradictions of it all, and the need to work within our own communities. (Interview No. 42)

For another woman, a lesbian of colour, the absence of other students of colour made disclosing her sexuality practically unthinkable:

I remember...arriving in Sudbury [for the "intensive" midwifery introduction for new MEP entrants] and my sister and my girlfriend dropping me off and them looking into the room and just looking at me and going "oh my God." Cause it was entirely white and it was very straight looking. And I walked in and said "I'm the only dyke" and I'm not...they know I'm brown, I'm not going to tell them that I'm a dyke! (Interview No. 41)

Unwilling to imperil the respectability available to her through her middle-class status, this woman chose not to identify herself immediately as a lesbian. As Kate Davy (1995) argues, it is only white women who can "demand the right to be 'bad' without reinscribing an already naturalized deviance" (p. 10).

Self-imposed silence is a doubled-edged sword. For one student, a reticence to speak about race issues during her clinical placements constituted a survival strategy. However, it also foreclosed the possibility of communicating with clients of colour on issues which fell beyond the bounds of white-defined
midwifery practice. She reflected on the process and with regret upon how her survival strategies in a racist environment caused her to impose silence on other women of colour:

It's interesting 'cause a sad thing about it is that I guess I don't...you don't realize it when you silence yourself, but you're not only silencing yourself in order to cope with white women who are hostile to your identity, but in doing that I think that I also, without realizing it, may silence other women of colour who come in my care because I'm so quiet about that aspect of who we are. Yeah, so that's kind of sad. It took me aback when I was at a birth with a woman of colour and she asked me directly, like one day...well two things. One day she asked me directly, she said...cause she was dealing with death, her baby had died. And she asked me directly, how in _______culture do they deal with death. She was of _______descent and she really wanted to know more about her cultural tradition in that and wanted to explore that with me. And another day we just ended up talking about race and I never, ever bring these things up because I have no...partly because I'm getting accustomed to being silent and partly because I don't know what the reactions are going to be. If I'm not in a safe place, if there was negative reactions, and so I've been sort of taken aback when it's brought up because it makes me realize that I probably give less opportunity for it to be brought up because I'm so much in a mode of silencing that aspect of myself. And in turn, probably indirectly silencing that aspect of other women of colour. So it's participating in it all. And that's the really sad aspect of it. (Interview No. 42)

Another student did not speak of racism to other racialized minority people, feeling that as the "model minority student" that if she discussed her experiences in the ethnic community with which she identified, she would deter other women of colour from applying to the MEP:

It's just nuts! Anybody asks how it is or...because it's so understood like the whole world is watching the Ontario program, the rest of everywhere in the universe is watching ME. If someone asks how the program is, it's like "oh, it's amazing, I love it. I NEVER, EVER talk about...[...] Like I want to unload and tell [community members] how hard it is and my close friends totally know, but I don't want to give that impression because it will deter other people from applying. Like I feel like I'm the "women of colour
representative" both within the program and as a midwifery student outside the program. (Interview No. 41)

Constrained to silence in the clinical setting, students of colour were often incited to speak in the classroom. In a role not unfamiliar to feminist native informants, these women found themselves helping "the First World engage in a politics of saving the women of the Third World" (Razack, 2000, p. 42) by expanding white students' understanding of "diverse" groups. The native informant role rendered these women a reliable commodity for consumption, always available to explain, argue for, and represent undifferentiated "communities of colour." This speaking role accomplished an endless re-racializing of students of colour. One woman spoke of "constantly feeling like the brown chick" (Interview No. 41). The native informant role also served to absolve dominant women of the obligation to examine their own roles in the construction and maintenance of difference. As one student argued,

[her professor] was constantly deferring to me to talk about issues of poverty, and class and anti-racist stuff. She was asking me to help teach the class. As much as on a superficial level, that's kind of flattering, but then I got kind of angry going "what the hell is your problem Why aren't you struggling professionally, not just as a teacher, as professor, but as a midwife? Why aren't you working on this stuff? (Interview No. 43)

Another woman expressed her frustration with constantly being compelled to speak in a program that propounded, as she put it, a

white liberal feminist rhetoric of [...] 'we want students who know how to work with diverse groups of people.' As opposed to 'we want a diverse group of students.' I don't want to do this. I don't want to be the educator. I don't want to be the one who talks about women of colour. And then at the same time have them not do it - not have a commitment to women of colour. (Interview No. 41)

The students were also required to perform as authentic native informants, who, as Sherene Razack (2000) notes, are "permitted no specificities, no
complexities in regard to class, histories or sexualities" (p. 44). One student, who identifies as bi-racial, found that when she revealed her ethnicity, she lost her claim to being the universal midwife. The response in the MEP, she claimed, was to assume that her mission would be to serve women of "her community." Her response was, "Like no, I can't! I can speak their language, but I'm not accepted in their culture. When I go to [an ethnic neighbourhood] and order things and stuff, I'm a novelty; people laugh at me!" (Interview No. 42). Another woman, reflecting not on her subordination but on the privileged dimensions of her identity, remarked upon the contradiction for her of being assigned the role of authentic native informant:

I'm not the representative of Third World students! I talk white, I dress white. I was raised here. I am Canadian. I'm not an immigrant woman. Like how much can I speak to immigrant women's needs when I'm not one? Like I was raised in an immigrant family but when people talk about making the student body more diverse, I should not be used as an example because I'm the perfect example of the acceptable person of colour. I'm middle-class. (Interview No. 41)

The three women quoted in the above section are able to perform whiteness, relying on class, educational and professional knowledge which make it possible for them to participate, under conditions of daily negotiation, in the white world of midwifery. They speak unaccented English and are proficient in the languages of feminism. And, importantly, they know how to decode Canadian racism so as to protect themselves from its worst ravages. As one student put it:

I do know that one of the reasons that I got through is that I've been raised here and in a sense I know how to play the game. I've gone to school with these people. I've gone to school with them as a kid. And I've worked here in Canada and so I've had to learn to cope and part of that means being silent in certain ways, knowing when to talk and when not to. Knowing how much of yourself to...like in most cases, people don't know about me. They think I'm nice and quiet, they have no idea. (Interview No. 43)
The same student who refused to tell her Canadian-born racialized minority friends about her racist experiences in the MEP hurried to inform friends who were immigrant midwives of colour “not to bother” applying to the College of Midwives’ Prior Learning and Experience Assessment program:

I know so many people who come to me, PLEA candidates who did not get in and now my answer is finally, “don’t bother” and to like have to say that to an immigrant friend of mine who’s an immigrant woman from the Philippines who’s trained there and has incredible skills, lives in poverty here and to say “you know what, you can never get in and you won’t.” Like her writing is not middle class, you have all the skills, you speak English fine, but it’s not good enough for this program. (Interview No. 41)

Aware of how very difficult negotiating the white space of midwifery has been for someone like herself who possesses many of the cultural competencies linked to whiteness, this woman was perfectly positioned to see just how unlikely it was that immigrant women of colour who possessed few white cultural competencies and decoding skills would succeed in becoming registered midwives in the province of Ontario. Their narratives of that process are the subject of the next chapter.

**Conclusion**

In this chapter I have argued that midwives in Ontario have pursued a respectable identity in order to claim social parity with physicians and make claims on the state. Among the impediments to this have been the existence of a sedimented archive of disreputable images of midwifery which has circulated for the last century and has been deployed in times of crisis to bolster the claims of modern medicine that it provides safer care to childbearing women than traditional, unscientific practitioners. New inscriptions have been written upon the pages of these older texts and used to discredit the re-emergence of midwifery in Canada. Among the discredited figures were counterculture midwives who had been central to the reintroduction of midwifery from the 1970s onward. With the
shift of the Ontario midwifery movement from a position that supported decriminalization of the practice to one which supported state-funding and regulation, a new midwifery subject was required. Such a subject was unmarked by the specificities of gender and by the non-rational thought associated with "spiritual midwifery" and could make claims on the state from a liberal humanist and universal subject position. Those practising midwives who fell outside of these norms by virtue of their investments in traditional motherhood, spirituality, iconoclastic dress, etc. found themselves marginalized within the movement.

With the establishment of the Midwifery Education Program came the installation of a normative midwifery subject, "the ambassador of the profession," whose investment with white cultural competencies is highly discernable. Midwifery aspirants and students strived to produce themselves in the image of this subject, disciplining aspects of their identities which failed to align with the perceived norm. For the few students of colour admitted to the MEP, negotiating a place at the midwifery table meant maintaining a silence around difference or engaging in a form of compulsory speech which rendered them useful to midwifery's imperial project of serving diverse populations but not including them among its ranks. The normative subject at the heart of the midwifery project is one which Canadian-born or -raised women of colour who possess a significant amount of white knowledge can approximate but never fully embody. As the next chapter will demonstrate, this normative midwifery subjectivity is out of reach for most immigrant midwives of colour who have either abandoned hope of rejoining their profession in Canada or encountered extraordinary obstacles to reclaiming a professional identity legitimately achieved in their countries of origin.
Perpetuation of a social formation in its racialized determination is enabled both by the microexpressions which constitute it -- the epithets, glances, avoidances, characterizations, prejudgements, dispositions, and rationalizations -- and by the accompanying racial(izing) theories, evaluations, and behavioral recommendations. They enable, in other words, common sense to be racialized and so the easiness, the natural familiarity of racial expression.

Theo David Goldberg (1993)
*Racist Culture*

[R]esistance clearly accompanies all forms of domination. However, it is not always identifiable through organized movements; resistance inheres in the very gaps, fissures, and silences of hegemonic narratives. Resistance is encoded in the practices of remembering and of writing. Agency is thus figured in the minute, day to day practices and struggles of third world women. Coherence of politics and of action comes from a sociality which itself perhaps needs to be rethought. The very practice of remembering against the grain of "public" hegemonic history, of locating the silences and the struggle to assert knowledge which is outside the parameters of the dominant suggests a rethinking of sociality itself.

Chandra Mohanty (1991)
"Cartographies of Struggle: Third world women and the politics of feminism"

Introduction

In the preceding chapter, I argued that the installation of a normative midwifery subject left some veteran midwives struggling for inclusion and compelled midwifery students and midwifery aspirants to police aspects of their
identities which they feared might be judged non-normative. Ontario midwifery could be seen, I argued, as a space where the cultural competencies associated with whiteness held sway together with an imperative for midwives to remain "unmarked" by perceptible forms of difference. If the compulsion to (white) normativity evoked such a vigilant policing among those who may have stood just slightly outside of its narrow circle, how then did it position those who occupied its very perimeters? This chapter, then, is concerned with the regulation of immigrant midwives of colour who, while possessing considerable midwifery credentials and experience, struggled for access to white knowledge and white cultural competencies. As the narratives of those interviewed indicate, everyday encounters with the midwifery apparatus and with practising midwives frequently communicated to women of colour that they were unable to perform as disinterested citizens acting for the "public good" and that they were unworthy to practise their profession in the Canadian context. Many women of colour simply retreated from the pursuit of registration or from participation on midwifery boards because of insurmountable obstacles. However, forms of resistance such as the circulation in communities of colour of stories of racism in midwifery, or non-participation in the Prior Learning and Experience Assessment process, were simply imperceptible to Ontario midwives for whom resistance was equated solely with forms of protest aimed directly at those in power, and with tactics which utilized their considerable academic, cultural and material resources.

At the heart of this chapter, then, is the intention to demonstrate how the habitually dominant behaviour of white people feeds and sustains larger systems of racial injustice. Such everyday racism, explains Philomena Essed (1991) "does not exist in the singular but only in the plural form, as a complex of mutually related, cumulative practices, and situations." "Some events may seem trivial," claims Essed, "but...it is much more important to see that each event activates the whole pattern of injustice of which it is part" (p. 147). That pattern of injustice can be discerned in the systems of globalization which cause many health care workers to migrate northward, frequently to be integrated into the
lower eschelons of a racially segmented health care labour force. However, such macroprocesses are sustained by the microprocesses of inferiorization and racialization which take place at the institutional and personal levels, and it is these everyday activities that I focus on here.

If, as Essed (1991) argues, encounters between subordinate and dominant groups/individuals are never free of attachments to historical records of subjugation and discrimination, then misunderstandings, breakdowns of communication and other problematic communicative events (such as those reported to me by the interview subjects) which transpire between hierarchically positioned subjects cannot be viewed as mere "technical glitches" (Razack, 1998b, p. 8). Indeed, if histories of subordination are to be addressed, then the trace of racial dominance must be sought in the expressions of racially privileged individuals and in the habits which structure their/our everyday encounters with racialized minority people. To be able to recognize how our behaviours reinscribe racialized evaluations, those of us in dominant positions must be responsible for knowing the histories that our words and actions may perpetuate. And we must learn, in conversation, about the responses that those words and acts engender. And finally, while engaging in those conversations, we must be prepared to be accountable for how we hear what the "other" is telling us. We will never hear everything that is said, but that does not mean that we must shrink from the imperative to keep listening. This chapter then represents my efforts to force one such conversation by amplifying, through display, contextualization and theorization, the narratives of some of those situated on the subordinate side of the equation so that those on the dominant side might begin to learn how, if even only partially, to apprehend such speech in an accountable manner.

How dominantly positioned researchers work with the narratives of subordinate subjects has been the topic of much debate and little resolution. In a recent article, Michelle Fine and Lois Weis (1996) argue that the narratives of socially privileged subjects and of those who have been "historically smothered"
need to be differentially theorized and contextualized. The voices of marginalized people, they argue, should be displayed on their own terms as a form of "narrative affirmative action," whereas those of dominant group members should be subjected to "generous" theorizing, "wild" contextualizing and "rude" interruption for the purpose of reframing (p. 266). I agree with the strategy of subjecting dominant discourses to extremely rigorous treatment and I have attempted to do so in these pages. I am less convinced, however, that "narrative affirmative action" is adequate to the task of representing the experiences of members of subordinate groups. While Fine and Weis' important work does bring to the consciousness of the bourgeois public narratives of poverty, racism and violence which they do not routinely hear, and I believe those efforts are laudable, I would argue that there is much to be lost by employing a strategy of simply displaying the data "performatively" (Lather, 1992, p. 89). As Angela McRobbie correctly observes, seemingly pure, uncommented-upon texts are "as ideologically loaded and as saturated with 'the subjective factor' as anything else" (McRobbie, 1991, p. 69). To undertheorize the narratives of subordinated women, then, risks having their lives equated merely with their subordinate status. Careful, respectful and historicized contextualization and theorization of these narratives can reveal how individual encounters are embedded in larger relations of domination and subordination. Such a strategy can also interrupt the dominant subjects' rationalizations and explanations of such encounters by foregrounding subordinate group members' narrated evidence of harm. Through careful reading, it can also draw attention to forms of resistance largely invisible to racially dominant groups. And, importantly, it can endeavour to interrupt the metonymic relationship assumed in First World countries between a speaking subaltern subject and the culture/community/ethnic group/geographic area with which she is identified (Carr, 1994). I undertake my interpretations with these possibilities in mind.

Advocating reciprocity, careful analysis and continous accountability in the research process can constitute yet another way that dominant subjects seek to
redeem marginalized ones. What has already been demonstrated, and what should be restated here, is that power in these unequal contexts is not something that the dominant researcher necessarily confers upon subordinate research subjects. Such subjects always already exercise power in the production of research knowledge. "If one considers power as a decentralized, shifting, and productive force animated in networks of relations rather than possessed by individuals," argues Aihwa Ong (1995), "then ethnographic subjects can exercise power in the production of ethnographic knowledges" (p. 354). Indeed, as I suggested in Chapter One, interview subjects intervene in numerous ways in the production of such knowledges. The deployment of a variety of narrative strategies, such as, omitting and suppressing emotion and experience, emphasizing and dramatizing the stories they offer, and euphemising and softening that which is unsayable in a direct manner, is paradigmatic of such intervention (Etter-Lewis, 1993). These narratives are also crafted by the narrator in relation to the identity of the researcher, the location and timing of the interview, the relationship established between interviewer and subject, the anticipated audience of the research, and the personal contexts which shaped the tale. I have attempted throughout this thesis to foreground the conditions in which all these relations of research are embedded, including: legacies of imperialism, histories of transnational migration, local conditions of racial formation, and the differential impact of these conditions on women. All of these shape not only the subjectivities of those whose words are displayed in this chapter, but my own as well. They shape both what I have been told and what I have heard.

**Women of colour and Aboriginal women: Three interview cohorts**

In the course of this research, as was outlined in Chapter One, I interviewed three separate cohorts of women of colour and Aboriginal women. The first cohort was comprised of five women who had served as representatives on midwifery boards or agencies between 1993 and 1996. Minimal demographic information is provided for these women in order to reduce the chance that they
will be recognized, although the names of those who participated on midwifery boards and committees is a matter of public record. As was outlined in Chapter One, this was an arrangement to which this particular cohort of women agreed. The second cohort is comprised of immigrant midwives of colour who chose not to seek registration and the third cohort represents those who did seek to become registered in the province through the Michener program or the PLA/PLEA programs described in Chapter Three. Demographic, educational, attitudinal and employment data for the women in cohorts two and three will be examined as a prelude to displaying and analyzing the narratives of those immigrant midwives of colour who have sought registration.

For the second and third cohorts, I offer a mapping of the following: the women's histories of migration and settlement, the scope of their education, their attitudes towards birth and medical technology, their family and class status, their work histories and their linguistic competencies, among other demographic material. I do this not only to satisfy academic conventions, but also in order to highlight some of the many similarities between practising midwives and those struggling to become registered. Such a strategy is helpful in ascertaining where boundaries between legitimate and illegitimate midwives have been drawn and in identifying the technologies that have been used to inscribe these borders.

**Women of colour and Aboriginal women on midwifery boards/bodies**

*For the native, objectivity is always used against him.*

Frantz Fanon (1963)
The Wretched of the Earth

This section explores the narratives of four women of colour and one Aboriginal woman who served on midwifery bodies between 1993 and 1996. All
served formally for at least a year. In order to maintain some degree of anonymity for these women, I refrain from naming the boards on which they served. Nor, for anonymity's sake, do I attach any indication of ethnicity or country of origin to direct quotes from this group of women. In order to minimize the chance that the women's identities will be deciphered, I also make no distinction between those whose appointments were created through governmental orders-in-council and those who participated voluntarily on midwifery bodies.

The number of women in this cohort is relatively small but, as I have pointed out, so have been the numbers of women of colour represented on midwifery bodies. Those interviewed do, however, represent an appropriately broad range of racialized minority groups in the province. Of the immigrant women of colour interviewed, one woman had arrived in Canada in the mid-1970s, while the other three had been here for between 10 and 15 years at the time of the interview. Three of the women came into their positions on these boards as community activists, while two had no prior affiliations which linked them politically with specific communities of colour. Only three of these women were trained midwives. As was discussed in Chapter Three, with the exception of Jesse Russell, a Metis woman from Thunder Bay, racialized minority women did not participate in policy-making activities related to the implementation of midwifery in Ontario until the establishment of the Transitional Council of the College of Midwives in 1993. At that time, two women of colour were appointed who had not been previously involved with midwifery in Ontario. Also in that year, an Advisory Council to the Prior Learning Assessment program was also established on which immigrant midwives of colour served prominently, although, as was argued in Chapter Three, with little impact on policies affecting women of colour who might seek registration.

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102 It should be kept in mind that while at the time of the interview, a given subject might have been in Canada for 10 years, she might have served on a board four or five years previous to the interview and would have been, at the time of her service, a relative newcomer to Canada.
Most of the women interviewed understood that they were appointed to their positions or invited to participate on boards as representatives of marginalized groups. Indeed, they saw their presence as critical to the achievement of equitable access to midwifery practice for immigrant midwives of colour. When discussing her participation one woman commented: "It made me feel that midwives from other countries have a chance. I was there not for me, but because we needed to give midwives from other countries a chance" (Interview No. 8). Another woman told me "I was really flattered that I'd been called. I did demonstrate my organizational skill and my connection with the immigrant women's group [which is what was] of interest [to the midwives]" (Interview No. 31).

Presuming that their responsibility was to speak on behalf of immigrant women of colour, some of the women interviewed pursued that goal unselfconsciously, only to be disciplined for failing to adequately represent "the public." One woman was surprised when accused by her colleagues on a midwifery body of lacking "objectivity" and of having a "conflict of interest" when she chose to highlight issues of particular concern to some immigrant women, most notably, the translation of midwifery promotional literature into languages other than English and French. Arguing from within the framework of midwifery discourse, she claimed that "informed choice" could only be operationalized for some women through access to language resources. She was subsequently accused of attempting to promote her community's welfare to the detriment of the "public good":

I was expected to speak out for immigrant women. I did not pussy-foot around either; I didn't beat around the bush. Immediately, I brought up the issue of language and language barriers. I immediately asked what the plan was to overcome that. My
question was: "In the past you were private practitioners, you could do whatever you like. Today, you're publicly funded. How do you overcome the language barrier to your client, not the other way around? Because they are the ones who entrusted you to meet their needs." [...] Maybe they were tired of me, even in the first few meetings, bringing this up, and the answer to me was, the ______ community has to come up with their own energy to meet their needs. That was the first statement that reminded me of my place. [...] They said the priority was "all" women first, therefore the budget cannot be spent on one group of women. I was told I have a conflict of interest. I did always use [her native language] as an example. I don't think I'm comfortable speaking for other ethno-racial groups. It certainly doesn't mean that they should only provide translated material [in that language]. Every time I bring up the ______ example it is because I have a better understanding of this community. And I was told that there's a conflict of interest there!

If it's the unique characteristic of your profession, which was not claimed by other professions - it was not claimed by the doctors, it was not claimed by the massage therapists - if you use that as your flag which you're waving, communication in an appropriate language and culturally appropriate to get that choice understood it's almost compulsory. It is compulsory. (Interview No. 31)

The questioning of this woman's ability to represent "the general public" and the suggestion that she was acting on behalf of a "special interest group" also arose during a meeting which she was chairing in which a white participant accused the College of Midwives of being biased towards immigrant women of colour:

At one point there was a confrontation. There was a member [of a midwifery-related body] who stood up and criticized the College of being biased toward immigrant women of colour. And when I asked her as chair, what kind of evidence do you have, then I was shouted down by the College staff who said that as chair, I could not challenge the person for evidence, that this was not "facilitating" the meeting. It was done in the open. It was totally intimidating to me as chair. And it was confusing, that meeting. One of the Filipino representatives was upset with the member's statement and wanted to confront that person. Then I became responsible for resolving that conflict and the staff was not backing me up. I tried to use my authority to ask for facts. I didn't want it to become a philosophical debate. If the individual says the College has been
biased towards immigrant women, not Canadian-born women, then I want to know how and why she said it, which is not bias, from the chair's position. I was accused by staff of saying that I'm presenting my position which is not neutral, so I'm not appropriate to chair that committee any more. (Interview No. 31)

As Richard Dyer argues, "non-white peoples are presumed to be still, and perhaps forever, at the stage of particular local sensations, not having made the move to disinterested subjecthood" (p. 38). Caught in an impossible double bind, this woman found herself installed in a position on a midwifery board, presumably in order to represent marginalized women, but then was informed that her comments and actions were tainted with self-interest. The dominant behaviours described above, without resorting to direct references to racial inferiority, inscribe a boundary between whiteness and "otherness" wherein white identity is ineluctably identified with "abstraction, distance, separation and objectivity" (Dyer, 1997, p. 38); the white person is, in Dyer's words, "everything and nothing" (p. 38). In this formulation, the "other" must remain mired in her particularity and is always something less than paradigmatically "woman." The "public good" can be seen as a rationalization which assumes a racializing function when deployed by dominant subjects to reassert dominance in a contested environment.

However, acquiescence to the dominant agenda, or a subsumation of interests which might be construed as particularist, did not guarantee that women of colour could participate as equals on midwifery boards. One woman of colour, who truly believed that midwifery implementation was a goal which could produce gains for all women, and who even acceded to policies with which she disagreed because she believed she had to "be loyal to the College and this is what's best for all at this time" (Interview No. 8), later bemoaned her own naivete. Included on the midwifery body in which she participated because she represented immigrant midwives of colour, she was prevented from participating directly in the formulation of policies for the Prior Learning Assessment process because, as
potential PLA participant, she was told, she had conflicts of interest.\textsuperscript{103} Unable to utilize the particular expertise which gained her entry to this body, she told me:

I started feeling as though my say was being dwindled and I was feeling excluded a little bit from a lot of the processes that needed to be enacted to put the PLA in place. Although I played a part in it, I still feel as though I could have played a better part, a better role. But I was isolated and I had a lot going on too. Then I didn't think much about it because I really trusted the midwives who were on the committee to really work for us. Maybe I was a little bit naive. Maybe I didn't know enough about government politics or the politics of a small group or a small network that was very, very strong. Maybe I was naive to think that I would have been welcomed totally with open arms. I don't know. And that we were all going to be welcome and be a big team and playing an important role in the welfare of mothers and babies in the community. I really, really thought so. But looking back now, I thought I was a bit naive, thinking that it was going to work well. (Interview No. 8)

Demonstrating how the "heroic tale" of midwifery's struggle for recognition was used to defer claims of inequity, she continued:

I'm now...years later, the process is not working and I can't see it working until changes are made and the attitudes of practising midwives right now change. Because they're still on a high and they still have this feeling that they are invincible, you know: "they can wait, foreign-trained midwives can wait because we've waited so long to get where we are today, they can wait a big longer."

(Interview No. 8)

New to Canada and to the politics of midwifery in Ontario, this woman could not entirely anticipate the obstacles nor adequately decode the exclusionary moves that would impede her participation as a midwife of equal stature on the board on which she served. Being the only immigrant midwife of colour on this particular body made any oppositional stance difficult to express. It is striking that for neither of the women quoted is a viable subject position

\textsuperscript{103} No such conflict of interest appeared to be perceived for the midwives who constituted the Curriculum Development Committee or the Registration Committee which formulated many of the policies which governed the entry of midwives into practice subsequent to legislation, policies to which all of them would be subject.
available. For the first woman, active advocacy on behalf of communities of colour - the stance she willingly assumes on the board - is branded as "not acting in the public interest." For the second woman, attempts to claim the unmarked subject position of "midwife" are thwarted when her foreign training and outsider status are seen to constitute a "conflict of interest" in relation to her offering input on the PLA/PLEA process. Whether they claimed identities which asserted or subsumed their status as racialized minority women, the women quoted above were marked as incapable of objectivity. Indeed, those who made special claims needed to be contained so that the illusion of a "public good" could be maintained and so that exclusions could be narrated as justifiable. Those who expressed loyalties or demonstrated ties to specific groups appear to have been construed as inadequate to the task of formulating "public" policy.

**Women of colour problematize their participation on midwifery boards**

As Philomena Essed (1991) has remarked, racialized minority women's comprehension of racism is not a function of "common sense" but is acquired, rather, through a "deliberate problematization of social reality" (p. 147). Two non-midwife participants in midwifery boards, women who had lived in Ontario for more than twenty years and who had years of community activism behind them, drew on sophisticated analyses and prior experiences of exclusion to construct their narratives of participation. One woman offered a complex criticism, clearly drawn from a history of past struggles, of the tokenism which had characterized her role on one midwifery board. As a woman of colour who did not display deference to the white board members with whom she served, she was often left out of the information loop, a practice which, as Leroy Wells (1998) has noted, "has the effect of disempowering, disenfranchising, and marginalizing" racialized minority people in white-dominated work settings (p. 396). "Moreover," argues Wells, "the combination of ambiguous communication, unreliable information, and incomplete feedback creates an unstable and highly stressful work
environment with significant negative effects on the role occupant" (p. 396). While occupying a position of putative power, informal forces undermined this woman's ability to actually deploy such power. Demonstrating that covert maneuvers of influence are difficult for isolated and minoritized people to challenge, and that larger circuits of racialized power always structure relations at the micro level, she described her role as chair of a committee:

I only managed to chair that committee for a year, that's when I played a leadership role. And that was very interesting. Decisions were made behind my back, undermining my position as a leader. There was also a veto, it was not my decision, it was the committee's decision by a more informal powerful clique. Even in the [recorded] minutes, a decision was made that two days later was changed because the more influential members of the movement decided that it isn't what they want. I asked why that was and basically I was told "Oh, we just want to get the work done fast. Oh, you weren't consulted? Oh, it's not intentional." But the undercurrent statement is "What can you do about it?" I think part of this is so-called, racist practice [...] I'm seeing a pattern that intimidation is a challenge so, you have no clout, so you have the foremost position to do certain things but you can't do it. The system is not on your side, the social system we're talking about. So who are you going to complain to? So what are you going to do about it? (Interview No. 31)

As with the woman who participated in Interview No. 8, the woman quoted above referred to her sense of isolation on the midwifery body on which she had served. Early in our conversation, this woman had negotiated the terms of her interview with me. Caution needed to be taken, she told me, because she was one of the few women of colour who had served on a midwifery board and one of the few who does a particular kind of advocacy work for women of colour. The lack of a critical mass of women like herself made it dangerous for her to speak out without jeopardizing future projects. "I don't have a collectivity" she told me. "If there is a collective, the anonymity is not as relevant" (Interview No. 31). Recognizing that isolation is an inevitable companion to tokenism and having
served as a "token" woman of colour innumerable times, she evaluated how that role was constructed for her on a midwifery body:

Yes, a token, well I mean realistically let's face it...in the process of inclusiveness, you couldn't possibly invite people of colour other than tokens. Meaning that you couldn't even invite a representative percentage of people to sit on [a midwifery body]. I'm not that euphoric to believe that. The fact that they recognize [her advocacy work] [...] is an improvement. So the entry point is pretty innocent. But when it comes to crisis time, like decision making, like the distribution of resources, those are the issues, and also like why is a decision made behind my back? So there is lack of full disclosure. (Interview No. 31)

In the wake of her problematic participation on a midwifery body, what this woman is able to articulate so clearly here are the conditions for "full partnership" whereby women otherwise hierarchically positioned might actually participate and benefit equally from a shared project. She suggests that accountability to a more broadly and diversely conceptualized public requires that power be shared:

So what my experience is, therefore, I learned...in genuine partnership there are three "f's". The first one is full disclosure, the second one is full participation. [...] And the third thing is full sharing of resources. I learned that. Those are the criteria for genuine partnership. So I'm not saying that when you and I meet together you have to address me by my (non-Anglicized) name, I'm not demanding that. I'm rather looking to these three aspects to make it meaningful: full disclosure, full participation and full sharing of the resources on this project. I don't want to share your house, but when you're doing that work to bring this common goal, the common goal is to make this service available to the public so, because this is a publicly funded profession now and the public would feel it's worthwhile to fund this project. (Interview No. 31)

The material conditions that constrained the participation of women of colour and Aboriginal women on voluntary and appointed midwifery bodies are also clearly elucidated. Access to flexible employment, Western academic and (white) cultural competencies and generous domestic support systems are seen to be fundamental conditions for participating in, in this subject's words,
"governance work." Some of these resources are, however, precisely those which are in short supply for immigrant women of colour and Aboriginal women. The material conditions described can indeed be seen to be unavailable to some immigrant midwives of colour, whose educational qualifications had often been gained outside of Canada, whose employment conditions (for example in nursing or home health or child care) may have been rigidly controlled and whose access to extended family or community supports may have been limited because of their histories of geographic dislocation. In outlining the conditions under which the "full participation" she refers to above can be achieved, she shows how involvement in public projects works differently for women who are positioned subordinately in the social matrix:

I hope people realize that for an immigrant woman to participate in this kind of governance work which has irregular hours, irregular demands, expectations, you need the kind of resource...the kind of job that you can go in and out of freely and the kind of family life you can go in and out of to produce that. [...] Because a lot of them would say, "Oh its not that we don't want to include women of colour it's just that there aren't too many of them who have that kind of skill." I can't accept that, you know. I'm talking about social resources. I'm talking about I could be a professor from [a country in the South] and yet I don't have the kind of job which allows me to go in and out and come to your meetings. I don't have the kind of family support system that I can push aside my child care and come to, to produce that kind of work. [...] At one point, Aboriginal women were criticized. "She can't head a certain committee because she can't present briefs" and I contradicted that to say "if writing skills are what you want, you can easily contract a university student to do that. But you are talking about these Aboriginal women who have rich knowledge and experience within the Aboriginal midwifery service." That's what you want, her ideas,

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104 In contrast to the immigrant women of colour interviewed for this study, a prominent Aboriginal woman had nothing but praise for her experience on a midwifery board. For this woman, exemption from midwifery legislation constituted a rare victory for Aboriginal women and, as was discussed in Chapter Three, Aboriginal issues in relation to midwifery did receive significant attention in the years prior to legalization. In addition, midwifery activists cultivated a dialogic relationship with Aboriginal women that was never in evidence in relation to immigrant women of colour. In light of this it is not surprising that praise was offered.
not her writing skill. You can contract a student to sit side by side with her, get that idea out." That suggestion was pushed aside. (Interview No. 31)\

Another woman, a long-time advocate for immigrant women of colour, harboured few expectations about the impact of her presence on the midwifery body on which she served. Her unenthusiastic description of the meetings that she had attended attested to how the participation and input of women of colour was regulated: "They were friendly meetings. They allowed us to express ourselves of course. It was not bad, basically, let's put it that way" (Interview No. 30). The frustration that she felt in not seeing immigrant midwives of colour gain a foothold in midwifery in Ontario was no different, she explained, than that which she had experienced in the other campaigns for employment equity in which she had participated, where the threat of lower professional standards always arose when immigrant people of colour sought inclusion. When asked if she felt that she had influenced policy, she responded:

No, I don't think so, but I wanted more to do because I know it's difficult to influence policy unless you're inside, right? And unless you know the steps to go about it. But...my goal wasn't for them [the midwifery movement]. What I wanted to say was "there are qualified midwives here, what they need is a chance to just prove themselves" [...] The frustration is just like in all groups when you try to push for accreditation. They think that if they include people from Third World countries...that they are lowering their standards. They are not, they're just opening up the pool, right? So I guess that's the frustration, it seems like they keep on harping on "standards, standards" but basically we're not saying "lower the standards" we're just saying "open it up" basically. (Interview No. 30)

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105 People who served on some bodies related to midwifery implementation were granted government per diem payments intended to compensate them for lost work hours. However, they still needed to be in a position to negotiate absences from the workplace. Other committees, however, offered no such compensation and required members to attend daytime meetings.
While four out of five of the representatives interviewed felt that they had been marginalized during their participation on a midwifery body, at least one woman believed that she had also failed those that she supposedly represented. Having spent considerable time consulting with groups of immigrant midwives of colour which had begun to meet informally in anticipation of the Prior Learning Assessment initiative, this woman felt that despite her own best efforts, she had not managed to influence policies that would speed the entrance to midwifery practice of the women she had met:

Through networking into the community - because I believe that community is important, because it is the community that midwives will be serving - we met with the Filipino Midwives Association, the Chinese Association, I got in contact with a couple of women I knew migrated and met occasionally here. They're spread all over the place and I contacted them and networked with some other midwives who are nurse-midwives from home and encouraged them, "let's get together." Some came to my home and I said "let me update you with what we're doing" and they were quite thrilled. They could see me playing that role and that's me, that's me. [...] They wanted a part in the process and when they saw that they had a nurse-midwife from this country they were quite thrilled and they contacted the College and they wanted to meet us. And they asked me to speak at a couple of their...they wanted my background and they wanted...they got that contact that they had somebody there for them. And I started feeling really, really like I had this whole weight, all these women on my shoulders and I felt so disappointed by the time proclamation had taken place, I kept saying "oh my God, there is no way. We're not going to have midwives from other countries starting to practise not maybe for the next ten years or so." [...] There's a lot of things being said in...outside, here, in the community, that you're not sure you should say you were involved at all. But I say it anyway. Because with a clear conscience, I can say that I tried and I really worked hard with my limited whatever, if they think it was limited knowledge or whatever it is. But I thought I brought a lot of experience and I was able to bring a lot to the College. (Interview No. 8)

Constrained and circumvented by covert circuits of power and locked into an untenable role as the speaking "other" whose contribution is never construed as objective or as linked to the "public good," women of colour interviewed here
who participated on midwifery boards in the period just to prior to and for the
three years following proclamation of midwifery legislation felt that despite the
considerable investment of time and energy that they had contributed, they had
not succeeded in opening up midwifery practice to immigrant women of colour.

**Immigrant midwives of colour who did not seek registration**

Five immigrant midwives of colour who chose not to pursue registration in
the province were interviewed in the course of this research. As was noted in
Chapter Four, hundreds of foreign-trained midwives attended midwifery
information meetings just following legalization, but relatively few ultimately
pursued registration. Interviews were conducted with this group to determine why
some immigrant midwives of colour might have decided against participating in
the PLA/PLEA process. Their comments and the accompanying demographic
information suggest possible explanations rather than verifiable trends among
these women.

Four of the women interviewed had immigrated to Canada in the mid-
1980s while one had come in 1994. Like many people of colour in Ontario, four of
these women lived in suburban areas while commuting into an urban area to
work. One woman both lived and worked within an urban area. All were currently
in their late thirties or early forties. Two of the five women had followed the multi-
stopped immigration routes so common in the transnational flow of immigrants,
including one which is well-known to Filipina nurses: Phillippines - Saudia Arabia -
Canada (Joyce & Hunt, 1982) and one familiar to Afro-Caribbean women
(particularly nurses, who often pursue basic or advanced training in the U.K.):
Caribbean - England - Canada (Rashid, 1990). Four of these women held
nursing positions at the time of the interview, including (sometimes
simultaneously because of part-time positions) as public health nurses and nurse
practitioners, and labour and delivery nurses. The woman who had most recently
immigrated worked as a home day care worker and as an occasional second
attendant in a midwifery practice. One of the women had entered Canada as a live-in caregiver even though she was a fully credentialled nurse and midwife at the time.

All five of the women interviewed completed three years of post-secondary nursing training and between one and two years of specialized midwifery education. All those interviewed had been trained in prenatal care, although this is not necessarily a part of midwifery training in some countries. As was discussed in Chapter Three, many in the Ontario midwifery community perceived foreign-trained midwives to be opposed to home birth. However, this cohort, as well as an overwhelming majority of the cohort of PLA/PLEA participants interviewed for this study, expressed no such opposition and had been trained to attend home births in their countries of origin.

While there are numerous possible reasons why immigrant midwives of colour might not have sought registration, for some, the stringency of the registration requirements seemed to represent a denigration of hard won skills and credentials. For one woman who had undergone three years of nursing training and two years of speciality midwifery training, non-participation in the PLA/PLEA was a reassertion of what she felt was her rightful status as a midwife:

For me, I think that I have my midwife license and I don't need people to evaluate me. That's what that is! (laughter). I think I'm competent enough to work in the midwife role, but in case they have to assess me again and have me do everything, I say that's just too much time and involvement, so I'd better not. (Interview No. 5)

In the same vein, another woman declared, "I'm not sure I even want to practise, I just want recognition for my credential" (Interview No. 29). Denigration of skills was also raised in relation to the profession-specific language exam. One woman, for whom English was a second language, acceded to the need for English testing for those for whom English was not their first language, but
reported the negative responses of her co-workers, many of whom were trained in England,\textsuperscript{106} to the requirement for an English examination:

They are demanding too much from the participants. And especially those who were trained in England, they said "why do they have to take the English exam. You know their first language is English." For us, that is not our first language so even if it is mandatory, it is ok for us. But for the American and British nurses, they said that if they will exclude the exam, then many nurses from England will do [the PLEA]. (Interview No. 2)

One of the likely reasons that some women did not choose to pursue registration was that they had, for some time, been working in stable and relatively well-paying nursing jobs. Pursuit of registration would have meant loss of income because of the time required to study and to attend mandatory courses. One woman spoke of valuing stability, an arguably precious commodity for those whose lives have been punctuated by transnational migrations: "My job is stable and secure and I prefer to just be in that role, not look for any particular change" (Interview No. 5). Another woman told me, referring to the extensive demands on the time and resources required of those pursuing registration, "some of us have to work for a living" (Interview No. 29). For these women, cost, an issue raised in Chapter Three, was also identified as a significant deterrent to seeking registration through the PLA/PLEA program.

Two of those interviewed worked in an urban hospital that was noted for serving a racially and ethnically diverse segment of the population as well as for the high percentage of foreign-trained midwives, largely women of colour, who worked in its labour and delivery department. For this unique group, lack of interest in pursuing regulation may be related to the fact that in this particular workplace, midwives working as labour and delivery nurses received a significant amount of recognition for their midwifery skills from both doctors and families.

\textsuperscript{106} This woman was a nurse in the racially diverse hospital mentioned below and it is likely that many of the English-trained co-workers to whom she refers were women of colour.
While rarely able to provide the continuity of perinatal care which is a cornerstone of the midwifery model and for which some were trained, these women were able to perform a range of tasks which were, in some cases, roughly equivalent to those they had performed when working as midwives in their countries of origin/training, including conducting the actual delivery of the baby, a task usually performed exclusively by physicians. Reported one woman, "we are checking the patients, examining the patient, delivering the patient, especially when the doctor cannot make it" (Interview No. 5). Another woman working in this hospital amplified the above comments:

We do deliver the babies with the doctor's signature, that means the doctor has to check everything to make sure of everything. Our doctors are supposed to be in there 24 hours, but they are not. They are not. We [nurses] often are the prime person to look after everything. (Interview No. 2)

This woman also described how well-respected she felt by the largely immigrant population she served in this hospital when asked whether she felt that her own experience as an immigrant was part of the expertise that she offered her patients. She contrasts the trust shown her by patients in this hospital with the questioning of her authority that occurs in a suburban hospital in which she also works:

I think that because of the relationship with the nurses and you know, the family, and so on, because if they see kind of the same language, same-looking, you come from the same places, they trust you. And then they more rely on you. If the doctor is not here, sometimes that's fine because "Mrs. _____," - they usually call you by the last name because it's a show of respect - "as long as you're here, it's ok. If you think that it is good, go ahead and do so." [...] There's more trust and [the patients] allow us to do a little bit more I think. [...] I think that they don't all the time say "I want to speak to the doctor" and "can I speak to the doctor first." something like that. (Interview No. 2)
The opportunities for communication and mutual respect which this woman describes may or may not be related to the unique environment in which she worked, where a largely racialized minority patient population, many of whom had emigrated from countries where midwifery care was the norm, was likely to encounter an immigrant midwife of colour during labour and delivery. The sense of authority conveyed by these women and by several others whom I encountered in the Childbirth Educator's Program, together with their relative lack of interest in pursuing midwifery registration, has raised numerous questions for me about the dynamics of subordination and dominance in a space in which caregivers of colour were present in significant numbers. In the absence of any substantive data about such dynamics, I can only conjecture that immigrant midwives of colour working as nurses in such a space might have preferred to remain in an environment where they expected and received a degree of respect not accorded them in white-dominated spaces. One of the women interviewed, clearly cognizant that midwifery in Ontario was dominated by white midwives and white clients, commented, "The thing is you know, all the midwifery clients are Caucasian, eh?; they're white. So maybe they don't really need those coloured people to help them to deliver" (Interview No. 2).

Some of the women also expressed a fear of increased vulnerability if they were to work with midwifery's largely white clientele. Three of those interviewed expressed fear of being held legally liable in the event of charges of malpractice were they to become registered midwives. Some of the women interviewed appeared to encounter litigious patients with relative frequency. One woman observed that in her experience "non-immigrant" clients were more likely to sue caregivers of colour than were immigrant patients of colour:

Yeah, I don't know why they are doing that. That is according to my observation, those non-immigrants they will just come here to deliver their babies, then complicated...something's wrong with the baby or sometimes something is wrong with them and then they will blame the hospital, the doctors and the nurses. (Interview No. 5)
There is, I believe, a complex set of impulses that leads these women to fear the threat of law suits. It is possible that as successful migrants, a serious challenge to their professional credibility, stability and material resources seems not worth the risk involved in practising midwifery. However, the woman quoted above conveys her own fear that the likelihood of being blamed by white women for less-than-perfect pregnancy outcomes is higher for midwives of colour than for white midwives. As Fanon (1992) reminds us," the black physician can never be sure how close he is to disgrace" (p. 225). The person of colour invested with professional expertise always seems anomalous in white society and her/his expertise is constantly under the threat of erasure. Having witnessed this dynamic in her own workplace, the woman quoted above is reluctant to raise the stakes by taking on more professional liability as a midwife and primary caregiver.

Unlike the other women interviewed, who as hospital labour and delivery nurses had received numerous notices in the years prior to legalization about routes to registration, the most recent immigrant among this cohort, a home child care worker, had not applied to the PLEA because she did not know it existed. I contacted this woman through a midwifery practice where she was working occasionally as a second attendant.\textsuperscript{107} Since I knew that two members of this practice had recently completed the PLEA, I was rather taken aback to learn that this woman had not been encouraged by her colleagues to pursue registration. In Chapter Five, I discussed how one veteran midwife expressed a sense of being besieged by too many women of colour and was unable to imagine taking on a second woman from a specific racialized minority group because she already utilized a second attendant from that group "at these births." This woman was that attendant. The failure of the midwives with whom she worked to inform her about and encourage her to seek registration is a prime example of

\textsuperscript{107}While normally two midwives are required to be in attendance at a birth, registered midwives may engage suitably trained assistants as "second attendants" under certain circumstances.
how racist exclusion can be effected through passive practices. A midwife with more than 20 years of experience from her country of origin, this woman was excited to learn about the prospect of becoming registered and I subsequently mailed her a copy of the COM's PLEA booklet.

Working with a circumscribed amount of data in attempting to learn why some immigrant midwives of colour did not even consider applying to the Prior Learning Assessment or Prior Learning and Experience Assessment programs, I find some possible explanations emerging. Many of these explanations are, I believe, linked to women's histories of transnational migration and their positions in a racially segmented labour force and society. Most were reluctant to jeopardize stable and relatively well-paying jobs by pursuing the time-consuming PLA/PLEA process. For the woman who had begun life in Canada as a live-in caregiver and for those who had migrated more than once in their lifetimes, material and professional stability can be seen as logical objectives. Fear of litigation also likely reflected a wish to avoid what might have been extraordinary risk for women of colour as well as a desire to maintain hard won professional, community and material status. Some of these women may also have been unwilling to trade what appeared to be an employment situation where their expertise was valued and where a critical mass of racialized minority workers and patients created a day-to-day environment less racist than that experienced in white-dominated institutions, which at least one woman explicitly recognized Ontario midwifery to be. Finally, some of the women interviewed, having undergone extensive training and possessed of years of midwifery experience, were simply unwilling to undergo the equivalent of a re-training process, a seeming negation of their hard-won expertise.
Immigrant midwives of colour: Microprocesses of exclusion and the pursuit of registration

Between July 1996 and November 1998, I interviewed twelve immigrant midwives of colour who had pursued registration. Two of the women were registered and practising at the time of the interview. Two of those interviewed had participated in the Michener Institute pre-registration program which has been described previously. Of the remaining ten, three participated in the first cycle of the PLA/PLEA which, as was outlined in Chapter Four, began in October 1994, while seven participated in cycle two, which began in October 1997. This breakdown is significant because cycle one of the PLEA is recognized by officials of the College of Midwives as having been significantly more problematic than cycle two. In an interview conducted in March of 1998, CMO Registrar Robin Kilpatrick described the first cycle:

But I think in terms of cycle one, we've come to see it as a prototype, meaning that you just try it out. You know it's not the model that you're going to end up with. You know it's not the best. It's the working model to see where's the problems. [...] So there were extremely long delays in the process that obviously affected the individual candidates' confidence. This concerns all sorts of things that were part of going through a process that was in development. [...] And certainly cycle one was painful in some ways for everyone including the College. (Interview with CMO Registrar Robin Kilpatrick and PLEA Coordinator, Jill Moriarity, March 11, 1998)

While cycle one participants apparently experienced more bureaucratic errors and delays, and while, as I have argued, such errors and delays are not infrequently interpreted by women of colour as racism because of previous individual experience or because of generalized knowledge about exclusionary behaviours acknowledged by people of colour, bureaucratic streamlining seemed not to diminish racially defined experiences for PLEA cycle two participants interviewed for this project. While it might be argued that an equal number of
participants from cycle one and cycle two would have given a more balanced picture of the PLA/PLEA process, in fact a predominance of cycle two participants actually allows an analysis of racially-defined incidents which are presumably less intertwined with bureaucratic incompetence and theoretically are more transparent to interpretation. 108

Participants came from all areas from which Ontario has received immigration in the last twenty years as described in Chapter Two. Four of those interviewed were born in the Caribbean. Three women identified their origins as Afro-Caribbean one as Indo-Caribbean. Two of those interviewed had emigrated from Africa, and one had come from the Philippines. Three had emigrated to Ontario from East or Southeast Asia. One woman had emigrated from an Arab country and one had come to Ontario from Central America. For eight of the twelve women interviewed, Canada was the second, third or even fourth country they had migrated to after leaving their countries of birth. For most, having come from British Commonwealth nations in the South, England was the first port in their transnational migration, although Saudi Arabia and the United States had been stops for two of the women.

Of the twelve interviewed, seven were native English speakers and five spoke English as a second language, 109 although one had resided and worked for 20 years in an English-speaking country. Participants ranged in age from mid-twenties to late fifties with an estimated average age of approximately 43. The

108 I in no way wish to imply that I believe bureaucratic incompetence to be wholly benign. Indeed, if, as I have argued in Chapter Three, people of colour experience delays, unresponsiveness, and mishandling of documents as racial prejudice, then a bureaucracy that expects to deal regularly with people of colour needs to be aware of how incompetence impacts differently on differently positioned groups. I would argue that an anti-racist solution to this problem would be to apportion adequate resources and training to segments of a bureaucracy which are likely to deal with the public, so as not foster racist exclusion through bureaucratic bungling.

109 Four out of the five women who spoke English as a second language held nursing jobs in which English fluency was indispensable. Indeed for only one woman, a very recent immigrant, did the interview pose a mild linguistic challenge.
women had immigrated to Canada between 1981 and 1996. Half had arrived within the five years previous to the interview. Seven of those interviewed were working as nurses, two were working as midwives and two worked in midwifery- or childbirth-related jobs at the time of the interview. One woman, who possessed a four-year Bachelor's degree in midwifery from her country of origin was employed as a telemarketer, and one worked as a home health care aide.

Nine out of the twelve women described middle-class upbringings in their countries of origin, often as children of teachers, physicians, or business owners. The remaining three were raised in working-class homes.

With one exception, all the immigrant midwives of colour interviewed had obtained nursing and midwifery credentials in government-accredited schools. All, except one woman who had simultaneously earned a Bachelor's degree in history and midwifery, had completed three-year registered nursing studies and had earned a midwifery credential during additional studies lasting from one to two years. Prior to her emigration, one woman had been sent by government health officials to receive special training in the U.S. in family planning techniques and advanced midwifery. Another woman had pursued an additional year of training as a public health nurse after completing her nursing and midwifery credentials. Those women interviewed who had undergone nursing training in their countries of origin and had arrived in the ten years prior to the interview had very little difficulty passing the nursing entrance exams or gaining equivalency from the College of Nurses of Ontario in order to become licensed, and most entered nursing careers immediately upon arrival in Canada. However, one woman, who arrived in the early 1980s from a Southeast Asian country was compelled to repeat her RN degree in order to be able to practise in Ontario. Only one woman was an empirically-trained midwife who had studied not in her country of origin, but in the United States as an apprentice midwife. Half of the women interviewed had completed their education in Great Britain.
This group, perhaps more than any of the others, exercised considerable power in the research encounter. On one two occasions women seized the agenda before I had even had a chance to begin the interview. Arriving at one of my first interviews with an immigrant midwife of colour, I found the woman waiting with a list of questions related to her upcoming PLEA exam. As I will argue below, access to knowledge related to midwifery in Ontario was not easily obtained by immigrant midwives of colour and the woman at this interview availed herself of a rare opportunity to get direct answers to her questions. We worked our way systematically through her questions before beginning the interview process. At a different interview, I became the object of a surprising reversal when the interview subject began to interrogate me about why I, as a white women, would be so interested in issues affecting women of colour. I will return to this incident in the thesis conclusion where I will attempt to answer her provocative and deeply relevant question.

Immigrant midwives of colour and midwifery philosophies

Eleven out of the twelve women interviewed indicated that they largely embraced the same philosophical tenets as Ontario midwives. The fear among some midwifery supporters, outlined in Chapter Three, that foreign-trained midwives held a "different philosophy of continuity of care, choice of birthplace, and informed choice" (Matthews & Thatcher, 1992, p. 21), appears unfounded in light of the interviews conducted here. Eleven of the women described their home birth experience to me. While it ranged from attendance at only a handful of births at home to "hundreds and hundreds" (Interview No. 8) all eleven women considered themselves competent and willing to attend women who chose to give birth at home. One immigrant midwife of colour, cognizant of Ontario midwifery philosophy as well as of the claim that foreign-trained midwives, particularly those who had emigrated from Britain, had an overly-medical approach to childbirth, refuted such a charge by claiming, emphatically, to be better prepared to attend home births than women trained in Ontario:
In my training I was taught to give people...to make sure that the clients have informed choice and I know what that means and I know how to do that. Choice of birthplace, most of the births that I have done have been in hospitals but I know that if a client wanted a home birth I feel confident to do that because the setting that I've worked in has equipped me to deal with emergencies. Whereas I know that some of the midwives here that trained in Toronto that have been practising prior to legislation haven't come across some of the emergencies that I've come across, haven't had to deal with some of the emergencies that I've had to deal with in a legitimate way, obviously because they couldn't take on high risk clients, for starters. They weren't allowed to deal with obstetrical emergencies. They weren't allowed to assist with obstetrical emergencies. Once things became complicated they had to hand the case over. Whereas midwives trained in England have to follow through. (Interview No. 7)

Claims that foreign-trained midwives were enamoured of medicalized childbirth sometimes carry a pejorative subtext in which Third World medical systems are viewed as the outdated remnants of British imperialism. Third World people appear in this formulation to slip from the moors of their ontological positioning as "traditional" and "non-technological" by mimicking the ill-advised obsession with technology that has infected the West. However, the women interviewed frequently resisted such claims and their inferiorizing subtexts, even asserting that the systems of maternity care from which they had come were superior to those encountered in Canada. One woman, who had served on a midwifery board and who was familiar with midwifery ideologies which eschewed unnecessary technology and championed women's choice, utilized that discourse to argue that unlike in Canada, maternity care in her country of origin had never employed coercive, inhumane nor inefficacious forms of care. Her narrative offers a vigorous resistance to claims that foreign-trained midwives were ideologically opposed to the philosophy of care in Ontario:

To be honest, I find that the system that we use at home, because we have this one-on-one, this on-touch, this is not a lot of technology interfering. I find it a superior system. [...] I look at it from this angle, we don't have people being hooked up and
strapped down with machines to check baby heart rate, fetal monitor and all the time these women can't walk around as they want. WE don't do that! WE give women the opportunity to walk as they want, do what they want during labour. The freedom to move. WE don't tell them they have to be strapped up like this and lie flat on their back if they don't want to. [...] I had to fight to observe three Cesareans when I was doing midwifery back home. If the same course was here, I would have to fight to see a normal delivery without an episiotomy. In all my years that I have been a midwife, I did one episiotomy and that was because I was delivering a preterm infant [...] I thought I was coming to this industrialized country with everything in place and I was going to move on. I never thought that I was going to be at the bottom of the barrel and struggling to be recognized for what I am and for what I have done, for who I am. (Interview No. 8)

While six of the twelve women interviewed had received their training in Great Britain, two had completed this training within five years of the date that the interview was conducted. Their views indicate that contrary to fears in Ontario that British-trained midwives were more comfortable with a subordinate and medically-oriented role in childbirth, recent midwifery graduates from the U.K., were philosophically in agreement with the principles of Ontario midwifery. While there had been a decline, linked importantly with the decrease in the number of home births in England, in British midwives' autonomy beginning in the 1950s, in the 1970s, various forces arose to challenge medicalized childbirth and the diminution of the midwifery role (Isherwood, 1995). Consequently, recent graduates were trained in an atmosphere in which challenges to medical dominance in childbirth were not unfamiliar, and those interviewed expressed maternity care politics congruent with the critical views of such groups as the Association of Radical Midwives (Weitz, 1987) which are similar to those espoused by Ontario midwives. One such woman, who has had extended

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10 An episiotomy is a surgical incision into the perineum intended to enlarge the birth canal during the second stage of labor. Its routine use has been in dispute for more than twenty years and only recently has medical opinion begun to advocate a judicious, rather than a liberal use of the procedure. See, for example. Lede, R.L., Belizan J.M., & Carroli, G. (1996). Is routine use of episiotomy justified? American Journal of Obstetrics & Gynecology, 174 (5), 1399-402.
experience with an Ontario midwifery practice, declared the Ontario system to be "a carbon copy of our philosophy, our training and our system" (Interview No. 7). However, the PLA/PLEA process appears not to have been identical for white British-trained midwives and their racialized minority counterparts. This is a point to which I will return below.

Half of those interviewed had some basic knowledge about the way midwifery was practised in Ontario before they began the Michener Pre-registration program or the PLA/PLEA process. Three had been enrolled in the Humber College/Women's College hospital childbirth educators program where the curriculum included substantial material on Ontario midwifery and childbirth reform. One had learned about Ontario's system from her colleagues in the Association of Radical Midwives in England who considered it "the ideal model of midwifery" (Interview No. 1). Another woman had actually worked as a midwife prior to legislation and one woman had been working as a second attendant in a midwifery practice since coming to Ontario. However, as I will illustrate below, only intimate knowledge of midwifery practice and the culture of alternative birth - resources available largely to white women - offered any advantage in the struggle to become registered.

As stated above, one woman interviewed disagreed with many aspects of Ontario midwifery practice. She regarded home birth as unsafe (but was prepared, nonetheless, to conduct births at home) and felt it wise to defer to medical authority in most matters related to childbirth. She also expressed distaste for the emphasis on sexuality in some of the assessments she had undergone which tested the extent of her knowledge on accommodating diversity in childbearing. She was particularly distressed by the requirement to understand the contexts and particular needs of lesbian women and their families. However, among the 17 immigrant midwives of colour interviewed for this thesis, her views are entirely singular. Indeed, they are antithetical to the views on midwifery practice expressed by every other woman interviewed. A remarkable confluence,
however, can be seen to exist between the professional knowledge and philosophical bent of the midwives interviewed for this study and the scope of practice and philosophy of care of registered midwives in Ontario. In addition, the majority of those interviewed had worked in the health care system in Ontario, spoke English fluently or relatively fluently and had some knowledge of the policies and practices of Ontario midwives. Despite these confluences, many of those interviewed found that routines of racism and forms of exclusion awaited them as they navigated the long and arduous road to registration. Indeed, of the ten women interviewed here who had participated in the PLA/PLEA program, only two have become eligible for registration.

"White knowledge": The unequal access to midwifery resources

In February 1998, I attended a meeting of the Toronto Association of Aspiring Midwives (TAAM). Established several years ago by women hoping to gain entrance to the Midwifery Education Program, the group identifies itself in its promotional flyer as "a collective of women committed to grassroots organizing and community education who are of the belief that pregnancy and childbirth are healthy, physiological, emotional, spiritual and transformative life events." It also functions as "a support network and study group which relies on the sharing of our individual knowledge skills, and training, [drawing] on outside resources [texts, videos, etc.] and other individuals' expertise." Of the nine women attending the meeting, eight were working as "doulas": women trained to provide emotional and physical support (but no clinical services) for laboring women and their families. One woman was also a student midwife. All were white. In the course of the last few years, more than half of the group's members have been admitted to the Midwifery Education Program. In a program which accepts only one out of every 15 applicants, this is an impressive achievement.

What struck me as I sat in the meeting was the extraordinary access these women had to the resources which could pave their way into the profession by
making them desirable candidates for the Midwifery Education Program. These resources provided precisely the kinds of knowledge which many immigrant midwives of colour lacked. I recalled, for example, the stack of outdated public library books on home birth and North American midwifery that one midwife of colour had on her table during our interview. That sad collection represented the extent of her access to a complex culture of alternative birth in which a variety of esoteric knowledges and cultural competencies held sway. My own shelves had grown crowded, over my 19 years of childbirth reform activism, with obscure and expensive journals, books obtained from specialized stores and catalogues, and films, pamphlets, and other material acquired from years of attending conferences both in and outside of North America. Unlike the woman I had interviewed, TAAM members had found numerous avenues through which to access this body of knowledge. Many participated in a variety of volunteer activities which put them in contact with midwives, doulas, childbirth educators and others who provided access to information about birthing alternatives. The presence in this group of university-educated women who had graduated from Women's Studies programs guaranteed that feminist formulations, understood to be the lingua franca of the Midwifery Education Program, framed discussions of reproductive health and care and allowed TAAM members to absorb and process some of the languages of feminism to which they might not otherwise be exposed. And, once TAAM members began to be accepted into the MEP, intimate knowledge of the attributes of the normative midwifery subject became increasingly available. One TAAM member described to me all that she had done to maximize her chances of acceptance:

I did palliative care on a volunteer basis with people with AIDS and I did the same work for pay, low pay, in a home care agency. I did a lot of volunteer work with teens who are mostly single having babies in the hospital with doctors who didn't have any support. So I became the labour support. I did do a training, I attended midwifery conferences in the United States. Like I knew what I had to do and I took advantage of the access and resources. [...] I didn't know anyone until I did that TAAM thing and started volunteering. [...] And suddenly, I, very quickly, almost overnight, like had it all at
my fingertips! I was like at the centre of it all, you know? Where I went and what I did and how I got there and all because of my background and my university training and I think a degree in Women's Studies in terms of just knowing how to just...I think...something like knowing the lingo of feminism or feminisms to, you know, make things work. (Interview No. 35)

Another TAAM member who later became a midwifery student told me:

I talked to all of them [TAAM members] and I met with some of them and I tried to figure out, I didn't know where you volunteer, where you go to get experience, who do you talk to, what are the organizations? And all these people were involved, they had knowledge. (Interview No. 36)

I identify this corpus of information as "white knowledge," knowledge which is available largely within and through networks of white women whose lives intersect only minimally with those of women of colour. As I hope to demonstrate below, women of colour struggled for access to these forms of knowledge, not always successfully, and their absence from an otherwise sound repertoire of midwifery competencies affected these women's abilities to successfully negotiate assessments and a variety of other interactions with white midwives and with the Ontario midwifery bureaucracy.

Lack of familiarity with midwifery practice in Ontario constituted one of the key information deficits for the women interviewed. One immigrant midwife of colour who had nearly completed the PLEA at the time of the interview complained that:

There was no real guidance for those who went through it first of all so all those who didn't have a good understanding of how things work in Ontario were at a disadvantage from the word "go." And that when it came to the sort of the periphery of midwifery, not the actual core skills, many of us were foundering finding ways of getting a good grounding so that we could move on. (Interview No. 15)

Although an education module on practice issues is included as part of the Prior Learning and Experience Assessment process, it is one of the last components
of the program. Most of the non-practising immigrant midwives of colour whom I interviewed had never visited a midwifery practice in Ontario. Some who have attempted to gain local knowledge of midwifery through contact with practising midwives have encountered obstacles, occasionally in the form of everyday racist practices. A woman who came close to finishing, but ultimately dropped out of the PLEA program spoke about how, after seeking out a midwifery practice where she might learn about the local realities of practice, she was relegated to housekeeping work rather than treated as a colleague:

I talked to the [midwifery practice] group and asked if it was possible sometime during the week, if I'm not working, to come in and observe how they do their practice. And she said "yes," so that day I went in. She sent me into the storage room while she put up the charts and did all the paperwork. And then when a client came, she didn't want me to be there...you need the client's agreement. She said "I'll call you later and see which client I can get to agree, but never, never. (Interview No. 3)

A woman who had served on a midwifery board, and was herself a midwife, described her efforts to link Ontario midwives with foreign-trained midwives in the period just following midwifery implementation. Regarded with suspicion by those she approached, and reduced, despite her position on a midwifery board, to supplicant status, she nonetheless frames her story to establish professional parity between Ontario midwives and those trained elsewhere:

Let's get midwives or women to work with these other (immigrant) midwives to share their experiences together, to work as a unit. Let us do it. They're begging. I begged. I begged, I had to really beg! I don't know what else to say, I went on my knees and I begged, "please", but it wasn't met with openness. It wasn't an open...it took a little begging, I was in negotiation, I literally begged to see what they did. And it wasn't because I wanted to monitor them. It wasn't like that. It was to share the same love, the same experience. And they could have done the same. (Interview No. 8)
A woman who had been my student in the Humber College/Women's College Humber childbirth educators program, and who had abandoned the PLEA process after waiting a year for a response to her application, which she subsequently discovered had been lost by the College of Midwives, commented on how her pursuit of registration might have gone differently if she had had access to more knowledge about the way the midwifery apparatus functioned:

I was excited and I was new and there was nobody to guide me, like someone inside from...like a midwife or maybe if I'd met you at the time, it would have been different! But I didn't know anybody from inside there or someone who could tell me that you have to be careful. (Interview No. 9)

Another example of a "white knowledge" requirement for immigrant midwives of colour was that they be able to interpret and translate cultural difference attributed to a variety of cultural "others." In the example below, a recently-arrived woman who had received high marks on her clinical examinations talked about one examination that she had failed:

Interviewee No. 15: There were questions that I remember saying to some of the others in the group that (the test) was asking about Native Indians and this particular couple wanted to burn blue grass or some kind of grass.

Sheryl: Sweet grass?

Interviewee No. 15: Sweet grass, as part of the cultural, you know...around birth and the fire regulations in the hospital were such that the smoke detector...how would you sort of work it so that the couple were...their needs were taken into consideration plus the hospital's. I had no...I mean I'd read about culture but that wasn't one of the things that I thought I'd answered very well. I wasn't so sure about what the meanings were for the couple of the blue grass or in fact what blue grass is and how broad that could be so...I suggested burning it outside the window, somewhere outside and that was one that I just hadn't answered very well. [...] I don't have any problems with anything to do specifically with midwifery. It's mainly with the issues that might be mainly the Ontario way of doing things. (Interview No. 15)
There are several troubling aspects to the requirement that immigrant midwives of colour display mastery of decontextualized fragments of cultural knowledge for various marginalized groups in Ontario. For recent immigrants, practical knowledge of how differently positioned minoritized groups negotiate medical care in the province cannot be acquired organically within a short time, and acquiring such knowledge through cross-cultural medical or nursing literature is highly problematic. As Waqar Ahmad (1996) has argued, "the effect of an emphasis entirely on cultural differences to explain inequalities and differences in health status or use of health care services is to pathologize 'culture,' making it the cause of as well as the solution to inequalities in health care" (p. 196). Such uses of 'culture' rarely explore the dynamic and contextual aspects of culture nor how attending to culture can obscure other dynamics of racism in the medical setting. The articulation of forms of difference, as Homi Bhabha (1994) argues, is crucial to the establishment of racial and cultural hierarchies. When called upon to demonstrate such knowledge, the immigrant midwife of colour can never claim the invisible position of "knower," but must always find herself re-inserted into the slot of the "other" who needs to be known. The immigrant midwife of colour, in other words, is instantaneously marginalized when culture is used to articulate difference, even when this is done in the name of "cross-cultural communication."

For one immigrant midwife of colour interviewed, navigating the registration process was made much easier because of her close relationship to an established midwifery practice. Before emigrating, she had used her vacation time to visit a midwifery practice in Ontario located for her by her husband's relatives. After immigrating to Canada, she negotiated to become a second attendant in this practice and began the PLEA process. Despite working for

minimal remuneration, she felt that her intimate contact with a midwifery practice has given her a significant advantage in the PLEA process:

Having worked with the midwives here, I felt that there were certain...luckily, I've had the chance to work with these midwives here because there are certain practices that are different which they expect you to know...the things that are done here and the things that are done there for different reasons and each person will justify why they do it. Clinical things. I know for sure that here they're very much up on Group B Strep as a major thing while in [her former country of residence] you just don't check or test for that unless there is a concern. [...] It's a very major thing here. [...] So there are certain things that they expect you to know that as a rule and if you omit it in the exam then you'll be penalized or marks taken away. And there are other little clinical things. I have a list here of all the things that they're checking for and it was very ambiguous. [...] So luckily for me, I know people who are going through the [Midwifery Education] program so I'd ask them. They're going through the OSCE's [objective structured clinical examinations] and stuff themselves, I'll ask them like "what is it like? What do they expect from you?" (Interview No. 7)

As the immigrant midwives of colour quoted in this section indicate, and as the example of TAAM cited above demonstrates, there was much practical knowledge about midwifery in Ontario that was accessible only to those who had informal access to alternative birth culture or to practising midwives in the province. For numerous reasons, including the outright refusal of admission to those spaces described above, immigrant midwives of colour had little access to knowledge about midwifery that might have facilitated their participation in the PLEA process.

White behaviours: Encountering the boundaries of belonging

In Chapter Five I attempted to outline the contours of the midwifery norm to which students and veteran midwives had been bent and to delineate the borders which had been drawn between respectable and repudiated midwives. Immigrant midwives of colour interviewed for this study identified a number of
moments in which they were made to understand that they stood outside of the parameters of that normative midwifery identity. Inasmuch as these reminders of difference took place in a context where white women constituted an overwhelming majority, they take on a racial dimension. It is helpful here to revisit some of the theoretical underpinnings of this thesis outlined in Chapter Four in which it was argued that practices may be deemed to be racist when they produce subordinations which are "coterminal with 'racially' different populations" (Anthias & Yuval-Davis, 1992, p. 13). I would argue, in light of this, that the effects of being reminded of one's failure to measure up to the norm functions differently for racialized minority women than it does for most white women, inasmuch as such a reminder works to reinscribe non-belonging to those for whom non-belonging is already a fact of everyday life. Such inscriptions belong to the arsenal of microexpressions of racialized power described in the opening epigraph of this chapter. Rarely accomplished through open expressions of racial antipathy, these forms of racial marginalization attach themselves to evaluations of supposedly non-racial characteristics: speech, deportment, education, etc., some of which are demonstrated in the narratives examined below.

One woman, a native English speaker, felt consistently de-skilled and inferiorized when her use of language was criticized by Ontario midwives. Frequently the only woman of colour present at midwifery events she attended, she talked about her feelings when in the presence of that group of midwives who were the first to be registered in the province:

I'm totally incompetent when I put myself against this group. That's how I feel. I'm not. I know I'm not. It's just I come across these midwives, [...] all the time and some of them I feel, I can't even talk to them. I can't. Not...it's not that I have anything against them, it's not anything like that, it's just the way they are, they way they talk [...] I found people correcting the way I spoke, all the time. And so I lost my confidence. I used to tell my husband, it's just the big words that everybody uses. You know, I'm trying to think, just political words. I can't even think. I seem to be able to talk to you OK but
with some people, I'll say a sentence and they'll say "oh, you mean this" and replace it with a bigger word. You know. I just felt that I had to sort of learn English all over again, you know, learn to sort of express everything in North American language. That's what I have to sort of say to myself, I've never come across that in [her previous country of residence], never. And I was in the midwifery field for at least a good ten years before I came here and all of a sudden I thought...and so it just made me nervous to speak to people, really.

And I suppose it still does, a bit. I just found it very difficult to take part in it because, again, I just thought that the language and everything was so high powered that I was just...I had nothing to contribute. Whatever I'd say, somebody would alter the way I would say it and I'd feel totally squashed. [...] By the time the [assessment program for trained midwives] came, I found it quite difficult to even contribute in the sessions because I was so much aware of this "handicap" that I have. (Interview No. 12)

One woman, who had succeeded in becoming registered and who knew several people who had failed the PLEA, argued that a lack of white cultural competencies, including the ability to frame interactions within feminist terms and to display political sophistication, was a stumbling block for even the most experienced midwives:

Some of them [other midwives of colour] couldn't get through because of the way that they talked. I mean how you say it. It's not what you know, it's how you say it. I think that is the main problem. I mean like so many nurses who work in L & D [labour and delivery] are far better skilled than any of the midwives, I must say, but they fail. And yet they have been doing this...like [monitoring] fetal distress day in and day out. They fail on that. I don't believe it. It's because of the way that they project themselves. "No, this is not the way you speak to clients." [...] "Middle class, feminism, empower women's body" and all that is what they want also. It is their downfall. I still visualize being only a midwife and nothing more, but seeing how they work now, you're more than a midwife, you must be very politically-oriented as well. (Interview No. 10)

Several of the women interviewed indicated that the impression among immigrant midwives of colour was that midwifery was as an elite white profession geared towards a white clientele and was a milieu in which women of colour would not be welcome. One woman whose work and advocacy activities afforded
her contact with many immigrant midwives of colour described her sense of how Ontario midwifery was perceived among that group:

Actually, most of the people that I talked to they wouldn't even consider applying to do the midwifery even though they're midwifery-trained. Midwives [from the region from which she had emigrated] are double-trained meaning RN/midwife. And quite a few of them I know were on the labour and delivery. Cause I know one lady, she used to work at __________Hospital and she says that she would never want to do it. She thinks it's, is the word "preppy"? It's a different type of class she thinks who goes into do midwifery and the clientele also, she didn't think it was geared to the clients who would really, probably benefit from the midwifery experience. She didn't feel part of the culture. She didn't feel as if this was for her. Like it's a different class of people. (Interview No. 13)

Occasionally, reminders of non-belonging were overt. One woman interviewed, whose experience of a period of supervision in an all-white suburban midwifery practice was highly stressful ("I felt like garbage, like crap," she told me) related that she was told that she should try to advertise herself within her own ethnic community because the clientele in that practice were "too sophisticated" for her (Interview No. 10). Ironically, in 20 years of practice in her previous country of residence, she told me, she had never delivered a woman from her own racialized minority group. Resorting to repetition in order to emphasize its emotional impact, another woman described in great detail an overt reminder of outsider status to which she was subjected during an encounter with an official from the Prior Learning and Experience Assessment process:

I was stunned by the first question. [...] I sit down and no... no...no..."what's you're name?" and so forth and they say "where are you from?" I was stunned!! Where are you from? She lost me there. I'm sorry, I don't know how I come across to you but I was....really had an attitude. I said "where am I from?!" I'm sure I said it worse than that. I just did not expect that question. I don't know why. I just did not expect that question. And somehow that was the furthest thing from my mind. It stunned me. "Where am I from?! What do I say? Do I say, where I'm living here in Canada?"
Do I say where I'm from in [her country of birth]? Do I say I'm a Canadian citizen? Cause I'm sort of used to that type of question. But it is an illegal question, you don't ask people that. I just thought "this is so inappropriate, what does this have to do with this [event]?" I'm not the only one who feels this way, you know. The girl, who came after me in line she found out and said "you were angry" and I said "Oh my God, did it show?" I was angry! I just feel that, oh yeah, I'm failed now because I know I answered the question but I just had a stiff back. Because I spontaneously said, "where am I from?! And I actually did this, as to say "why are you asking me that?" and "how dare you ask me that?" and "what has this got to do with this [event]?". Anyway, I did answer. I said "I'm a Canadian citizen, I'm originally from , and I live in ,", whatever. I don't remember if I said that, but I know I said "I'm a Canadian citizen and I'm originally from ", yeah. Maybe I said three things. But that just threw me off. I just didn't think it was an appropriate question and especially when it comes...we are sort of...I don't know, it's like...a racist question. It is a racist question; that's the best way I can describe it. I was uncomfortable and that's when I know that something is not nice. And I felt very uncomfortable. That's the best way to put it. (Interview No. 13)

Having entered this particular midwifery-related event prepared to emphasize her expertise (she is a native English speaker, trained midwife and seasoned Canadian medical worker) this woman is assaulted with that oft-employed Canadian weapon of othering "where are you from?" "To exist," writes Homi Bhabha (1994), "is to be called into being in relation to an othemess, its look or locus" (p. 44) and arguably the question "where are you from?" performs the "call" in the incident narrated above. The question operates as an engine of differentiation, simultaneously installing the two women in positions of dominance and subordination in relationship to belonging inside the Canadian nation, and inside the midwifery profession. For the white interviewer, the convergence of race and difference is activated when the body of colour enters the room. The question "where are you from?" guarantees that the woman of colour is "sealed into...crushing objecthood" (Fanon, 1992, p. 220) in which her status as immigrant person of colour, and the inferiorizing discourses which attach to that status in Canadian society foreclose prior claims to subjecthood. However, this woman refuses to be sealed into this space on the margins. She realizes the
costs, but feels compelled, nonetheless, to exert her subjecthood in the form of a claim to Canadian citizenship as an overriding marker of her identity. An incident such as that described above may appear accidental but cannot be construed as innocent. Rather, it is an indication not only of how the "racializing evaluations" cited by Goldberg in this chapter's opening epigraph are used with seeming impunity in everyday situations, but how state institutions such as midwifery help regulate subjects as hierarchically positioned citizens in a world of global migrations (Ong, 1996).

Do white immigrant midwives fare better in the PLEA process than their racialized minority colleagues? Anecdotal evidence about who has successfully completed the PLEA process suggests that this indeed the case. At least one immigrant midwife of colour interviewed, a woman who had successfully completed most of the PLEA program, believed that for British trained midwives of colour, the process had been more difficult to navigate than it had for white British midwives. As Philomena Essed (1991) notes in her study of Black women in the Netherlands and the U.S., racialized minority women only name an experience as "racism" after every other explanation is rejected as inadequate. Like Essed's subjects, and like other women interviewed for this study, the woman quoted below is hesitant to identify the difficulties of immigrant midwives of colour with racism. However, she ultimately sanctions this explanation because no other interpretive schema can account for the difference she perceives between the experience of women of colour and that of white women immigrants from the U.K. 112 This woman, who has had extended contact with

112 I can only offer a crude conjecture about the source of such a hesitation. The British National Health Service (NHS) has faced numerous charges of racism in recent years. While 8% of nurses and midwives in the NHS are racialized minority people, they rise much more slowly in the nursing hierarchy than do their white colleagues (Beecham, 1995) and few rise to managerial positions (Rashid, 1990). A recent article which reported on unions' and professional associations' testimonies about racism in the NHS claimed that "Parents are telling their children not to follow them into the NHS. It has a bad reputation because of the way it treated people. Black health service workers are demoralised and disillusioned with the NHS and they are not convinced that their voices are being heard" (Watson, 1998 p. 5). It would be difficult, I believe, having left a racist
PLEA participants, offered the response below when asked whether she thought that for some people the PLEA process had been relatively unproblematic:

I've spoken to a few. I've spoken to a few who said it's OK [...] Yes, yes, white British women. And they came over very confident, very masterful people. And they're the kind of people I see within the profession at the moment, very...almost militant kind of people, you know. Yes, I mean the girls who I ask them what the process is like "it's ok, you'll be fine". And "it was piece of cake, it was just a matter of waiting." [...] I have to say. And I don't want to say that that's a definite...that there's definite discrimination on their part, but it's very odd that all the...I would say three quarters of the midwives who expressed dissatisfaction with the process or had problems with the program have been women of colour and then ones that have shown really positive and have found the process not a problem have been white. Definitely for me. And I wasn't looking for that. I wasn't particularly looking for it so it's got to be. (Interview No. 7)

Narratives of Resistance

Despite the fact that anti-racism initiatives have been launched to confront inequities in Ontario's health care system, a concerted political effort to counter marginalizing practices has not yet been organized by, or on behalf of, immigrant midwives of colour wishing to become registered in the province. Indeed, as I posited in the introductory chapter, open resistance to these practices might jeopardize the professional futures of immigrant midwives of colour. However, as Chandra Mohanty (1991) argues in the opening epigraph, resistance to domination must be understood to occur in forms other than employment situation, to have to face its replica in one's new country of residence, particularly when that country is touted, as is Canada, as a tolerant multicultural state.

conscious articulation or organized protest, and evidence of resistance needs to be sought in everyday practices. Some of these practices, as Gayatri Spivak (1988) has shown, constitute forms of subaltern speech. However, all speech, claims Spivak, "entails a distanced decipherment by another, which is at best an interception" (Spivak, 1999, p. 309). I am in no way positioned to intercept all evidence of resistant behaviours engaged in by the immigrant midwives of colour interviewed here. In fact, it is likely that quite the opposite is the case. Because of my dominant positioning in the racial hierarchy, many resistant behaviours and attitudes, no doubt, were never shared with me. Despite "studying to be political" (Spivak, 1999, p. 378) about the ways that race structures global, local, institutional and interpersonal dynamics, I am probably not positioned to see many of elements of resistance that were in fact articulated in the interviews. However, I feel compelled to devote some of the pages of this chapter to highlighting those forms of resistance which I have attempted to intercept. I do so in order to bolster Mohanty's claim that interpretations of resistance, agency and sociality must be broadened so that we may see a wider range of actions as constituting resistance to marginalization.

A few resistant behaviours have already been described. For some women, agreeing to be interviewed for this thesis constituted a form of resistance and they offered their narratives as a way to redress, in a public way, some of the wrongs they had themselves experienced. The women of colour who sat on midwifery boards frequently resisted the agenda of white midwives and midwifery activists by arguing for attention to issues of language and access. Immigrant midwives of colour also offered resistant narratives in which they used North American childbirth reform discourse to frame their own skills and experience, rendering this expertise commensurate with that of women trained in Ontario. And many, if not most, of the women interviewed continued to refer to themselves as midwives even though the use of that title is proscribed by law for those not registered with the College of Midwives of Ontario.
I believe that resistance inheres in the very willingness to offer a narrative which challenges the "heroic tale" that dominates public discourse around midwifery in Ontario. Indeed, while many spoke of their admiration for the midwifery project and for those who brought it to fruition, no immigrant midwife of colour interviewed for this study spoke in positive terms when asked the question: "Can you tell me about your experience with the PLEA?" The narratives were organized entirely around experiences of exclusion, marginalization, and frustration. As one woman who dropped out after completing a significant portion of the PLEA summarized it, the process was "tough, expensive, time-consuming, stressful and degrading" (Interview No. 3). Several of those interviewed offered broad criticisms of exclusion in the registration process. The women often projected beyond their own experiences of marginalization to encompass those who had access to fewer resources (money, facility in English, etc.) than they did. The woman quoted below, herself a native English speaker, cited the wasted expertise of those whose ambitions were thwarted because of inadequate performance on the initial language exam. Indeed, she disputed Ontario midwifery's claims that it is seeking a diverse pool of care providers:

There were a few people who were in the same situation as me that English was their first language. And there were some people there that English wasn't their first language but I felt they were fluent enough in English to be able to pass the test, I felt. And also I feel that to pass an English proficiency test was a very...if they wanted people from diverse backgrounds, as they say they do, and you know I just feel that the language proficiency test was actually a way of excluding a lot of people. Because even if your first language wasn't English, then if you had the knowledge and the skills and the wherewithal to pass the rest of the assessment that you need to without that, then I feel that the better for the profession because you need people that have more than one language. Or maybe their English isn't as strong but they're talented and they're good midwives and they can go through the process without maybe having fluent English or can kind of...I don't know what they were expecting really. I just felt that it excluded. Because I was told that half of the people failed and I was surprised about that. (Interview No. 7)
Asked why she thought the numbers of immigrant midwives practising in Ontario were so meager, another PLEA candidate interviewed accounted deftly, in the quote below, for numerous aspects of exclusion, including lack of financial resources and the need for candidates to possess cultural competencies associated with dominant groups. A recognition of processes of racialization also inheres in this quote as this woman criticizes the failure of Ontario midwifery to find Third World “grass roots” midwifery practice - that is community based, client centered, low-technology midwifery - commensurable with "grass roots" practice in Ontario. "Grass roots" status, she implies, is only valued when it describes the origins of white women's activism:

It's upper middle class people who really started this movement. According to my memory, readings. Number two, in the first set of recruitments, they eliminated outsiders. Why they're not there, you're asking? I don't know if I'll finish the process because of finance. I'm working, I have a son. I have my commitment, I have a mortgage. So finance. We're not rich people. I'm thinking about myself here. I'm working, I have to concentrate on my job. It's not like I'm going to go half a day here to study. [...] Yeah it's the whole sort of background development. You know, although it's grass roots, for us in [her region of origin] and it's even mentioned, midwifery here is mentioned as grass roots. But what type of grass roots? You know! (Interview No. 13)

Resistance to exclusion can be seen not just in narratives but in women's actions as well. In marked contrast to the Midwifery Education Program which fosters community-building among students through a week-long intensive residential workshop at the beginning of the program, as well as through student organizations and everyday contacts, the PLEA process was described by participants as isolating, offering little that would allow women to connect. Nonetheless some women attempted to build contacts among PLEA participants and personally collected names and addresses of other women of colour they met at AOM or PLEA activities. The woman quoted below made such attempts and hints that while little
has come of her efforts so far, the potential for mobilizing women of colour exists:

When I go to these (PLEA) things I try to take down names, as many as I can so I have names, but we've never done anything with the names as such. Like yesterday I talked to somebody that I met there. But in terms of group activity there hasn't been much. But some people are really stressed by this situation, I feel, and maybe I'm wrong, that they have the energy and it's not being used. [...] They should be given a medium. (Interview No. 1)

The circulation of stories of racism and exclusion constituted another resistance strategy. One women described in detail the rumours of racism within Ontario midwifery that she encountered in 1996 while attempting to maximize her knowledge of childbirth issues through volunteering in labour and delivery departments, attending conferences, and enrolling in academic courses related to women's health:

I attended many conferences that year, I went to Hospital's two conferences that dealt with women's health and one at the Convention Centre. So most of the time, whenever I met other women in other positions, especially in the childbirth field, or in (hospital) birthing areas, they talked about this, and from other midwives too. Other midwives who have chosen now to practise nursing instead of midwifery. They were saying that because "we are"...like the ones I knew were from maybe the Caribbean and Guyana and Jamaica, so most of them were black, so they told me that "because we are black and although we have good experience, they don't want us to go [into midwifery]. And I did a women's health course and I did research actually about midwives and I found that it wasn't just me, that I'm not the only one struggling to get through the PLA. (Interview No. 9)

The discussions of racism that she encountered actually discouraged this woman, who held a recently acquired baccalaureate degree in midwifery from her country of origin, from continuing to pursue registration after she discovered that her PLEA application had been lost by the College of Midwives. As discussed in Chapter Three, such bureaucratic errors are likely not intentionally
racist, but may be interpreted by racialized minority people as discrimination because of both previous experiences of racist treatment and historical records of exclusion in Canada. While at the time, the woman quoted above did not attach racist meanings to her experience with the College of Midwives, circulating discourses of racism about midwifery in Ontario engendered in her a great reluctance to challenge the bureaucracy that had curtailed her efforts to become registered. As a practising Muslim, this woman always wore a head scarf in public and she was reluctant, for that reason, to appear in person at the College of Midwives to argue her case:

That was one of the reasons that I didn't push that hard. At the time, I was wearing a religious head covering, right? So maybe I didn't have the strength to go ahead because maybe that would be like one of the things, if they are saying that racism is going on you know, against women of colour...that was one of the things that has taught me not to go forward. (Interview No. 9)

The circulation of stories describing the midwifery apparatus in Ontario as unwelcoming to women of colour can be seen as a resistance strategy aimed at warning those who might seek registration against the marginalizing behaviours that they could encounter in the PLA/PLEA. This raises once again the issue of how subaltern speech is intercepted and by whom. The small numbers of women of colour who have succeeded in the PLA/PLEA, and the program's high attrition rates may be attributable to structural obstacles such as those described in Chapter Three. However, non-participation must be also read as a form of speech which proclaims to whomever is listening that participation in a process that might yield significant rewards may simply not be worth the price of enduring the practices of racist exclusion

**Conclusion**

In this chapter I attempted to trace some of the microprocesses of white dominance which have regulated the participation of women of colour in the
establishment of a revitalized midwifery profession in the province of Ontario. I have also attempted, from a vantage point delimited by privilege, to discern some of the resistance strategies employed by those interviewed and others whom they represented in their narratives. What requires foregrounding here is that in the presence of a significant convergence of philosophy, experience and education, evidence of the incommensurability between midwives of colour and white midwives was persistently produced not only through policy, but through everyday encounters between women of colour and white women engaged with midwifery in Ontario. The grounds for these claims of incommensurability include the lack of a variety of cultural competencies and inadequate knowledge of local practices and sensibilities which were much more easily available to white midwifery aspirants in the province than to immigrant women of colour. Indeed the public articulation of a white racial identity as midwifery's norm was so loud that many women of colour who had had little contact with midwives or the midwifery apparatus in the province perceived themselves as unwanted on midwifery's journey and chose not to attempt the registration process. The triumph of white women's formulation of midwifery norms and practices was guaranteed by the minoritization and tokenization of women of colour who attempted to make midwifery practice and service more accessible to racialized minority women in the province.

Seeing the face of racial dominance is a daily occurrence for most people of colour in white majority contexts. For the racially dominant, however, not seeing how such dominance operates unintentionally through the deployment of "epithets, glances, avoidances, characterizations, prejudgements, dispositions, and rationalizations" (Goldberg, 1993) is also an everyday occurrence. It has been my intention in this chapter to bring white midwifery's illusion of innocence into conversation with the evidence of harm articulated through words and actions by women of colour who have met the face of their/our dominance. It is difficult, if not impossible, in the presence of such evidence, to claim that racist effects do not attach themselves to acts which can be rationalized as unrelated to
racialized forms of power. "The question," argues Leslie Roman (1993), "is not whether the subaltern can speak. Instead, it is whether privileged...white groups are willing to listen when the subaltern speaks, and how whites can know the difference between occasions for responsive listening and listening as an excuse for silent collusion with the status quo of racial and neocolonial inequalities" (p. 73)

The challenge for those who wish to interrupt such circuits of power is to begin to see those moments when racial meanings are mobilized in and through seemingly neutral acts. Racially dominant people can learn, argues Alison Bailey (1998), "to think and act not out of the 'spontaneous consciousness' of the socially scripted locations that history has written for us, but out of... traitorous (privilege-cognizant) scripts" (p. 7). Such scripts can never be crafted in isolation but must be authored in partnership with marginalized people and through engagement with theories of anti-subordination which are rooted in collective struggle.
Chapter Seven

Conclusion

[The important question...remains whether the emancipatory impulse of feminism can only become possible through the construction of unequal subjects...]

Inderpal Grewal (1999)
"Women's Rights as Human Rights': Feminist Practices, Global Feminism, and Human Rights Regimes in Transnationality"

This thesis began with a question: how, given their numbers in the population, did immigrant midwives of colour come to be under-represented in Ontario’s newly legalized midwifery profession? This question has important implications beyond the immediate context of the research for at least two reasons: 1) There is an urgent need to determine whether, as Inderpal Grewal suggests in the above epigraph, feminist emancipatory projects require hierarchical relations. In other words, does the advancement of white women hinge on the continued subordination of women of colour? and 2) If under-representation such as that described in this thesis is not natural or inevitable (“all immigrants require a catching-up time" “things are fundamentally different here”) then what are the practices that bring it about?

It is the mapping of these practices and of their linkage to a problematic race-blind epistemology that has been the key accomplishment of this thesis. The exclusions mapped here, I contend, were produced through a race-blindness reflected in the notion of universal womanhood, and through a variety of micro- and macroprocesses, which, in the absence of any recognition of how racial dominance works, served to subordinate women of colour.
Race blindness, I would argue, enabled almost every exclusionary policy and process documented in these pages. The clear message that this thesis conveys is that when race is not addressed directly and consistently as a factor which operates in a daily and unerring way to give women different and unequal lives, then racism inevitably is reproduced. Because the Ontario midwifery movement understood its project as one which would benefit all women equally, it could and did avoid recognizing that women's stakes in the politics of midwifery reflected the ways in which they were positioned by race. Indeed, messages which emphasized that race mattered, even when spoken directly by racialized minority women, remained inaudible to those who pursued the re-emergence of the profession. As a consequence, the movement to legalize midwifery could not and did not avoid enacting racist exclusion.

Documenting the macroprocesses and microprocesses which produce and reproduce inequality has been key here. As many scholars have argued and as I have detailed in Chapter Two, white women's mobility in the West has been enabled by the available labour of Third World migrant women who are often channeled into jobs in the labour force which white women have abandoned. This process frequently involves the significant deskilling of migrant professionals. The presence in the health care sector in Ontario of substantial numbers of immigrant women of colour and the exodus from nursing of non-immigrant women is a case in point.

It is clear that the midwifery apparatus has participated in this deskilling of immigrants of colour and in the ongoing construction of a local racial hierarchy, by putting into place policies which rendered the professional training and other competencies of immigrant women of colour inadequate. Even those midwives of colour who had extensive and parallel professional preparation in their countries of origin, who spoke English as a first language or adequately as a second language, and who had had unblemished midwifery careers - sometimes of more than twenty years duration - found that the exceedingly high cost of assessment
procedures, the demands for additional baccalaureate credentials, and requirements in terms of time away from work and family, made the continued pursuit of a midwifery career in Canada untenable. As I have noted, only two of the ten women interviewed who had participated in the PLA/PLEA process have become eligible for registration.

Resources such as financial aid, and personal and academic support systems such as those which were developed for the largely white student body who are being groomed as the “ambassadors to the profession,” have been glaringly absent from the process through which immigrant women of colour must pass in order to resume their professional status as midwives in Ontario. Immigrant women of colour who have chosen to participate in this process have encountered numerous additional obstacles. These have included: a frank lack of access to practicing midwives in the province and to relationships where knowledge of local conventions of practice might be acquired, reinforcement of their outsider status through references to national origin and to “inadequate” cultural competencies, and bureaucratic errors and delays which are not infrequently interpreted by women of colour as discrimination because of previous individual experience or because of people of colour’s generalized recognition and acknowledgement of the connection between such practices and everyday racism. Never intentionally racist nor clearly discriminatory by liberal standards, these practices and policies nonetheless have created racist effects because their impact was more perceptibly negative for women of colour than it was for white women.

Beyond the thesis research

Every thesis project must necessarily be limited in scope. And while the vision from a given social location undoubtedly limits scope, so do material constraints on the collection and interpretation of data and concerns with keeping the research sufficiently focused so as not to interrupt the flow of the developing
argument. Indeed, the work at hand suffers from all these limitations. I would like, therefore, to touch briefly on two topics which I consciously did not undertake to develop, but which might have enhanced this thesis and might fruitfully be explored in the future. In regards to those omissions that are beyond my conscious intent, I eagerly await the critical responses of future readers.

Data about white immigrant midwives, including those from Eastern, Southern and Western Europe, were not included in this study. However, anecdotal evidence indicates that this group has been more successful in entering the midwifery profession in Ontario through the College of Midwives’ Prior Learning and Experience Assessment program than have women of colour. It is possible to speculate that the experience of “near white” groups such as Eastern European immigrants might yield particularly interesting data on how race operates to produce exclusions and inclusions. Indeed a more detailed comparison of how white immigrant women and immigrant women of colour have fared in the PLA/PLEA process could shed light on the processes through which white immigrants make social and material gains which, as recent research definitively demonstrates, situate them far more advantageously in the Canadian social matrix than visible minority immigrants (Lian & Ralph, 1998).
Insurgent possibilities: How things change

Full of voice, she slipped out of the velvety darkness that was her mother's womb, into the light. I was overcome. I watched as Qwyn, this tiny golden-umber coloured soul, caught by an opaque rubber gloved doctor, in a white coat, was separated from the placenta and bundled into blanched cloth. I stood there for a moment and wondered how she would come to know of herself, blinded by the glare of snow? What would this fair world tell her? I experienced such a sadness for her – or maybe it was for myself.

Djanet Sears (1997)
"Notes of a 'Coloured Girl...' 32 short reasons why I write for the theatre."

Finally, I would have liked to explore some of the insurgent, recuperative, and anti-racist possibilities of a racially diverse midwifery community. While avoiding essentialized notions of female identity and questionable metaphysical spaces, I want to stress here that the event of birth is a critically important one. Whose reproduction is supported and celebrated and whose contained and regulated should be a pressing question for those doing research at the nexus of race, gender and nation, as well as for those who care about the pernicious effects of racism. If, as I have argued, racist culture is alive and well in Canada, then it should not come as a surprise that the act of producing racialized minority babies within a white majority society, might engender no less an uneasy white response than does the entrance into Canada of immigrants of colour. Indeed, there is convincing evidence that women of colour endure

specific forms of gendered racism when they deliver their babies in Canadian hospitals.\textsuperscript{115}

I have no clear ideas about how racialized minority midwives might be able to use midwifery care in order to mitigate the transmission of messages of white moral authority and cultural dominance which are encoded during birth. I do, however, continue to have faith in the model of a community-controlled (acknowledging the many erasures that the concept of "community" enacts) out-of-hospital birth centre which might have pursued hiring policies and adopted practices which privileged rather than penalized immigrant midwives of colour and could have provided a very public site for consciously reconfiguring the childbearing experiences of marginalized women. It is my belief that having few immigrant midwives of colour makes the possibility of recuperating birth from racist practices less likely. This, I would argue, renders the midwifery establishment complicit in a system of racial dominance which, as Djanet Sears describes so poetically and so tragically above, leaves its imprint from the moment of birth.

\textit{Accounting to the research subjects}

The question of complicity must also be raised once again in relationship to my own participation in the systems of domination and subordination outlined in this research. In one of the interviews which I conducted with immigrant women of colour, I became the object of a surprising reversal when the interview subject began to interrogate me. In the transcript segment below, I am held

\footnote{\textsuperscript{115}In ten years of teaching childbirth education courses in urban hospitals in Toronto, I witnessed significant evidence of medical racism in which the reproductive lives of racialized minority women were the subject of pejorative commentary and women of colour frequently were the victims of aggressive and sometimes violent intervention. For visible minority women's descriptions of their experiences of such racism, see Jiminez, M. (1991). Teniendo a mi hija (Having my baby). Healthsharing, Fall, 1991, 19-20, and Patel, S. & Al-Jazairi, I. (1997). Colonized wombs. In F. Shroff (Ed.), \textit{The new midwifery: Reflections on renaissance and regulation}. Toronto: Women's Press.}
accountable for my positioning and for the benefit that the research will yield me, and am forced to explain in detail my own motivations as well as the intentions of my project:

**Interviewee No. 10:** The only reason, I agreed to do this interview is that...the paper that you sent me showed that you're not biased...you know after reading part of the paper and I thought "who is this Sheryl?" If she's white, why does she have to speak up for these ethnic minorities? This intrigues me! That's why I wanted to meet you! What advantage or benefit will she get out of this?

**Sheryl:** That's a very important question that you're asking.

**Interviewee No. 10:** So, this is the thing, I mean, what is there in it for her? Is she doing it genuinely or is she doing it for something else? I'm being honest. This is my honesty.

**Sheryl:** They are very important questions and they are questions that I need to answer. [...] 

**Interviewee No. 10:** I thought well maybe there's some advantage. Is she going to pursue some other career? I'm being honest.

**Sheryl:** And I think the honest answer is yes. [...] There's no question that doing this work gets me a Ph.D., which may or may not get me a job teaching, which is a very prestigious job and there is a kind of a fad now for anti-racism stuff. They want somebody who knows about racism. And it gives me an advantage to be doing this kind of work as opposed to doing something more traditional, standard, right? [...] 

**Interviewee No. 10:** Because you can do any other topic, other than racism.

While I endeavoured to address some of these challenges in the introduction to this thesis, this woman's questions assume an increased saliency and an even greater urgency as this thesis project comes to an end. My focus must, in this phase, shift from a concern with textual strategies of accountability to a quest for more perceptibly material ones. The woman interviewed above asks if my engagement with this research is a "genuine" one and I interpret
genuineness here to mean a commitment to circulating the data effectively as a tool for change rather than using it only as an instrument for professional/personal advancement. How, it must be asked, do I envision my responsibility for the knowledge which I have produced in these pages? If this thesis is not to serve simply as a vehicle for conferring status and authority on its author, and for positioning white people once again as “the heroic agents of racism’s decline” (Weigman, 1995, p. 2) what course should be pursued? I can only suggest here some of the ways that I can carry out the promise of accountability with which I undertook and negotiated interviews with all of those who, by agreeing to be interviewed, took not inconsiderable risks.

First, I must emphasize that after the anti-oppression theories have been foregrounded, the unanticipated connections traced, and the broad conclusions drawn, nothing about the relationships of inequality described here can be said to have changed in any substantial way. We are left instead with an identifiable set of unequal relationships, attendant material inequities, and a trail of individual and collective indignities whose resolution is not accomplished through even the most thorough cataloguing. Interventions such as this one can only hope to have effects if they receive enough public exposure to actually interrupt circulating discourses and fragment their seamless tales. Consequently, I do have a responsibility to make sure that those who might be able to use this thesis for transformative purposes are able access its contents. The data contained here, for example, may be of use to community activists and those in non-governmental agencies who struggle with equity issues related to foreign-trained professionals. It is clear that prior learning assessment programs, while ostensibly more flexible and equitable than other forms of credentials assessment, are not exempt from racist processes. Some of my work might provide ways of talking about the racist effects of bureaucratic procedures and intersubjective encounters on immigrant people of colour who seek such assessment. I also believe that insurgent voices in the midwifery community require the documentation of racist and other exclusionary processes that this
thesis offers in order to concretize a public struggle for equity that might redress the inequities of the last several years and pave the way for future policies which do not create exclusions.

There is a final reason which makes distribution of the findings of this thesis critically important if I am to be accountable to the women who have participated in this research. As I have noted, my intent here has been to bring Ontario midwifery’s illusion of innocence into direct contact with evidence of the harm that racial dominance enacts. It is my perhaps naïve assumption that the white midwives and their supporters who have been heedless of the resistant behaviours of women of colour, might be more attentive to evidence of an academic and “scientific” nature. I admit, however, to being largely pessimistic about the possibility of any official/institutional reconsideration of the process through which midwifery has re-emerged and through its relationship to racialized “others.” However I believe that what I owe those who shared their stories with me is to establish an historical record (with all its conscious and unconscious constructions and omissions as well as its positioning within dominant epistemological frames) which makes continued ignorance of racist exclusions and other inequalities a form of willful ignorance and which consequently renders ongoing discriminatory practices volitional and indefensible.

A final word: accounting for our “bloody genealogies”

In response to Inderpal Grewal’s question in the opening epigraph of this conclusion, I must answer that the evidence gathered here substantiates her suspicion that feminist imperatives are impossibly modernist constructs firmly grounded in the construction of unequal subjects. Unequal relations between immigrant midwives of colour and white midwives, and between Third World women and Ontario midwives, remain firmly in place even as the re-emergence of midwifery is hailed as a “victory for women.” Such an outcome, it seems, is
unavoidable when, in the course of formulating our feminist projects, those of us in dominant positions insist on our innocent positioning, failing to account for what Jane Flax (1998b) has deemed the "bloody genealogies" (p. 142) of our subjectivities. If there is even a glimmer of hope for constructing political projects which do not reproduce hierarchical relations among women and other pernicious effects of modernity then such genealogies and the material and discursive conditions from which they spring must be the subject of a painful but necessary accounting.
Bibliography


Ontario Interim Regulatory Council on Midwifery (1991a). Equity Committee meets special groups face to face to research midwifery needs. The Gazette 2(1), 5.


Ontario Nurse-Midwives Association (n.d.) Pamphlet: For your information.


Appendices

Appendix A - Information letter for research participants

Date

Dear (name of potential participant).

I am a student at the Ontario Institute for Studies in Education of the University of Toronto currently working on my Ph.D. thesis entitled "Obstructed Labour: Race and Gender in the Re-emergence of Midwifery in Ontario." In my work, I am researching how different groups have participated in, and benefited differently from, the movement to legalize midwifery. This letter is intended to invite your participation in an interview which will provide material for part of my thesis.

Participation in this research will allow you to contribute to an interpretation of the history of the midwifery movement. If you have played a policy-making role, it will offer you a chance to interpret why and how various decisions impacted differently on different social groups. If you have an interest in practising midwifery and have not been given an opportunity to do so in the province, participation in this research offers you a chance to discuss your relationship as a trained midwife to the process by which midwifery has become legal and to discuss the current state of midwifery in the province as it affects you.

While I myself am a long-time supporter of the midwifery model of care, and this study is not intended in any way to raise doubts about or to undermine the importance of that model, it will raise questions as to how successful the midwifery movement in Ontario has been in making midwifery practice accessible to a diverse group of women. It is important for you to know that your participation will contribute to an analysis which may be critical of the political decisions of the midwifery movement.

If you agree to be interviewed, you will be asked to sign a "Letter of Consent to Participate in Research" in which you agree to have any remarks you may make in the interview recorded and used in my thesis and in any articles or books I may write about my work.

Prior to the preparation of the thesis, you will be sent a transcript of the interview and if you feel that your views have not been accurately represented on the tape, you may contact me so that clarification can be made. Your anonymity
is of utmost concern to me and I will take special precautions not to include information which would allow you to be identified in my work unless you choose to be identified. Using categories that I provide, you will be asked to indicate on the transcript how you would like me to identify the source of all quotations that come from our interview. Upon completion of the thesis, I will be happy to make a copy available to you, if you so wish. It is important to understand that while I undertake to express your ideas accurately, the written report of this research may contain criticism of your opinions or remarks.

At every point, your anonymity will be maintained. Copies of the questionnaires, tapes and transcripts in my possession will be kept locked up and may only be accessed by myself and Prof. Sherene Razack, my thesis advisor, and members of my thesis committee, Prof. Ruth Roach Pierson and Prof. Kari Dehli. These documents will be labeled with code names which will also be used to refer to you in any written report. At your request, your contribution can be deleted from the tapes and transcripts following the submission of my thesis. You may withdraw from the study at any point.

Please accept my thanks for your willingness to participate in this project.

Sheryl Nestel
50 Ellsworth Ave.
Toronto, Ont. M6G 2K3
(416) 658-3135
e-mail <snestel@oise.utoronto.ca>

Dept. of Sociology and Equity Studies in Education
Ontario Institute for Studies in Education of the University of Toronto
252 Bloor St. West.
Toronto, Ont. M5S 1V6
Appendix B – Poster posted in two Toronto hospitals’ labour and delivery departments soliciting study participants

Are you a trained midwife from the Caribbean, China, the Philippines, Africa, the Middle East or South Asia?

I am a doctoral student at the University of Toronto doing research for my dissertation which analyzes barriers to access to the midwifery profession in Ontario. I am interested in interviewing women trained in midwifery from the Caribbean, China, the Philippines, Africa, the Middle East or South Asia. I am particularly interested in interviewing labour and delivery/postpartum nurses who have interacted with Ontario-trained midwives over the past ten years.

Interviews typically last 1-1 ½ hours, are tape recorded and can be conducted anywhere and at any time which is convenient to you. Extreme care is being taken to protect the identities of those interviewed. This research is supported by a Doctoral Fellowship awarded by the Social Science and Humanities Research Council of Canada.

If you are interested in contributing to this research, please contact:

Sheryl Nestel
Tel. (416) 658-3135
e-mail <snestel@oise.utoronto.ca>
Dept. of Sociology and Equity Studies in Education
Ontario Institute for Studies in Education of the University of Toronto
252 Bloor St. W.
Toronto, Ont. M5S 1V6
### Appendix C: List of Acronyms and Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AOM</td>
<td>Association of Ontario Midwives</td>
</tr>
<tr>
<td>CAC</td>
<td>Community Advisory Council (to the Prior Learning Assessment Program)</td>
</tr>
<tr>
<td>CDC</td>
<td>Curriculum Development Committee</td>
</tr>
<tr>
<td>CDN</td>
<td>Canadian Dollars</td>
</tr>
<tr>
<td>CMO</td>
<td>College of Midwives of Ontario</td>
</tr>
<tr>
<td>HPLR</td>
<td>Health Professions Legislation Review</td>
</tr>
<tr>
<td>IRCM</td>
<td>(Ontario) Interim Regulatory Council on Midwifery</td>
</tr>
<tr>
<td>MEP</td>
<td>Midwifery Education Program</td>
</tr>
<tr>
<td>MIPP</td>
<td>Midwifery Integration Planning Project</td>
</tr>
<tr>
<td>MTFO</td>
<td>Midwifery Task Force of Ontario</td>
</tr>
<tr>
<td>OAM</td>
<td>Ontario Association of Midwives</td>
</tr>
<tr>
<td>ONMA</td>
<td>Ontario Nurse-Midwives Association</td>
</tr>
<tr>
<td>OSCE</td>
<td>Objective Structured Clinical Examination</td>
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<tr>
<td>PLA</td>
<td>Prior Learning Assessment</td>
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<tr>
<td>PLEA</td>
<td>Prior Learning and Experience Assessment</td>
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<tr>
<td>RM</td>
<td>Registered Midwife</td>
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<tr>
<td>TC</td>
<td>Transitional Council of the College of Midwives</td>
</tr>
<tr>
<td>TECMI</td>
<td>Toronto East Cultural Mentorship Initiative</td>
</tr>
<tr>
<td>TFATP</td>
<td>Task Force on Access to Trades and Professions</td>
</tr>
<tr>
<td>TFIMO</td>
<td>Task Force on the Implementation of Midwifery in Ontario</td>
</tr>
</tbody>
</table>
**TOEFL:** Test of English as a Foreign Language

**VON:** Victorian Order of Nurses
Appendix D: Chronology of the re-emergence of midwifery in Ontario

1973
Ontario Nurse-Midwives Association (ONMA) founded

1976
Home Birth Task Force formed

1981
Ontario Association of Midwives formed (OAM)

1982
Coroner’s inquest into baby death in Kitchener-Waterloo area
College of Physicians and Surgeons of Ontario bans physician participation in home birth

Health Professions Legislation Review (HPLR) begins

1983
Midwifery consumer group, Midwifery Task Force of Ontario (MTFO) Forms
Joint submission of the OAM and ONMA to the HPLR

1985
Association of Ontario Midwives (AOM) formed through merger of OAM and ONMA
Coroner’s inquest into baby death on Toronto Island
HPLR recommends incorporation of midwifery into Ontario’s health care system

1986
Task Force on the Implementation of Midwifery in Ontario (TFIMO) appointed by Ministry of Health

1987
Publication of Report of the Task Force on the Implementation of Midwifery in Ontario
1989
Interim Regulatory Council on Midwifery (IRCM) appointed by Minister of Health
Curriculum Design Committee (CDC) appointed by Minister of Health

1990
First reading in the Ontario Legislature of the Midwifery Act
Midwifery Integration Planning Project (MIPP) launched

1992
Michener Pre-registration Program for practising midwives begins

1993
February - Transitional Council of the College of Midwives of Ontario appointed
September - Midwifery Education Program begins in three Ontario universities
Community Advisory Committee to the Prior Learning Assessment project established

October - 63 midwives graduate from Michener program
Committee for More Midwives organizes
Association for Philippine Midwives forms
December 31, proclamation of Midwifery Act, 1991
Transitional Council becomes College of Midwives of Ontario (CMO)

1994
First cycle of Prior Learning Assessment (PLA) launched

1996
First class of the Midwifery Education Program graduates

1997
Second Cycle of Prior Learning and Experience Assessment (PLEA) launched
Appendix E: Interview schedule for immigrant midwives of colour

1. Can you tell me something about your background - where and when did you grow up? Can you tell me something about your socio-economic and educational background?

2. When and why did you decide to become a midwife?

3. Can you tell me about the training process that you underwent to become a midwife? What is your personal philosophy of midwifery?

4. Please tell me about the work of midwives in your country of origin. How do they fit into the medical care system? Did you do prenatal and postpartum care? Did you attend home births?

5. When you came to Canada, did you know what the state of midwifery practice was at the time?

6. When did you first hear about the Ontario midwifery movement? What did you think about it at the time?

7. Did you ever participate in activities or organizations which worked for the legalization of midwifery in Ontario? If yes, which ones, when, and in what capacity? What was your experience of these organizations? If no, why didn't you participate?

8. Ivy Bourgeault (1996) has described an “elite” of midwives who were at centre of midwifery activism. How would you position yourself in relation to this group?

9. In the course of your involvement with midwifery in Ontario, do you recall the participation of other women of colour? What can you tell me about their participation?

10. Why did you decide to pursue/not to pursue registration? IF SUBJECT DID NOT PURSUE REGISTRATION GO TO QUESTION 13 OR, IF SUBJECT SOUGHT REGISTRATION OR HAD PRE-REGISTRATION EXPERIENCE:

11. Can you tell me how you came to participate in the Michener/PLA/PLEA? What was your experience of this process?

12. What percentage of your own clientele, in the years prior to legislation consisted of women of colour? Now?
13. Given the fact that nearly half of all the women who have expressed an interest in practicing midwifery since 1987 are visible minority women, how do you understand the current situation in which just 5% of midwives in the province are aboriginal women or women of colour?
Appendix F: Interview schedule for white “non-elite” midwives

1. Can you tell me something about your background - where and when did you grow up? Can you tell me something about your socio-economic and educational background?

2. When and how did you become involved in midwifery?

3. What was your experience of the Michener Institute integration project?

4. Is there anything about your personal style, your history, etc. that might be seen to be in conflict with the image that the midwifery movement has wanted to project since the struggle for legalization began?

5. Have you participated in any groups which have worked for the legalization of midwifery? Which ones? In what capacity?

6. How would you describe the people with whom you have worked in the midwifery movement? What demographic/social/educational characteristics did you seem to share? How did differences manifest themselves within the movement?

7. Ivy Bourgeault (1996) has described an "elite" of midwives who were at the centre of midwifery activism. How would you position yourself in relation to this group?

8. In the course of your midwifery activism, do you recall the participation of any women of colour? What can you tell me about their participation?

9. What percentage of your own clientele, in the years prior to legislation consisted of women of colour? Now?

10. Did you ever leave the country to gain midwifery expertise? Where did you go? Can you describe the setting, clientele, working conditions, etc.? How do you feel your experience influenced your status as a midwife in Ontario? Did you go abroad to obtain birth numbers for admission to the Michener Institute program?

11. Given the fact that nearly half of all the women who have expressed an interest in practicing midwifery since 1987 are visible minority women, how do you understand the current situation in which just 5% of midwives in the province are aboriginal women or women of colour?
Appendix G: Interview schedule for white members of midwifery bodies

1. Can you tell me something about your background and about what you do now?

2. Can you tell me about your relationship to midwifery in Ontario?

3. What bodies have you served on and when were you appointed to them? How did you come to be appointed? How long did you serve?

3. What specific issues were you involved with in the legalization process?

4. How did (body served on) understand the issue of "foreign-trained" midwives? Which committees/members addressed this issue? What positions did they take?

5. How, in your estimation, did the Task Force on the Implementation of Midwifery's recommendation that candidates for the Midwifery Integration Project (Michener Institute) be resident in the province for twelve months prior to the program get finalized as a requirement that midwives had to have practised in the province in the period prior to regulation?

6. What is your understanding of the professional and demographic composition of the IRCM/TC/CMO?

7. Were there specific issues relating to "equity" which arose in the IRCM/TC/CMO? What were they? Who raised them? How were they addressed?

8. Given the fact that nearly half of all the women who have expressed an interest in practicing midwifery since 1987 are visible minority women, how do you understand the current situation in which just 5% of midwives in the province are aboriginal women or women of colour.
Appendix G: Interview schedule for women of colour who participated on midwifery bodies

1. Can you tell me something about your background and about what you do now?

2. When and how did you get involved with the midwifery movement in Ontario?

3. Can you tell me about your participation? Did you go to meetings, etc? How often, where and with whom?

4. What were your expectations for the participation of immigrant midwives of colour in midwifery here?

5. Have you spoken with them about this process?

6. How do you explain their absence?

7. How do you think they should proceed; what might change things?