Alegal Midwives: Oral History Narratives of Ontario Pre-Legislation Midwives
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Elizabeth Mae Allemang
Humanities, Social Sciences & Social Justice Education
University of Toronto

Abstract
This study examines the oral histories of midwives who practiced in Ontario without legal status as a counter practice to mainstream maternity care in the two decades prior to the enactment of midwifery legislation on December 31, 1993. The following questions are answered: Who were Ontario’s pre-legislation midwives? What inspired and motivated them to take up practice on the margins of official health care? Current scholarship on late twentieth century Ontario midwifery focuses on a social scientific analysis of midwifery’s transition from a grassroots movement to a regulated profession. Pre-legislation midwives are commonly portrayed as a homogenous group of white, educated, middle class women practicing a “pure” midwifery unmediated by medicine and the law. Analysis of the oral history narratives of twenty-one “alegal” Ontario midwives reveals more complex and nuanced understandings of midwives and why they practiced during this period. The midwives’ oral histories make an important contribution to the growing historiography on modern Canadian midwifery.
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### Acronyms

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<td>AOM</td>
<td>Association of Ontario Midwives</td>
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<td>CAM</td>
<td>Canadian Association of Midwives</td>
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<td>CMO</td>
<td>College of Midwives of Ontario</td>
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<td>CNO</td>
<td>College of Nurses of Ontario</td>
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<td>CPSO</td>
<td>College of Physicians and Surgeons of Ontario</td>
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<td>HBTF</td>
<td>Home Birth Task Force</td>
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<td>HPLR</td>
<td>Health Professions Legislation Review</td>
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<td>ICEA</td>
<td>International Childbirth Education Association</td>
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<td>MANA</td>
<td>Midwives Alliance of North America</td>
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<td>MEP</td>
<td>Midwifery Education Program (Ontario)</td>
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<td>MTF-O</td>
<td>Midwifery Task Force of Ontario</td>
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<tr>
<td>MUMC</td>
<td>McMaster University Medical Centre</td>
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<tr>
<td>OAM</td>
<td>Ontario Association of Midwives</td>
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<tr>
<td>OMA</td>
<td>Ontario Medical Association</td>
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<tr>
<td>ONMA</td>
<td>Ontario Nurse Midwives Association</td>
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<tr>
<td>TFIMO</td>
<td>Task Force on the Implementation of Midwifery of Ontario</td>
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<td>VON</td>
<td>Victorian Order of Nurses</td>
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**Introduction**

In 1970s Ontario, midwives were visibly practicing without legal status in response to childbearing women’s desire for alternatives to mainstream maternity care. These “alegal midwives”\(^1\) were working on the margins of official health care, attending home births and providing midwifery care to a small but vocal minority of childbearing women.\(^2\) They were informed by similar practices of unofficial midwifery in other parts of Canada and the United States, as well as by international models of formally recognized midwifery. At the time of midwifery’s modern emergence in Ontario, Canada was the world’s only western industrialized nation and one of only nine World Health Organization member countries without legal provisions for midwifery.\(^3\) Societal knowledge about midwifery had been eroded by medicine’s growing monopoly in childbirth over the course of the twentieth century, even though this was not the first time midwifery was practiced in Canada.

Midwifery has a long, but discontinuous, history in Canada. Broadly defined as non-physician childbirth attendance, midwifery represented a central form of unofficial domestic health care prior to the rise of professionalized medicine and nursing.\(^4\) A growing body of historiography on Canadian midwifery documents diverse official and unofficial practices that flourished in indigenous and immigrant communities, despite midwifery’s incorporation into legal definitions of medicine as early as the late eighteenth century in Upper Canada.\(^5\) Historians have also documented diverse patterns of midwifery’s decline over the course of the twentieth century that accompanied significant shifts in the organization of maternity care. Midwifery failed to become an organized and recognized profession in Canada, as health care professionalized and modernized in the first half of the century, a situation unlike that of other industrialized nations. Childbirth was gradually displaced from the domestic sphere and relocated into a growing network of health care institutions that were staffed by medical and nursing health professionals. The medical management of childbirth increasingly relied on technological interventions. Public and professional confidence in scientific approaches to childbirth bolstered support for modern obstetrics as a superior form of care. Several prominent public health campaigns for midwifery’s legal recognition were unsuccessful early in the century, and renewed interest in public policy for midwifery in the 1960s similarly failed to secure legislative reform. Historians agree that midwifery was virtually non-existent in Canada.
by the middle of the twentieth century. Practices that persisted in remote regions of the country underserved by doctors or in distinct cultural and religious communities had all but disappeared by the early 1970s, the time of midwifery’s modern re-emergence.

The late twentieth century revival of midwifery in Ontario was rooted in national and international childbirth reform movements that re-configured childbearing as a normal and healthy life event, in opposition to biomedical discourse that viewed pregnancy and childbirth as pathological and potentially dangerous. “Natural childbirth” ideologies and practices that were developed by international obstetricians at mid-century gained popularity in postwar Canada. Natural childbirth reform advocates called into question the safety of obstetrical interventions for mothers and babies, particularly the routine use of obstetrical analgesia that dominated North American maternity care. Natural childbirth discourse promoted women’s conscious awareness at birth as medically and psychologically superior for mothers and babies because it facilitated maternal-infant bonding. The performance of natural birth was conflated with women’s essential maternal and feminine nature. Improved maternal and infant health outcomes and new psychological imperatives in childrearing practices prompted concern for the social experience of childbirth. The beneficial effects of maternal-infant bonding were extrapolated to the building of healthy families and communities that resonated with public desire for social stability and security following the war years. Natural childbirth’s claim to the “natural” romanticized “primitive” women’s natural childbearing capacity to give birth without the assistance of medical technologies, while overlooking the harsh realities of high rates of maternal and infant mortality among women living in low resource settings. Natural childbirth practices were based on childbirth preparation programs and labour support that were physician directed. Interested women, largely middle class and well educated, were taught psychological and physical techniques to cope with the pain of labour.

Although the practices of natural childbirth did not alter medical or institutional authority, they did offer women some degree of agency in being conscious for their babies’ births. As the ideals and practices of the natural childbirth movement gained popularity in 1970s North America, they became part of “family-centred maternity care,” mainstream maternity care’s response to demands for childbirth reform. Childbirth education programs proliferated, fathers gained entry to the delivery room to provide labour support, babies were able to “room in” with their mothers, and birthing rooms were remodeled to resemble home settings. Despite these
reforms and transformations to physical birthing spaces, medical procedures continued to dominate women’s experience of childbirth.\textsuperscript{14}

Dissatisfaction with normative maternity care’s continued reliance on the technological management of childbirth led some women, mostly of the white, middle class, to seek alternatives outside formal systems of health care. Social movements of the 1960s and 1970s influenced more radical challenges to medically-managed childbirth. Under the influence of sixties counterculture and second wave feminism, some women reclaimed the traditional practices of home birth and midwifery as a means to take control of their birth experiences and redefine medical and institutional practices that had come to dominate North American maternity care. Home birth was deeply intertwined with modern revivals of midwifery, as they were both seen to be compatible with counterculture ideals of self-sufficiency and natural ways of living and feminist ideals of female empowerment and resistance to male medicine.\textsuperscript{15} Women from a range of political and philosophic perspectives were attracted to home birth and midwifery, including traditionalists with conservative family values, women from distinct religious communities, and feminists seeking reproductive control and empowerment.\textsuperscript{16} Consumer-led home birth and midwifery movements were evident in western Canada, Ontario, and Quebec by the second half of the seventies under the influence of parallel movements that emerged in the United States earlier in the decade.\textsuperscript{17}

Women’s dissatisfaction with mainstream maternity care not only stimulated renewed interest in home birth and midwifery childbirth alternatives, it also inspired some women to learn and practice midwifery. Midwives with international credentials living in Canada lacked professional recognition and employment opportunities. Many internationally trained midwives also had nursing credentials that enabled them to work as nurses in the Canadian health care system.\textsuperscript{18} Women and men\textsuperscript{19} who grew up in North America, where midwifery did not have official status, lacked direct access to recognized midwifery training and practice. While some aspiring midwives accessed training and practice opportunities in North American settings with “home birth doctors”\textsuperscript{20} or practicing midwives attending out-of-hospital births, these opportunities were often scarce, informal, and outside of the law. The decision to work in illegal or alegal practice settings necessitated conscious intent. Practitioners faced challenging working conditions by practicing in a private model of payment on the margins of official health care, potentially facing possible legal harassment and criminal prosecution.\textsuperscript{21} These conditions limited
accessibility and consequently, midwifery was primarily taken up by women with social, racial, and economic privilege.22

Despite these limitations, a small number of midwives set up practices in their communities in a model of private payment or incorporated midwifery into their nursing roles in designated “extended role nurse” projects in select Canadian hospitals.23 Some midwives had formal training from outside Canada, whereas others found routes to informal training inside North America. It has been estimated that less than several hundred midwives practiced in Canada in the pre-regulation period.24 The absence of formal mechanisms to track practicing midwives or midwife-attended births in Canada during this time, as well as the lack of standardized definitions for midwife practitioners and midwifery practice, complicates these estimates. Reportedly high rates of practitioner turnover due to burnout from the demanding working conditions of illegal or alegal practice further exacerbate these uncertainties.25

After a decade of lobbying by midwives and their supporters, Health Minister Murray Elston announced the Liberal government’s intention “to establish midwifery as a recognized part of the Ontario health care system” in the provincial legislature on January 23, 1986.26 Elston appointed a four member interdisciplinary task force to determine how best to implement a system of midwifery in the province. The Task Force on the Implementation of Midwifery in Ontario investigated international midwifery models of education and practice, examined the state of midwifery in Canada, and held public hearings across Ontario to determine how best to structure a sustainable and effective midwifery profession. The recommendations contained in their 1987 report formed the basis for the framework of regulated midwifery in Ontario.27 Over the following six years, planning work was undertaken to prepare for midwifery’s integration into the publicly funded health care system. On November 25, 1991, Bill 56: An Act respecting the regulation of the Profession of Midwifery was passed into Ontario law as part a package of legislative reforms governing the provincial regulation of health care professions.28 Two years later, on December 31, 1993, Bill 56 came into force.

Ontario’s landmark legislation represented the first comprehensive regulatory framework for midwifery in the modern Canadian health care system. Approximately sixty midwives who had been practicing without legal status in the previous two decades were registered with the midwifery governing body to legally practice in Ontario on January 1, 1994.29 They qualified as Ontario’s first registered midwives by successfully completing a government sponsored
assessment and upgrading program at the Michener Institute for Applied Health Sciences in Toronto for midwives who were able to demonstrate evidence of active Ontario practice. With midwifery’s recognition as a self-regulating and publicly funded profession, midwives became an official part of the Ontario maternity care system as primary health care providers for “normal” childbearing women and their “healthy” newborn infants. Ontario was heralded in the health professions literature and the public press as the first province or territory in Canada to legally recognize midwifery. Ontario’s midwifery system has been internationally recognized as a model for midwives’ professional autonomy and for its woman-centred philosophy of care. The midwifery profession in Ontario has grown to almost six hundred registered midwives who attend over ten percent of births in the province.

RESEARCH QUESTIONS

A large body of interdisciplinary literature has been generated on Ontario midwifery’s transition from an unofficial practice to a legally recognized profession. Debates about the impact of midwifery’s changing legal status construct understandings of pre-legislation midwifery, largely through analyses of midwifery’s move from outside to inside the official health care system from a social science perspective. The lives of alegal midwifery practitioners are not well understood in the current record of pre-legislation midwifery. The archetypical midwife figures of counterculture mother and feminist activist that dominate Ontario and North American midwifery discourse do not adequately reflect the complexity of the interviewees and their lives.

Historical study of the pre-legislation period of Ontario midwifery is a new field of historical inquiry given its recent history. In order to better understand the Ontario midwifery revival and to contribute to the nascent historical record of this unique and transitory period of midwifery, this thesis considers the following questions: Who were the women and men who chose to practice midwifery in Ontario without legal status? Why did they become midwives? Oral history forms the central research method used to investigate these questions. Discussion and analysis of the oral history narratives of twenty-one midwives who practiced before legal recognition in Ontario provide an opportunity to learn about this period of midwifery history through the voices of the practitioners themselves. The midwives’ narratives are interpreted in relation to current theories of the Ontario midwifery revival that are contained in scholarly, professional, and popular literature.
RESEARCH RATIONALE

This research makes an original and significant contribution to the historiography of midwifery in Canada. The historical record on Canadian midwifery is a small but growing field of scholarly inquiry that theorizes midwifery’s past before its late twentieth century renewal. Documentation of midwifery’s modern re-emergence in Canada is preoccupied with its transition from a grassroots consumer-led movement to a regulated health profession in Ontario as the first province to officially recognize midwifery. Understandings of midwifery practitioners and why they practiced without legal status in Ontario are limited. Research examining midwives and their motivations to practice in home birth and midwifery revivals in other regions of North America are similarly limited. The oral history narratives of midwives who practiced in Ontario in the two decades prior to midwifery’s legal recognition constitute a primary body of research evidence that contribute to the scholarship of unofficial practices of midwifery in Ontario and, more broadly, in North America. This research is timely as some pre-legislation Ontario midwives are growing older and have retired or are nearing retirement. One interviewee passed away during the writing of this thesis.37

This is a unique and compelling period in the history of Canadian midwifery. The model of pre-legislation practice was foundational to the philosophy and structure of the regulated system of midwifery in Ontario and influenced the evolution of regulated midwifery in other regions of Canada. Historical investigation into midwifery’s past in Canada followed its late twentieth century revival, influenced by developments in the fields of social history and women’s history. Historical understandings of Canadian midwifery have evolved from early publications of the 1980s that established singular and heroic narratives of midwifery and its decline to more recent theories of multiple and varied histories.38 The historical record of Canadian midwifery continues to be informed by a growing body of research evidence; however, historical scholarship on modern practice revivals is largely absent. Although midwifery’s re-emergence and recognition in Canada are recent phenomena, the period of practice prior to Ontario’s legislative reform no longer exists and it is sufficiently distant from the present to make it a suitable field for historical investigation.

Little is known about midwifery practitioners and their daily lives, despite the enormous attention Ontario midwifery has received in the last two decades. While midwives have informed scholarship that accompanied and followed Ontario’s landmark midwifery legislation
as research subjects and in some cases as lead researchers, their personal and professional experiences have largely been interpreted by others through a lens of professionalization. The literature on modern Ontario midwifery that is dominated by contested debates about the impact of midwifery regulation, both from within and outside the midwifery community, is infused with a discourse of loss of midwifery’s outsider status. Although midwifery’s formal recognition was initially interpreted as a positive achievement for childbearing women and the midwifery profession, critical perspectives on midwifery’s professionalization were increasingly voiced by scholars and popular writers. Analyses of the perceived benefits of legalization, such as improved accessibility to midwifery care, education and professional registration, were overshadowed by concerns about the erosion of midwifery’s essential qualities as a counterculture alternative by its “incorporation” into formal systems of health care, education, and the law. Understandings of pre-legislation midwives have been shaped by these contested debates about midwifery’s changing legal status and the discourse of loss of midwifery’s outsider position. Midwives experiences as pre-legislation practitioners are under explored in Ontario midwifery literature, given the preoccupation with the impact of midwifery’s integration into the Ontario health care system.

This thesis uses an oral history methodology to document and preserve oral testimonies from midwifery practitioners themselves about who they are and why they practiced in the Ontario midwifery revival. The lens of investigation is shifted away from the period of transition to regulated practice and onto midwives’ experiences entering midwifery practice on the margins of the official health care. This thesis explicitly does not address midwives’ transition to regulated practice or midwifery’s professionalization, as these topics have been the subject of intense investigation. Its findings assist in filling gaps in the current record of pre-legislation Ontario midwifery that has largely been generated outside the field of history. They also add complexity to existing representations of midwifery practitioners that have been interpreted in relation to their changing legal status and identities.

The starting point of this research that explores the interviewees’ personal backgrounds and social histories has relevance to the historical record of Canadian midwifery. The term midwife is often used broadly in midwifery literature to refer to non-physician childbirth attendants without qualifying personal or professional variation within this occupational category. The absence of a standardized professional identity or set of practices for midwives complicates the
study of Canadian midwifery, in both historical and contemporary contexts, blurring the understanding of the concepts of “midwife” and “midwifery.” For much of Canadian history, midwifery represented a diverse rather than a singular set of practices and midwives’ personal and professional identities varied widely. Historical evidence of pre-legislation midwifery is also constrained by its informal status and marginalization to official health care and the law. The use of oral history as the central research method helps to address some of these methodological challenges of definition and available evidence. In this context, the midwives’ narratives represent a legitimate and living source of evidence that adds new understandings about midwives who practiced in the pre-legislation period.

Formal mechanisms to document and record midwifery history in Canada are virtually absent, both from within and outside the midwifery profession. In most other countries in the world, midwives are recognized as the lead care givers for childbearing women. Midwives attend over eighty percent of births internationally. Consequently, midwives are a sizeable professional group with well-established identities and histories in countries outside Canada. There is significant academic infrastructure to support midwifery scholarship in other high resource nations where midwifery has a longstanding professional status. Midwives themselves are often the lead researchers of midwifery history and centres for the history of midwifery exist, sometimes with specialized midwifery history publications. This is similar to the professions of nursing and medicine in Canada where specialist researchers and formal research centres in the history of the professions have been established.

This research has the potential to make an important contribution to midwifery education in Ontario. As a new profession in Ontario, and more broadly in Canada, the infrastructure to support midwifery research and scholarship is limited. Undergraduate midwifery education has been established in Canada; however, distinct graduate programs in midwifery have yet to be developed. The baccalaureate midwifery programs that exist in Canada are relatively new and are primarily focused on clinical education. The number of Canadian midwives with graduate degrees working in academic positions is small; midwifery research remains limited, given the dual demands of undergraduate education and professional practice faced by many midwifery faculty members. The majority of Ontario registered midwives are relatively new practitioners. Many were educated in the Ontario baccalaureate program that was founded in 1993 or they were trained and credentialed outside Ontario and qualified for registration by successful
completion of the International Midwifery Pre-registration Program. With the existing limitations in historical scholarship, the majority of Ontario practicing midwives have little knowledge or understanding of this pre-legislation period of midwifery. This gap in historical knowledge is significant given this period of practice was foundational to the philosophy of care and model of regulated midwifery practice in Ontario.

THESIS OUTLINE

This thesis presents the findings of oral history interviews with twenty-one midwives who practiced in Ontario sometime during the two decades prior to the enactment of midwifery legislation at the end of 1993. The oral history narratives of the midwife interviewees are discussed in relation to current understandings of midwives and their aspirations that were identified from a reading of the literature on modern midwifery revivals in Ontario and other parts of North America.

Chapter 1, “Writing Ontario Midwifery History,” examines the historiography of Ontario midwifery and the methodology used in this study. The oral history narratives of the midwife interviewees are treated as a body of primary research evidence that require analysis and contextualization, much like conventional historical sources. An overview of the literature that informs Ontario midwifery is provided in order to contextualize the midwives’ narratives. This literature includes scholarship on historical and contemporary practices of midwifery in Ontario, as well as literature that considers midwifery in a Canadian and a North American context. Understandings of Ontario midwifery are shaped by its interrupted history and by its shared history with midwifery in other parts of Canada and the United States. Historical study of midwifery in the North American context focuses on the distant past prior to midwifery’s twentieth century decline and renewal, whereas historical scholarship on modern practice revivals is virtually absent. Knowledge about late twentieth century Ontario midwives and why they practiced on the margins of official health is informed by the large body of social science research focusing on midwifery’s transition from alegal to legal practice.

The midwives’ oral history narratives are explored in the following two chapters that are organized according to the two central research questions examined in this thesis. Each chapter addresses distinct themes that emerged from the analysis of the oral history narratives. The ways
in which the midwives’ narratives support or contradict current theories of pre-legislation midwifery and the areas where they contribute new perspectives are highlighted. Other areas of inquiry with relevance to the historical study of the Ontario midwifery revival, such as how the midwives learned and practiced in the alegal Ontario setting, are not addressed in this thesis and constitute areas for future research.

Chapter 2, “Before Midwifery,” examines the interviewees’ narratives of their life histories before they learned and practiced midwifery. Areas that are explored include: their personal backgrounds; their educational and occupational histories; and the social forces that played a role in shaping their coming of age into adulthood and into midwifery. The midwives’ personal history narratives are discussed in relation to changing social conditions in the lives of women in mainstream English Canada to reflect their demographic profile. This discussion is structured by distinct historical periods given the forty year divergence in the ages of the interviewees. The lived experiences of two Mennonite interviewees who were Ontario registered nurses and international mission nurses are also discussed, as well as the experience of the one male midwife.

An analysis of the interviewees’ personal history narratives support the dominant image of pre-legislation midwives as a homogenous group of white, middle class, well educated women that is commonly portrayed in Ontario midwifery literature. At the same time, the interviewees’ narratives reveal more nuanced portraits of age, gender, class, culture, religion, nationality, and sexuality than has been previously understood. Contextualizing the interviewees’ lives before midwifery in relation to changing social conditions for women further unsettles assumptions about midwives’ homogeneity by providing more complex and varied portraits of midwives practicing in the modern Ontario revival. While many of the interviewees were expressly influenced by the counterculture and second wave feminism, regarded as key influences in midwifery’s resurgence in late twentieth century North America, these social movements were not the only forces that shaped their identities or experiences. Postwar gender and family ideals, and traditional Mennonite values of family, service and community were other forces that shaped the life experiences of some of the interviewees and their entry into midwifery.

Chapter 3, “Finding Midwifery,” focuses on the factors that inspired and motivated the interviewees’ decisions to become midwives and to take up practice in the unregulated Ontario setting. Their narratives are discussed and analyzed in relation to existing understandings of
what inspired and motivated midwives to practice in Ontario during the pre-legislation period. Given the absence of literature directly addressing midwives’ inspirations, the body of literature documenting and analyzing midwifery’s modern re-emergence in the broader North American context is also reviewed. Many of the interviewees remembered the informative and inspirational impact of American home birth and midwifery literature written for childbearing women and aspiring midwives that was published in the early years of the American midwifery revival. This literature largely portrays midwifery as a counterculture practice that was taken up primarily by mothers who wanted to support other women in natural childbirth alternatives. This portrait of midwifery is reinforced in Canadian publications that configure midwifery as a counterculture “woman-centred” alternative to mainstream “medicalized” maternity care. Feminist interpretations of midwifery that evolved with the women’s health movement envisioned midwifery as symbolic of female empowerment, appealing to aspiring midwives across a range of political orientations to feminism.

The interviewees vividly recalled their inspirations and motivations to learn and practice midwifery in official and unofficial settings. Chapter 3 examines four distinct and recurring themes expressed by the interviewees: inspirational factors rooted in childhood and adolescence; personal childbirth experiences and support of other new mothers; professional backgrounds in nursing; and progressive social movements and midwifery activism. Many remembered multi-layered and interconnected influences or experiences, rather than a single narrative, about how they found midwifery and what informed their decisions to practice. These narratives, much like those about their personal backgrounds, both conform to and diverge from current understandings about why midwives practiced without legal status. These findings add new evidence to the limited existing scholarship on midwives’ inspirations and motivations to practice.

This thesis research makes a significant contribution to the emerging historical record on late twentieth century revivals of midwifery in Ontario and elsewhere in North America. Its findings add new understandings and nuanced dimensions to current understandings of midwives and their inspirations contained in the large body of literature that accompanied midwifery’s modern re-emergence, largely within the field of social science. The oral history narratives of Ontario pre-legislation midwives contribute to the historical preservation of this transitory period of
Ontario midwifery, one that was foundational to the current model of regulated midwifery and that has garnered national and international attention and respect.

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1 I am using the term “alegal” to mean having no legal status. There is general consensus among scholars that the legal status of Canadian midwifery was ambiguous at the time of midwifery’s modern re-emergence. The status of midwifery varies across Canada given health care governance occurs at the provincial and territorial levels. Historically in Canada, midwifery was incorporated into emerging legal definitions of medicine in the nineteenth century in most regions of the country. Although nurses were able to officially deliver babies in remote regions of the country well into the twentieth century and are sometimes referred to as “midwives” or “nurse midwives,” Newfoundland was the only Canadian province with a midwifery act independent from medicine at the time of midwifery’s modern re-emergence. Eleanor Barrington details the rise of the Canadian midwifery movement in the 1985 popular publication *Midwifery is Catching*. Barrington notes midwives were practicing in “an insecure legal limbo” in late twentieth century midwifery revivals in Canada. She provides a summary of the legal status of midwifery in a table by province and territory, noting national variation in the inclusion of “midwifery” into the statutory definition of medicine. She refers to Ontario’s legal status as “debatable” because midwifery was not included in the statutory definition of medicine in the 1974 revision to the Ontario Health Disciplines Act. She also notes there were no midwives licensed to practice in Newfoundland at the time of writing her book, despite provincial midwifery legislation. See Eleanor Barrington, *Midwifery is Catching* (Toronto: NC Press, 1985), 137, 140-141. Brian Burtch similarly refers to the “uncertain” and “precarious” legal status of pre-regulation Canadian midwifery as either “alegal (having no clear status in the law)” or illegal.” Burtch notes the legality of unofficial midwives’ actions could be tested in case law given this ambiguity and that midwives were potentially subject to prosecution for criminal negligence or practicing medicine without a license in jurisdictions where midwifery was defined as a medical act in health legislation. Burtch reports on Canadian midwifery cases that came under criminal and coroner investigations and were subject to public inquests during the pre-legislation period. See Brian Burtch, *Trials of Labour: The Re-emergence of Midwifery* (Montreal and Kingston: McGill-Queen’s University Press, 1994), 4, 158-189. In their narratives, many of the interviewees referred to their pre-legislation practice as “alegal.” They understood midwifery was not explicitly defined as a medical act in Ontario, unlike in other regions of Canada at that time. They remembered feeling they were unlikely to be prosecuted for practicing medicine without a license, despite being aware of the potential of investigation by the provincial coroner’s office. Several of the interviewees detailed their direct involvement in coroner’s inquests in the pre-legislation period.

2 The Task Force on the Implementation of Midwifery reports the annual rate of out-of-hospital births occurring in Ontario in the period 1980 to 1985 ranged between 0.4 and 0.5 percent. These figures represent unplanned and unattended births, as well as planned home births by home birth attendants including unrecognized midwifery practitioners. See Mary Eberts, Alan Schwartz, Rachel Edney, and Karyn Kaufman, *Report of the Task Force on the Implementation*
of Midwifery in Ontario (Toronto: Queen’s Printer for Ontario, 1987), 108-109. Vicki Van Wagner reports that in the mid-1980s, approximately fifty midwives had established practices in Ontario and were caring for approximately fifteen hundred childbearing women per year in “Women Organizing for Midwifery on Ontario,” Resources for Feminist Research/Documentation sur la recherche féministe 17, no. 3 (September 1988): 115. This number of midwife attended births represents less than one percent of the total live births in Ontario for 1985 of 132,208, as reported by Eberts, Schwartz, Edney, and Kaufman in Report, 109.

3 Barrington, Midwifery is Catching, 14.


7 Non-physician care givers continued to provide primary care to childbearing women after mid-century in regions of the country where physician care was unavailable or restricted. Nursing historian Jayne Elliott examines the role played by nurses in primary health care provision in the Red Cross outpost medical program in rural and remote regions of Canada beginning in post-World War I, with a particular focus on Northern Ontario, in “A Negotiated Process: Outpost Nursing Under the Red Cross in Ontario, 1922-84,” in Caregiving of the Periphery: Historical Perspectives on Nursing and Midwifery in Canada, ed. Myra Rutherdale (Montreal and Kingston: McGill-Queen’s University Press, 2010), 245-277. Evidence supports the continued practice of traditional midwives in Aboriginal and Inuit communities well into the second half of the twentieth century. For example, see National Aboriginal Health Organization, Midwifery and Aboriginal Midwifery in Canada (Ottawa: National Aboriginal Health Organization, 2004). Nurses with international midwifery credentials, as well as nurses who took post-graduate training in “advanced obstetrics” or “outpost nursing” at one of several nursing programs in Canada, were hired to provide primary maternity care in a network “nursing stations” located in remote Aboriginal and Inuit communities in the post-World War II period. “Advanced practice” nursing programs were located at the University of Alberta, Memorial University in Newfoundland and Dalhousie University in Nova Scotia. Beginning in the 1970s, childbirth services in nursing stations declined sharply when the federal government instituted a policy of routine evacuation of childbearing women from remote northern communities to hospitals in the south at the end stages of pregnancy for childbirth. For a discussion of the role of outpost nurses
in maternity care provision, see Kate Plummer, “From Nursing Outposts to Contemporary Midwifery in 20th Century Canada,” *Journal of Midwifery & Women’s Health* 45, no. 2 (March/April, 2000): 169-175. Childbirth services have since been re-integrated into some of these remote communities, with renewal of Aboriginal midwifery practices in northern, as well as southern, Aboriginal communities. For a discussion of late twentieth century initiatives for “bringing birth back to the community,” see Jude Kornelsen, Andrew Kotaska, Pauline Waterfall, Louisa Willie, and Dawn Wilson, “The Geography of Belonging: The Experience of Birthing at Home for First Nations Women,” *Health & Place* 16, no. 4 (July 2010): 638-645. Cecilia Benoit has documented extensive networks of community-based and “cottage hospital” practices of midwifery that persisted in Newfoundland and Labrador well into the second half of the twentieth century in *Midwives in Passage: The Modernisation of Maternity Care* (St. John’s: Institute of Social and Economic Research, Memorial University of Newfoundland, 1991). Midwifery’s persistence has also been documented in distinct cultural and religious communities, such as among Mennonite communities by Marlene Epp in *Mennonite Women: A History* (Winnipeg: University of Manitoba Press, 2008), 77, 84.


This ideology of essential femininity in natural childbirth discourse is particularly evident in the work of Grantly Dick-Read. For an analysis of gender in Dick-Read’s work, see, for example, Tess Cosslett, “Grantly Dick-Read and Sheila Kitzinger: Towards a Woman-Centred Story of Childbirth?” Journal of Gender Studies 1, no. 1 (May 1991): 29-43.


The “cooptation” of natural childbirth ideologies and practices into mainstream maternity care and increasing rates of obstetrical interventions that accompanied the “domestication” of hospital birthing units is discussed by Barbara Katz Rothman in “Awake and Aware, or False Consciousness: The Cooptation of Childbirth Reform in America,” in Childbirth: Alternatives to Medical Control, ed. Shelly Romalis (Austin: University of Texas Press, 1981), 150-180. See also, Maria Fannin, “Domesticating Birth in the Hospital: ‘Family-Centered’ Birth and the Emergence of ‘Homelike’ Birthing Rooms,” Antipode 35, no. 3 (July 2003): 513-535. The persistence of medical routines and technologies in 1980s Canadian maternity care is evident in two surveys of obstetrical practices in Canadian hospitals conducted in 1980 and 1985 by the

15 There is a vast body of social scientific analysis about the modern re-emergence of home birth and midwifery as counter practices to normative medical maternity care in late twentieth century North America and the formative influence of countercultural and feminist ideologies. See, for example, Katherine Beckett and Bruce Hoffman, “Challenging Medicine: Law, Resistance, and the Cultural Politics of Childbirth,” Law & Society Review 39, no. 1 (March 2005): 131


17 For a discussion of the patterns of midwifery’s re-emergence in 1970s Canada following American revivals of midwifery, see Barrington, Midwifery is Catching, 34-38.

18 In 1985, the College of Nurses of Ontario requested its 136,000 registered nurse and registered nursing assistant members complete and return an information slip sent with its membership renewal package indicating informal or formal backgrounds in midwifery. Just over 5,400 members reported having formal backgrounds in midwifery, although the accuracy of these findings is difficult to interpret as no definition of midwifery was provided to the respondents. In 1986, the Task Force on the Implementation of Midwifery co-sponsored a follow up survey with the CNO to gather more detailed information about the midwifery backgrounds of these members that are summarized in Eberts, Schwartz, Edney, and Kaufman, Report, 148, 150-151.

19 Historically and cross culturally, midwifery is a female dominated occupation. I am aware of only one man who practiced midwifery in Ontario in the pre-legislation period, Larry Lenske, who is an interviewee in this thesis. In this thesis, I will refer to midwives using the pronoun “she” and the noun “women.”

23-24; and Barrington, *Midwifery in Catching*, 34. The roles that physicians played in modern revivals of home birth and midwifery, such as home birth practitioners and teachers to aspiring midwives and as medical back up support, have been under explored by scholars. The dichotomous portraits of midwifery and medicine that dominate early historical scholarship on midwifery in Canada’s distant past have been complicated by historical evidence of mutual support and collaboration. See, for example, Wendy Mitchinson, “Midwives Did Not Disappear.” The overly dichotomous interpretations of midwifery and medicine that dominate literature on modern midwifery revivals in North American settings require critical analysis, with attention to the complexity and nuance in the relationships of midwifery and medical practitioners.

21 Burtch, *Trials of Labour*.


23 Three Canadian hospitals established midwifery pilot “demonstration” projects in the 1980s where nurses were delegated the responsibility to deliver babies within existing health care legislation, including Vancouver’s Grace Hospital in 1981, Hamilton’s McMaster University Medical Centre in 1983, and Foothills Hospital in Calgary in 1991. See Sheila Harvey, Karyn Kaufman, and Alison Rice in “Hospital-Based Midwifery Projects in Canada,” *Issues in Midwifery*, ed. Tricia Murphy-Black (Edinburgh, UK: Churchill Livingstone, 1995), 189-206.


25 Burtch notes significant attrition in the number of midwives practicing in British Columbia from the mid-1980s to mid-1990s that he attributes to the tenuous legal and material conditions of practice in *Trials of Labour*, 33, 188 and 200. Barrington reports “Three hundred births is a commonly cited burn-out point” in *Midwifery is Catching*, 50.
A record of Murray Elston’s announcement can be found in Ontario, Legislative Assembly, *Debates (Hansard)*, 33rd Legislature, 1st Session, Issue L096 (January 23, 1986), (Toronto: Office of the Legislative Assembly, 1986).


The size of the first group of registered midwives is variously reported in midwifery literature as somewhere in the range of fifty-five to seventy. A 1994 Ontario Ministry of Health publication on the Regulated Health Professions Act notes “about sixty midwives are registered with the College of Midwives of Ontario.” See Amanda Kreidie, “Modern Moms, Ancient Art,” in *Health Times: A Publication of the Ministry of Health* (Toronto: Queen’s Printer for Ontario, 1994), 4.

The Michener Institute’s Midwifery Pre-registration Program is described in Holliday Tyson, Anne Nixon, Arlene Vandersloot and Kate Hughes, “The Re-emergence and Professionalization of Midwifery in Ontario, Canada,” in Murphy-Black, *Issues in Midwifery*, 172.

See Ontario, Legislative Assembly, “An Act Respecting the Regulation of the Profession of Midwifery.”


A large number of publications on Ontario midwifery’s changing legal status and professionalization accompanied and followed midwifery’s legal recognition. See the Bibliography for a listing of these publications that will be referred to and referenced throughout the thesis.
36 The distinction between primary and secondary source material is complicated given the recent history of the pre-legislation period of Ontario midwifery practice.


38 A prominent text addressing the evolution of historiography on Canadian midwifery is Biggs, “Rethinking the History of Midwifery in Canada.” Historical scholarship on Canadian midwifery will be discussed in more detail in Chapter 1 in the Historiography section.

39 Participant observation and key informant interviews involving practicing midwives who worked in Ontario prior to midwifery regulation form a central research method in many of the prominent social science texts on Ontario midwifery, including the works of Ivy Lynn Bourgeault, Margaret MacDonald, and Sheryl Nestel. Midwives who are also social science scholars of Ontario midwifery include Betty-Anne Daviss, Susan James, Mary Sharpe, and Vicki Van Wagner.

40 Prominent texts addressing debates about midwifery regulation in Ontario include Jutta Mason, *The Trouble with Licensing Midwives*, Feminist Perspectives series no. 20 (Ottawa: Canadian Research Institute for the Advancement of Women, 1990); and Van Wagner, “Why Legislation?” For more recent analysis of debates regarding midwifery policy in Ontario, see Philippa Spoel and Susan James, “Negotiating Public and Professional Interests: A Rhetorical Analysis of the Debate Concerning the Regulation of Midwifery in Ontario, Canada,” *Journal of Medical Humanities* 27, no. 3 (September, 2006): 167–186; and Stephanie Paterson and Cherry Marshall, “Framing the New Midwifery: Media Narratives in Ontario and Quebec during the 1980s and 1990s,” *Journal of Canadian Studies/Revue d’études canadiennes* 45, no. 3 (Fall 2011); 82-107.

41 For a discussion of diverse conceptualizations of midwife and midwifery in Canadian history, see Wendy Mitchinson, *Giving Birth in Canada*, 70-71; and Biggs, “Rethinking the History of Midwifery in Canada.”

42 Biggs, “Rethinking the History of Midwifery in Canada.”


44 For example, the United Kingdom Centre for the History of Nursing and Midwifery was founded in 2000 by the Royal College of Nursing, the professional body for nursing and midwifery, and Queen Margaret University College in Edinburgh. This centre publishes a biannual bulletin and holds a yearly colloquium. It is associated with the European Association for the History of Nursing. For the midwifery page of their official website, see “Midwives,” UK
Centre for the History of Nursing and Midwifery, accessed June 26, 2012, http://www.nursing.manchester.ac.uk/ukchnm/midwives/. A centre of midwifery history was also established in 2009 at the University College of Dublin. See the UCD Irish Centre for Nursing and Midwifery History official website, accessed June 23, 2012, http://www.ucd.ie/icnmh/. In addition, the Australian Nursing and Midwifery History Project was founded by the School of Nursing, University of Melbourne. See the Australian Nursing and Midwifery History Project official website, accessed June 23, 2012, http://www.anmhp.unimelb.edu.au/.


Chapter 1

Writing Ontario Midwifery History

HISTORIOGRAPHY

The historical study of midwifery is a new and growing field in Canada. Ontario midwifery historiography is entwined with Canadian midwifery scholarship, as well as with a large body of historical scholarship on American midwifery that shares a similar history of decline and renaissance.¹ Beginning in the 1970s, midwifery captured the attention of historians influenced by developments in historical research concerned with understanding the lives of ordinary people. As “history from below” became the guiding principle of the evolving field of social history in the 1960s, research into the lives of women drew particular attention from historians influenced by second wave feminism. Despite early feminist discourse linking women’s oppression to their mothering roles,² motherhood was embraced as a feminist issue and a suitable area of inquiry in the 1970s, with recognition of its transformative potential for women.³ The study of motherhood from a historical perspective provided insight into how this gendered dimension of women’s lives was socially constructed over time and place.⁴

Research on mothering inevitably encompassed the study of women’s experiences of becoming mothers. As a result, a large body of historical literature has been generated over the last several decades exploring women’s experiences of giving birth and supporting one another in childbirth. Histories of female care giving entered the discourse of women’s history beginning in the early 1970s and created lasting portraits of midwives that continue to inform theories on midwifery’s past, as well as debates about current practices. Historical evidence indicates the care of childbearing women was considered part of the female domestic economy before the rise of scientific medicine and its evolving monopoly in childbirth.⁵ Midwives are generally assumed to be women; however, their social status and professional status have been interpreted in dichotomous ways. The dominant feminist historical narrative configures midwives as knowledgeable and skilled practitioners who provided a range of health care services in local communities.⁶ Other historical theories construct midwives as marginal figures, lacking the education and social status of male medical practitioners who relied on modern, scientific methods of managing childbirth.⁷ The historical study of midwifery is complicated by
the lack of a uniform or transparent understanding of what constitutes a midwife and by the lack of evidence of the daily lives of ordinary women.\(^8\) In addition, the term midwife has been used uncritically to refer to diverse forms of childbirth attendance provided by a range of non-physician care providers. Theoretical understandings of midwifery have also been constrained by their focus on western history.

Ontario midwifery historiography assumed a particular form that reflected its decline over the first half of the twentieth century and its re-emergence in the second half of the century. In Ontario, as in Canada and in many parts of the United States, midwifery did not become an integral profession with the modernizing of maternity care, nor did it persist as a traditional practice on a significant scale. This is dissimilar from most other countries in the world where midwifery is integral to the provision of health care and is recognized as a profession or a traditional health practice. In most regions of North America, childbirth was gradually incorporated into a growing hospital system over the first half of the twentieth century and maternity care was increasingly incorporated into the professions of nursing and medicine. By mid-century, the practice of midwifery had diminished to a marginal practice in the United States and it had all but disappeared in Canada, with the exception of remote regions not served by doctors or distinct cultural or religious communities.

Early histories of American childbirth that appeared in the first half of the 1970s were often extrapolated to a North American context. American midwifery literature pre-dated Canadian publications and influenced scholars of Canadian midwifery. These histories not only offered understandings of childbirth practices that pre-dated childbirth’s medical management, they also informed and were shaped by contested debates about modern midwifery. Early feminist histories that valorized midwifery as an ancient womanly art ran counter to medical histories that demonized midwives as unskilled and dangerous practitioners. Feminist narratives provided inspiration to the fledgling modern midwifery movement by constructing female midwifery’s demise and rebirth as a heroic tale with gender and professional rivalries with male medicine that mirrored modern practices. In their influential history of women healers, feminist scholars Barbara Ehrenreich and Deirdre English argued the loss of midwifery resulted from the suppression of midwives as powerful and skilled female healers by a rising patriarchal medical profession that had its roots in the European and American witch hunts of the early modern period. They also asserted the late twentieth century revival of midwifery represented the
reclamation of traditional female knowledge in a modern radical feminist challenge and resistance to hegemonic male medicine.\textsuperscript{9} In contrast, medical narratives portrayed unofficial modern midwives as uneducated and unsafe, often drawing linear comparisons to midwives of the past.\textsuperscript{10} Although these early histories of American midwifery have been critiqued as polemical and unsubstantiated,\textsuperscript{11} the dichotomy of female midwifery and male medicine persists in historical and modern narratives of unofficial midwifery in the United States and continues to inform theories of midwifery’s decline and re-emergence.\textsuperscript{12} More recent historical scholarship on American childbirth and midwifery has unsettled these “grand narrative” histories by providing more complex, and in some cases highly collaborative, portraits of the relationship between practicing midwives and physicians.\textsuperscript{13}

Scholarship on Canadian midwifery paralleled the growth and organization of social movements for midwifery in late twentieth century Canada, building on a large body of American literature. Publications documenting and analyzing distant and contemporary practices of midwifery Canada were increasingly visible by the late 1970s.\textsuperscript{14} Historical research demonstrated midwifery was not a new practice in Canada, despite the prevailing dominance of medicine in Canadian maternity care. Historians uncovered evidence of longstanding practices of midwifery in indigenous and European settlement communities in early Canada and illustrated the vital role that midwives played in the provision of community health care prior to the modernization and institutionalization of health care. Scholarship on late twentieth century Canadian midwifery detailed the foundational principles and practice structures of modern midwifery and its challenge to normative maternity care, as well as the impact of impending regulation and professionalization.\textsuperscript{15}

Despite longstanding historical practices of midwifery in Canada, the failure to integrate midwifery into modernizing systems of maternity care contributed to midwifery’s demise and a loss of societal knowledge about midwives and their practices. Existing research on Canadian midwifery is predominately constructed along lines of gender and midwives’ relationships to medicine, the health care system, and the law. Understandings of historical and modern practices of midwifery in Canada are dominated by the binaries of female/male and midwifery/medicine, and they are intertwined by common narratives of marginality, domesticity, femininity, and nature. Midwifery’s changing status also dominates Canadian midwifery scholarship. Researchers have focused their attention on midwifery’s twentieth century demise,
renewal, and subsequent legal recognition, particularly in Ontario as the first province to legally recognize and integrate midwifery into the publicly funded health care system.\textsuperscript{16}

Scholarly inquiry into Canadian midwifery is marked by theoretical shifts that reflect changing trends in historical and feminist analyses.\textsuperscript{17} Three distinct periods of scholarship are evident from a review of the Canadian midwifery literature of the last several decades that can broadly be categorized as recovery, reflection, and reinterpretation.

\textit{Recovery}

The first prominent wave of Canadian midwifery scholarship appeared in the 1980s, at a time when midwifery was emerging as a challenge to mainstream maternity care. Writings on midwifery published before this time were limited and based largely on folkloric or anecdotal understandings.\textsuperscript{18} Scholars documented historical and emerging practices of midwifery that were unfamiliar to mainstream Canadian society accustomed to medical hegemony in childbirth. Historical studies of this period were largely generated by interdisciplinary researchers working in the burgeoning field of women’s history. Scholars uncovered evidence of past practices of midwifery in archival legislative records, professional journals, and the public press. They mapped similar trajectories in midwifery’s decline over the course of the late nineteenth and early twentieth centuries, ones that paralleled the professionalization of medicine and nursing and the transition of birth place from home to hospital. They also constructed midwifery’s demise along lines of gender and professional boundaries that echoed early American historical accounts. The erosion of midwifery was attributed to a range of factors that included economic rivalries with medicine and nursing, medical science’s growing monopoly over childbirth, the evolution of a hospital-based maternity care system, the legal incorporation of midwifery into the professional practice of medicine, and the rise of the specialized field of obstetrics.

Historian Suzann Buckley’s 1979 examination of social reform campaigns to improve infant and material mortality in late nineteenth and early twentieth century Canada documented unsuccessful efforts by social reform organizations to establish formal systems of midwifery for poor and geographically isolated women.\textsuperscript{19} According to Buckley, the medical profession undermined support for midwifery by highlighting professional concerns about the safety of midwifery practice. She cited contested debates in the medical press about the “midwife problem” of unregulated practitioners contributing to poor maternal and infant health outcomes.
Buckley also identified resistance from the newly professionalized nursing profession that was reluctant to integrate the domestic labour of midwifery into nursing practice. This reluctance stemmed from midwifery’s association with the working class image that nurses were working to distinguish themselves from.

Two articles appeared in a 1983 issue of *Ontario History* that attributed midwifery’s early twentieth century decline to its failure to professionalize along with medicine and nursing. Historian Jo Oppenheimer linked the fall in midwife-attended births in early twentieth century Ontario to the growing enforcement of late nineteenth century legislation that made non-medical midwifery illegal and the transition in place of birth from home into a growing hospital system. Historian and sociologist C. Lesley Biggs’ study of the “Case of the Missing Midwives” tied the decline of Ontario midwifery to the institutionalization and medical monopolization of childbirth. Biggs traced the evolution of legislation governing the practice of medicine in Ontario over the period 1795 to 1900 and the accompanying demise of female midwifery. The first act to regulate the practice of medicine in Upper Canada was passed into law in 1795, making it illegal to practice “physic, surgery or midwifery” without a medical license. Biggs highlighted the practical limitations in enforcement of this act due to the widely dispersed population and the scarcity of medical practitioners that resulted in several revisions in the first half of the nineteenth century, ones that explicitly exempted female midwives from licensing requirements. In 1865, however, the exemption for midwives was removed and “midwifery” was incorporated into the practice of medicine, making it illegal to provide childbirth services without a medical license in Upper Canada. Biggs concluded that male physicians gained control over childbirth through restrictive legislation, as well as by undermining midwives’ credibility. She illustrates how acceptance of the superiority of medicine’s scientific and technologic approaches to childbirth was bolstered by physicians’ claims of midwives’ ignorance and lack of skill.

Canadian midwifery writer and analyst Jutta Mason’s appendix to the 1987 *Report of Task Force on the Implementation of Midwifery Ontario, “A History of Midwifery in Canada,”* is referred to as “the first comprehensive account of its kind to be published in Canada.” Mason provided a detailed overview of official and unofficial practices of midwifery that existed in Canada’s past in both aboriginal and immigrant communities. She also described the role played by nurses with international midwifery credentials or post-graduate training in the provision of
obstetrical services in geographically remote regions of the country. Mason documented the persistence of midwifery on the margins of mainstream maternity care in Canada well into the second half of the twentieth century. She attributed the virtual disappearance of midwifery in the first half of the twentieth century to the erosion of local female childbirth networks and “a popular birth culture” of non-intervention resulting from an increasingly dominant interventionist male medical profession predicated on science and technology. Mason linked midwifery’s re-emergence in late twentieth century Canada to the influence of the postwar natural childbirth movement on childbearing women’s growing dissatisfaction with “the medical birth culture.”

Early publications on midwifery’s modern revival in Ontario documented the nature of midwifery practice and the factors influencing its re-emergence. Prominent theories about why midwifery reappeared in late twentieth century Canada centred on women’s dissatisfaction with medical interventions in childbirth and their desire for natural alternatives outside the official maternity care system. Social movements of the 1960s and 1970s, particularly the counterculture and second wave feminism, were considered key influences in midwifery’s renewal. Toronto journalist Eleanor Barrington’s 1985 *Midwifery is Catching* was the first major publication to document the modern midwifery movement in Canada. Barrington noted the formative influence of the “sweep of social change of the 1960s” on midwifery’s re-emergence as a counter model of practice to mainstream maternity care.23 She outlined the care principles of Canada’s “new” midwifery, including expertise in normal birth and “continuous care, preventive care, holistic care and individualized, family-centred care, and argued for the formal recognition of midwifery in Canada.”24

Detailed accounts of emerging practices of midwifery were also evident in official documents of the early midwifery movement in Ontario. A series of briefs addressing the regulation of midwifery were submitted to the Ontario Health Professions Legislation Review panel in the early 1980s by a coalition of organizations representing practicing midwives, midwifery consumers, and Ontario registered nurses with international midwifery credentials.25 These briefs proposed a model for a direct entry, self-regulating profession that was informed by local and international practices of midwifery. The midwifery organizations envisioned midwifery as distinct profession from nursing and medicine. They detailed philosophic care principles and structures for practice that were inherent in modern practice revivals, including birth as a normal
life event, informed choice, woman as decision maker, continuity of care, choice of birth place and appropriate use of technology that were later integrated into a regulated model of midwifery.

The roots of discontent within the midwifery community about legal reform were evident by the late 1980s. In 1988, Jutta Mason authored a chapter on Canadian midwifery in an anthology of international systems of midwifery. Mason presented an historical overview of midwifery in Canada that incorporated discussion of the emergence of modern practice revivals and campaigns for midwifery’s legal reform. She drew parallels between the erosion of historical practices of midwifery by an emerging medical profession and the potential loss of modern midwifery’s autonomy and woman centered orientation by its legal recognition and integration into the medically dominated health care system.

Canadian midwifery scholarship of the 1980s is characterized by universal interpretations of modern and past practices of midwifery. Early historical constructs of midwives as traditional neighbour women or heroic frontier figures became iconic symbols in Canadian midwifery historiography, despite growing evidence of diverse histories of midwifery. These figures not only informed historical discourse on Canadian midwifery, they also influenced popular understandings of midwifery at the time of its modern renewal. In her analysis of modern Ontario midwifery, medical anthropologist Margaret MacDonald noted the formative role that tradition and the neighbour and frontier midwife motifs played in the identity formation of modern midwives and their practices. Gender and professional rivalries underscored early theories of midwifery’s decline and renewal that have similarly contributed to a lasting discourse of dichotomous models of midwifery and medicine. The valorization of midwifery as superior form of woman-centred maternity care permeates midwifery discourse of this period. Mason’s theories of the erosion of neighbour networks of midwifery and popular birth knowledge about normal birth by interventionist medical practitioners continue to inform scholars of Canadian midwifery. Barrington’s narrative of modern midwifery’s “renaissance” as a grassroots feminist movement to reform institutionalized obstetrical medicine typifies understandings of midwifery’s modern re-emergence in Canada, evoking Mason’s historical narrative.

Reflection

In the 1990s, theoretical understandings of historical and modern practices of Canadian midwifery came under critical scrutiny by scholars who exposed their lack of complexity. New
directions in historical inquiry uncovered evidence of local and varied practices of midwifery that challenged the limitations of singular histories to reflect the diversity of midwifery’s past in Canada. A growing body of historical scholarship demonstrated regional and temporal variations in Canadian practices of midwifery, adding nuance and complexity to existing understandings. Scholars provided evidence of official traditions of midwifery that strayed from the dominant image of midwives as neighbour women. Historian Hélène Laforce’s study of midwifery in New France provided evidence of formal systems of midwifery education and Church regulation that complicated historical narratives that viewed midwifery as an informal, empirically based practice. Laforce detailed the transplantation of a well-established system of midwifery from France that thrived from the mid-seventeenth century until the late nineteenth century in New France, when medicine established a monopoly in the care of childbearing women and excluded midwives as economic rivals.

Historian and sociologist Nanci Langford’s historical account of midwifery on the prairies in the period 1880 to 1930 illustrated a range of childbirth practitioners that co-existed in frontier settlement communities. Oral history narratives of women who lived in rural western Canada during this period formed the basis of Langford’s research. Women remembered the scarcity of skilled practitioners that often led them to rely on family members, including their male partners, or neighbour women for assistance in childbirth. These women also recalled their need for self-reliance in childbirth when their husbands were distant from home, at work or travelling to access help. The range of skilled attendants described by Langford’s interviewees included women recognized as midwives in European or aboriginal communities who possessed a range of formal or informal preparation, as well as medical practitioners with formal training to assist women in childbirth.

In her extensive research on midwifery in Newfoundland and Labrador, sociologist Cecilia Benoit also used an oral history methodology to gather evidence about women’s experiences giving birth or assisting other women in childbirth. Benoit documented multi-faceted practices of midwifery, including systems of home-based care, local “cottage” hospitals and outpost clinics. The preparation of the midwives in her research ranged from empirical to formal training, including nursing prerequisites in some cases. Benoit related the gradual and varied transition of midwifery that accompanied the modernization of health care in Newfoundland and Labrador. She described traditional community practices that persisted in isolated regions into
the post-World War II period. Rather than vanishing with the modernizing transition of birth from home to hospital, midwifery was incorporated into system of small cottage hospitals that thrived between the 1930s and 1960s and continue to persist in northern areas of the province.

Midwifery was also extensively practiced in immigrant communities in the first half of the twentieth century, as traditional customs of midwifery were retained in the Canadian context and helped to preserve cultural identity. Historian Marlene Epp documented the multi-faceted and integral role played by midwives in the provision of health care in Mennonite settlement communities. Epp portrayed midwives as trained and respected health care providers whose work extended beyond assistance at childbirth to encompass other significant components of community health care, such as bone setting and undertaking. Portraits of individual formally trained midwives who relocated to Canada, such as British trained nurse midwife Myra Bennett and Icelandic midwife Gudrun Goodman, similarly highlighted the complex and varied roles that midwives played in rural and remote regions where medical care was limited or inaccessible. Nursing historian Judith Young’s examination of midwives and nurses in nineteenth century Toronto indicated midwives were most commonly widows from working class backgrounds whose motivations stemmed from the economic need to earn an income in order to support their families. Growing scholarship on aboriginal midwifery provided evidence of variations in midwifery histories among First Nations and Inuit communities that also challenged the singular concept of traditional aboriginal midwifery inherent in Canadian midwifery discourse.

More complex explanations were also forwarded in this period of midwifery scholarship to explain the disappearance of midwifery in Canada, ones that go beyond the dominant narrative of occupational tensions between midwifery and medicine. Scholars presented evidence of more complex and variable relations among midwives and physicians, which sometimes included cooperation and collaboration, in contrast to the overly dichotomized relationship of midwifery and medicine that dominates midwifery scholarship. In his examination of physicians’ attitudes toward midwifery in nineteenth century Ontario, medical historian James Connor asserted that the erosion of midwifery was more complex than “simply male physicians vs. female midwives.” Connor argued the modernizing medical profession was preoccupied with economic competition with unlicensed “irregular” medical practitioners, and that other factors significantly contributed to midwifery’s demise, including attrition, restrictive legislation, and failure to organize as a profession. Connor provided evidence of “complex and interconnected” inter-professional
relations that suggest the modernizing medical profession was not monolithic in its opposition to midwives. In her landmark study of Canadian childbirth practices in the period 1900 to 1950, historian Wendy Mitchinson similarly argued the dichotomy of non-interventionist midwives and interventionist physicians permeating historical narratives was overly simplistic and that medical opposition to midwifery was more muted than commonly understood. Mitchinson’s historical analysis of Canadian midwifery demonstrated evidence of diverse forms of practice and variations in patterns of decline. Sociologist Beth Rushing’s assertion that midwifery’s mid-century demise resulted from social and market forces also complicated traditional theories of medicine’s “occupational imperialism.” Rushing cited changing trends in market relationships of supply and demand with urbanization and immigration as undermining the occupational power of midwives and enabling medicine’s dominance in the division of labour in maternity care. Judith Young attributed the decline of midwifery in late nineteenth century Toronto to working class midwifery practitioners’ need to reinvent themselves as nurses out of financial necessity in the context of growing social demand for multifaceted health care in an increasingly urbanized environment. Despite general agreement that midwifery’s rapid decline accompanied the modernization of health care, scholars identified variations in patterns of midwifery’s disappearance and the persistence of practices in communities that were geographically isolated, socially marginalized or culturally distinct well into the second half of the twentieth century.

Scholars of Canadian aboriginal midwifery tied the loss of traditional childbirth knowledge and the accompanying erosion of cultural self-sufficiency and competency to twentieth century assimilationist policies aimed at bringing childbirth under direct government control. In her study of the colonization of childbirth among aboriginal peoples of northern Canada, historian Patricia Jasen noted that the impact of postwar policies of routine evacuation of childbearing women from northern communities to distant hospitals in the south also fostered resistance among aboriginal women. In some communities this led to the organization of birth centres closer to home that blend traditional midwifery and modern obstetrical practices.

Reflective analyses of modern practice revivals were also evident in the 1990s that provided more complex interpretations of unofficial midwifery. Critical perspectives on Canadian midwifery as a white, middle class reformist movement undermined claims to midwifery’s universality. Scholars called attention to the lack of diversity of care recipients and care
providers in the midwifery community that was variously tied to midwifery’s precarious legal position and to the exclusionary practices of professionalization and regulation.\textsuperscript{45} The relevance of the defining features of the midwifery model for women from marginal and diverse communities, such as informed decision making, normal birth and choice of birth place, also came under scrutiny.\textsuperscript{46} Scholars of Ontario midwifery noted significant philosophic variations and tensions among midwives and their supporters that were exacerbated by contested debates about legal reform, disrupting a vision of midwifery as a cohesive and singular movement.\textsuperscript{47} More complex portraits of midwifery’s modern re-emergence were forwarded that extended beyond narratives of midwifery’s reclamation as a traditional gendered practice or as a countercultural or feminist challenge to medicalized childbirth. Sociologist Mary Teresa Fynes attributed the development and “legitimation” of midwifery in Ontario to a convergence of interrelated social, economic, and political factors that had their roots in the decade preceding the grassroots practice revival. Some of these factors were familiar in midwifery discourse, such as consumer dissatisfaction with mainstream maternity care and the influence of second wave feminism and the women’s health movement. Fynes also identified other complex factors that stimulated official interest in midwifery, such as the rationalization of health care costs, projected shortages of obstetrical care providers, an existing framework for the review of Ontario health legislation, vocal public support for prevailing practices of home birth and midwifery, and prominent public inquests into home births attended by alegal midwifery practitioners.\textsuperscript{48} Sociologist Brian Burtch’s examination of midwifery and the law in Canada provided a more complex portrait of midwifery in unregulated settings. Burtch described the demanding and tenuous legal position of midwives working without official status. He noted pre-legislation midwifery was not simply unregulated or regulated by childbearing women as some scholars have suggested, but was instead regulated by the criminal justice system. He argued that unofficial practices of midwifery were constrained by the “threat of criminal prosecution, a coroner’s investigation, or charges of practicing midwifery without a license.”\textsuperscript{49}

The study of midwifery from a social science perspective intensified during the 1990s with the trend toward regulation. Sociologist Ivy Lynn Bourgeault identified the evolution of a “more critical and less reflexive” relationship between the midwifery and social science communities that she argued played a role in advancing the social science of midwifery.\textsuperscript{50} Dichotomous portraits of midwifery’s changing legal and professional status and its integration into formal systems of health care dominate scholarship of this period. Late twentieth century scholarship on
Ontario midwifery in particular was shaped by its status as the first Canadian province or territory to legally recognize midwifery. Publications that appeared in the early 1990s contemplated the impact of impending midwifery legislation on the midwifery model and philosophy of practice. As the decade progressed and midwifery began undergoing a transition to regulated practice, debates about the impact of midwifery’s changing status grew increasingly polarized. Scholars who emphasized the benefits of legal recognition identified improved access to midwifery services for childbearing women and to educational and practice opportunities for midwifery practitioners as potential outcomes.51 Midwife and midwifery scholar Vicki Van Wagner argued the recognition of a legal, community-based model of midwifery would create a sustainable and autonomous profession and facilitate women’s autonomy in childbirth.52 The discussion of the perceived beneficial outcomes of midwifery regulation, however, were often overshadowed by concerns for the loss of midwifery’s autonomy and integrity by its incorporation into the formal systems of health care and the law. Scholars expressed particular concern about the potential for the erosion of midwifery’s founding principles and model of practice by shifting midwives’ accountability from women in care to medical standards and institutions.53

Critical perspectives on midwifery regulation shaped knowledge about the pre-regulation period of practice through narratives of reclamation and loss that were reminiscent of historical narratives of the loss of networks of female care giving. Jutta Mason’s critical analysis of Ontario midwifery, The Trouble with Licensing Midwives, resembled her historical narrative of the neighbour midwife. Mason portrayed the early modern midwifery movement as an informal network of friends and neighbours supporting one another in natural birth alternatives to the medical management of childbirth. She compared the loss of Ontario midwifery’s position outside formal systems of health care to childbirth’s displacement from the domestic sphere earlier in the century and the gradual erosion and eventual demise of past practices of Canadian midwifery.54 Critical scholarship on legal reform valorized midwifery outside official health care, in both historical and modern contexts, and continued to emphasize binaries of midwifery and medicine that obscure understandings of midwives and their practices. Unofficial midwifery was configured as unmediated by institutionalized medicine and state authority and idealized as a pure form of midwifery. Scholars characterized pre-regulation Ontario midwifery as an informal community network of women caring for other women in a “wholistic model” of care in opposition to the “technocratic biomedical model” of institutionalized maternity care.55 Critical
scholarship on midwifery regulation also divided midwives along legal and professional lines. Community-based midwives working in partnership with childbearing women outside the law and health care institutions were juxtaposed against professional midwives working in partnership with medicine and state regulators.\textsuperscript{56}

\textit{Reinterpretation}

Scholarship on Canadian midwifery was transformed by the contribution of nuanced and critical theories of the late twentieth and early twenty-first centuries, as well as by the passage of time. It is almost two decades since modern practices midwifery were first regulated in Canada and the emotion regarding midwifery’s legal and professional transformation is more muted. The period of transition in midwifery’s position from outside to inside formal systems of health care and the law was a time of uncertainty and anxiety for midwifery scholars and their research informants, many of whom were midwifery practitioners and consumers. Several prominent Canadian midwifery scholars have recently revisited and reinterpreted their theories on historical and modern practices of midwifery. Lesley Biggs reflected on her 1983 study of “The Case of the Missing Midwives” in an article published over two decades later in a 2004 anthology of Canadian midwifery. Her stated goal was to “retell the story of the history of midwifery in Canada, but with the hindsight of twenty years of debate within feminist historiography and feminist theorizing more generally.”\textsuperscript{57} Biggs recognized her narrative of midwifery’s demise in early twentieth century Ontario that she attributed to inter-professional economic rivalries with medicine and medicine’s growing monopolization of childbirth failed to capture the complexity of Canadian midwifery history. She also acknowledged the concept of the neighbor midwife that dominated historical scholarship reflected a particular historical location in Upper Canada that was not transferable to the wider Canadian context. Biggs concluded that diverse and complex models of midwifery existed in pre-Confederation and Confederation Canada and that “no singular history of midwifery exists but rather many.”\textsuperscript{58} She theorized midwifery’s decline varied in time and place and was “intimately tied to particular configurations of professional interests, race, colonization, class, industrial development, and regional politics.”\textsuperscript{59} Cultural anthropologist Robbie Davis-Floyd re-visited her dichotomized models of midwifery and medicine that permeate North American discourse, calling for a “hybrid” model for birth midwifery and postmodern midwives blending art and science.\textsuperscript{60} Margaret MacDonald and Ivy Lynn Bourgeault contributed a chapter on the model of regulated Ontario midwifery to a 2009
anthology of international birth models entitled *Birth Models that Work*. The editors of this anthology, including Davis-Floyd, defined successful birth models as those that improve the standard of care for mothers and babies by “combining the best of obstetrical care with the best of contemporary scientific research, ancient wisdom, basic common sense, and compassion to create systems of knowledge, skills, and practice that truly serve mothers, babies, and families.” Bourgeault’s analysis of the success of Ontario midwifery acts to temper her earlier critical perspective of Ontario midwifery’s transformation from an “egalitarian social movement” to a hierarchical profession, one that would distance midwives from the women they served.

Midwifery revivals of the late twentieth century are beginning to be documented from an historical perspective. Fynes and Bourgeault provided “social history” accounts of events that led to the official recognition and professionalization of midwifery in Ontario. Although the large body of social science literature on Ontario midwifery provides an important source of evidence about the modern midwifery movement, its focus on midwifery’s transition from an alegal practice to a regulated profession obscures understandings of midwives and their lives. Prominent midwifery social science scholar Ivy Lynn Bourgeault noted this gap in her concluding remarks to *Push! The Struggle for Midwifery in Ontario*, where she states her research lens of “macro” policy level analysis overlooks discussion of the “challenges of everyday practice of midwifery.” Initiatives to preserve this period of Canadian midwifery history are emerging, in addition to scholarship focused on the experiences of pre-legislation practitioners. Quebec midwife and midwifery scholar Céline Lemay’s study of midwifery in the Province of Quebec in the pre-legislation period examines the experiences of pre-legislation midwives. A midwifery archive was established at the University of British Columbia that houses documents related to the pre-legislation period of practice and contains oral history interviews with midwives, nurses and physicians who practiced in the early home birth and midwifery revivals in British Columbia. The development of a midwifery archive in Ontario is underway.
METHODOLOGY

This study uses the qualitative research methodologies of oral history and textual analysis to investigate the pre-legislation period of midwifery in late twentieth century Ontario. As a transitory and compelling period in the history of Ontario midwifery that had profound influence on the model of regulated midwifery, with the passage of almost thirty-five years since midwifery’s visible re-emergence in Ontario, it has become a suitable area for historical inquiry. Given the limitations of primary research evidence on contemporary Ontario midwifery, oral history represents both a useful and relevant methodology and source of evidence. The oral histories gathered in this research represent raw data to be compared and used with other evidence on this period of Ontario midwifery. The oral history interviews were conducted and interpreted according to the ethical principles of the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* and an ethics protocol approved by the University of Toronto Research Ethics Board.68 (See Appendix A for the Ethics Approval Letter for this study from the Office of Research Ethics at the University of Toronto.) The addition of the midwifery practitioner’s voice to the current record of Ontario midwifery provides new evidence for understanding the roots of the modern practice revival, its events and actors.

The target population for this study was Ontario midwives who practiced during the pre-legislation period of practice spanning from the second half of the 1970s to December 31, 1993, when midwifery legislation came into force. Access to this participant group was complicated by the absence of a formal mechanism to track midwives who practiced without official status. As a member of the group under study, I am aware that a significant proportion of the target population became registered midwives with the College of Midwives of Ontario, the provincial regulatory body for midwifery. Approximately seventy-five midwives attended the government sponsored Pre-registration Program for Midwifery, a one-time only assessment and upgrading program for Ontario practicing midwives held in Toronto at the Michener Institute for Applied Health Sciences in 1992 and 1993. I am also aware that several other pre-legislation practitioners later qualified as registered midwives by successfully completing the Ontario baccalaureate Midwifery Education Program or the College of Midwives of Ontario’s assessment program for internationally trained midwives. Many of these midwives are still practicing in Canada or are working in midwifery related organizations, and therefore could be contacted. I sent a notice (see Appendix B) inviting participation in this study to Ontario
midwifery practices and to Canadian midwifery related organizations by email, or by fax were email was unavailable. Contact information for midwifery practices and organizations was found on the website of the Association of Ontario Midwives. I also sent this notice to the Canadian Association of Midwives and the Association of Ontario Midwives to be posted on their websites and in their respective publications, the *Canadian Journal of Midwifery Research and Practice* and the *Ontario Midwife.*

Thirty-five individuals contacted me to express their interest in participating in this study. I sent a consent form (see Appendix C) that described the nature of the study and the scope of their involvement. A voluntary demographic survey (see Appendix D) was also sent to collect information about the backgrounds of interested participants. The Consent Form outlined anticipated risks and benefits of the study in order to facilitate informed consent for participants. The anticipated risks were judged to be minimal and the benefits seen to outweigh potential risks of vulnerability. I anticipated participants would appreciate the opportunity to share their stories as a contribution to Canadian midwifery historiography and to make them available to future generations of midwives. At the same time, I acknowledged participants’ professional reputations with inter-professional colleagues could be affected by choosing to expose their personal histories of alegal practice. Although midwifery in Ontario has been regulated since the mid-1990s, it is possible that midwives may continue to experience marginalization in the formal maternity care system that is still dominated by medicine and nursing. Anonymity was offered, as were the use of a pseudonym and the genericization of potential identifiers for those participants who wished to remain anonymous. Participants were informed that I would be interpreting their stories according to my research interests and, although I would be interpreting their stories, I would be using excerpts from their transcripts to relate their stories. I spoke by telephone with those who agreed to participate to review the research process and their participation, as well as to answer any questions.

I chose a sample size of twenty, anticipating this size of a participant group would adequately reflect the diversity of Ontario pre-legislation practitioners in terms of background, education, and practice location. This number represents over one quarter of the practitioners admitted to the Michener Institute Pre-registration Program for Midwifery. Although estimates of the number of midwives practicing in Ontario during the pre-legislation period are complicated by their unofficial status, this number represents a significant proportion of the commonly cited
figures of fifty to one hundred. Selection criteria were formulated to prioritize diversity of practice location, including rural and urban settings, as well as diversity in age, and educational and professional backgrounds. These criteria also prioritized a diversity in the participants’ educational and practice experience backgrounds including informal and formal midwifery training and experience, and previous nursing education and practice.

The pre-determined selection criteria based on age, geography, training, and educational and professional backgrounds were not applied because the volunteer participants reflected diversity along these lines. Twenty interviewees were chosen from the pool of interested participants on a first come, first serve basis, in addition to one interviewee for a pilot interview, making a total of twenty-one. At the time of the interviews, the ages of the interviewees ranged from forty-three to eighty-six, with the majority in their mid to late fifties. Approximately one third of the twenty-one interviewees had professional backgrounds in nursing and one third had formal training in midwifery from outside Canada prior to taking up alegal practice in Ontario. While concentrated in southern Ontario, the interviewees worked and lived in a range of geographical settings, rural and urban, during the pre-legislation period of practice. Reports of the number of years they practiced as alegal practitioners in Ontario varied from two and seventeen. The interviewees were easily identifiable as members of the targeted population of Ontario pre-legislation practitioners. All had attended the Michener Institute Pre-registration Program for Midwifery and were among the first registered midwives in Ontario. They met minimum standards for clinical experience used by the Pre-registration Program to define active Ontario midwifery practice and they were assessed by international midwifery faculty to meet entry to practice standards set by the College of Midwives of Ontario. However, this participant group did not fully reflect the population of pre-legislation Ontario midwives. I was not contacted by midwives who practiced in the pre-legislation period who did not apply to the Pre-registration Program for Midwifery or who did not qualify for or successfully complete the program. In addition, this study sample did not include midwives with international midwifery credentials who did not practice in the pre-legislation period in Ontario or registered nurses with experience delivering babies in labour and delivery hospital units under direct physician supervision.

Semi-structured interviews were conducted using an interview guide (see Appendix E) that incorporated broad categories for discussion and sample prompting questions. Although these discussion categories and questions were used to structure the interview process, the semi-
structured approach to interviewing was chosen to allow for dialogue, interaction, and flexibility in the interviewees’ telling of their own stories.\textsuperscript{75} The first interview conducted was considered a pilot to test and refine the interview process. Interviews were done in person in the homes or midwifery clinics of the interviewees, with the exception of three that were conducted by telephone where geographical distance did not allow for an in person interview. The interviews were typically one and a half to two hours in length. In several cases, a second follow up interview was arranged to clarify information shared in the first interview. The interviewees were asked to describe their personal histories, their inspirations and motivations to practice, and how they learned and practiced midwifery. The interviews were digitally recorded and transcribed with permission and later analyzed for themes. Each interview unfolded uniquely, as interviewees elaborated on different areas of experience. The interviewees’ narratives were complex and multi-faceted. Analysis of the oral history interviews revealed the distinctiveness of each narrative, as well as areas of similarity and difference.

All participants agreed to be identified by name and to have their interviews recorded and transcribed, although several requested to review their interview transcripts to make final revisions or deletions. All participants were also willing to donate photographs of themselves as pre-legislation midwives and to have their photos taken as part of the data collection process. Materials collected in this research were stored securely with locked access and were available only to me as the researcher and my research supervisor. Most, although not all, of the participants consented to the donation of their audio recordings, interview transcripts, and photographs to the provincial professional association for midwives, the Association of Ontario Midwives, for archiving. (See Appendix F for a letter from the Association of Ontario Midwives stating their willingness to house donations of materials from this research study.) Those interviewees who did not wish to donate their materials to the AOM agreed to the destruction of their research materials five years following the completion of this thesis to avoid their unauthorized use.

My practice and interpretation of oral history are influenced by feminist theoretical considerations of the central role of gender in shaping oral narratives and narrative analysis, as well as attention to the relations of power in the interviewer/interviewee relationship.\textsuperscript{76} Feminist historians have emphasized the democratization inherent in oral history and its potential for the leveling of the hierarchy between the researcher and the researched.\textsuperscript{77} Oral history facilitates the
production of knowledge by those who lived history, centring their words in the writing of history.\textsuperscript{78} The potential for agency of interviewees in an oral history methodology was an important consideration for the midwife interviewees. Although in a few cases, Ontario midwives have been the lead researchers in social science investigations into midwifery’s changing status, they have usually come under the research lens of social scientists as “others” in their transition from outside to inside official health care and the law. In both the pre-legislation period and the early years of regulated practice, midwives’ work on the margins of official health care also came under intense scrutiny by the state, the dominant maternity care professions of medicine and nursing, and the media.

When I circulated the notice to Ontario midwifery practice groups and organizations announcing my research study, a number of interested participants contacted me to enquire about how their stories would be used. They expressed reservations, either directly or indirectly through hesitation and questioning, about once again coming under a research lens about their lives and their work; they were worried their words would be appropriated in unanticipated ways. Most interested participants seemed reassured that the primary goal of this research was to document their stories of how and why they practiced in Ontario prior to legal recognition. Their concerns about potential vulnerabilities were balanced by their willing enthusiasm to share their experiences as pre-legislation practitioners to expand the existing record of Ontario midwifery and to inform future generations about some of the roots of regulated midwifery. In accord with the principles of the \textit{Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans}, respect for human dignity, free and voluntary participation and informed consent were integral to my conduct and interpretation of the oral history interviews.

Recent feminist scholarship has unsettled theoretical assertions of equality in the interviewer/interviewee relationship by suggesting claims to equality are misleading and illusory.\textsuperscript{79} As American historians Sherna Berger Gluck and Daphne Patai argue, historians’ ultimate power of editorial control over the production of history needs acknowledgement and explication.\textsuperscript{80} In my informed consent materials and discussions with potential interviewees, I explained my role in translating their words to a written format and how their narratives would be used in written products and oral presentations. All interviewees consented to recording and transcribing of their interviews. I shared the Interview Guide with each participant in advance of their interview. The use of the semi-structured interview format facilitated dialogue and allowed
the interviewee to direct the conversation within the broad categories listed in the Interview Guide. Interviewees were informed they were free to decline to answer any questions or to withdraw from the study at any time without reproach or judgment. I sent all interviewees a copy of their transcript for review; however, only four of the twenty-one interviewees made changes. In recognition of the challenges of translating the spoken to the written word, I attempted to keep editing of the transcripts to a minimum with a focus on flow of reading.\textsuperscript{81} I also used large excerpts from the oral history narratives throughout my thesis to use the midwives’ words to recount who they were and what inspired and motivated them to practice. I was attentive to the presence of silences and emotions during the interviews and, when analyzing the transcripts and my interview notes, I probed more deeply for meaning beyond the interviewees’ spoken words.\textsuperscript{82}

As a researcher and a member of the group being researched, my “complex positionality” had potential to compound my subjectivity and the power dynamics inherent in the oral history research relationship.\textsuperscript{83} I was aware that my previous relationship with participants might engender feelings of safety and comfort in the interview process or, alternatively, feelings of awkwardness and discomfort. I have been a practicing midwife for over twenty years in Ontario. I trained informally as an “apprentice” midwife during the early years of midwifery revival and I practiced illegally for almost ten years. I was actively involved in the work for the legal recognition of midwifery in Ontario and I qualified for registration with the College of Midwives by the same mechanism as the interviewees, by attending the government sponsored “pre-registration” upgrading and assessment program. I was known to many members of the targeted participant group and I am a colleague to a number of the interviewees in my midwifery practice, the Ontario midwifery community or the Ontario Midwifery Education Program. At the time of the enactment of midwifery legislation in Ontario, I was the Co-Registrar of the College of Midwives of Ontario, the regulatory body for midwifery. For a two year period, I was in a position of authority over members of the participant group who sought registration as midwives with the College of Midwives.

Throughout this research, I strived to maintain awareness of how my position and beliefs might influence the direction of my interview questions and my interpretations of the data.\textsuperscript{84} I assumed a position that American studies scholar Judy Yung calls “attentive listener,” hoping to “remove my partiality and allow a range of viewpoints and voices to emerge.”\textsuperscript{85} I looked to the
oral history narratives for themes to shape the organization of my thesis, rather than impose a pre-determined structure. I was surprised by the complexity and depth of discussion in the interviews and in my analysis of the oral history narratives, confronting me with the need to limit the scope of my investigation. I made the decision to focus my thesis on two of the four broad areas addressed in the interviews – the midwives’ personal histories and their inspirations and motivations to practice. Future studies that explore how the interviewees learned midwifery and how they practiced in the alegal Ontario setting will make a valuable contribution to the historiography of this period of Canadian midwifery.

The validity of oral history has been widely debated by historians and other interdisciplinary scholars over the last several decades, stimulating a vast range of theories about its relevance to the writing of history. Early practices of oral history by social and feminist historians in the 1960s and 1970s focused on the recovery of voices “hidden from history” as authentic and truthful representations of the past. Theoretical and methodological developments in social history and feminism contributed more nuanced interpretations of oral history that call for a more cautious and conscious reading of oral evidence. The postmodern turn of the late twentieth century was influential in seeing oral history as a socially and culturally mediated process, a narrative construction shaped by complex forces including memory, language, and ideologies. Oral history scholars pointed to the subjective nature of oral history and the inter-subjectivity of the interviewee and interviewer in the co-creation of oral histories. As the field of oral history research proliferated in the humanities and social sciences, reflective scholarship across disciplinary boundaries situated oral testimony in the realms of myth making, storytelling and public memory. Throughout this thesis, I use the term “narrative” to refer to the midwives’ oral histories in recognition of the subjective and mediated nature of oral evidence.

Acknowledgement of the subjectivities inherent in an oral history methodology does not diminish the value of oral testimony in the writing of history, as stated by Gluck:

…there is not any single answer to the increasingly complex questions raised about the practices of women’s oral history. Yet, as the debate continues, many historians would still argue about the need to recover women’s voices…it remains an important tool both for empowering women, by bringing forth their voices and their sometimes hidden forms of resistance, and for advocating on their behalf by documenting their experiences of discrimination and subordination.
In her examination of feminist debates of women’s oral history and the postmodern turn to narrative form, Canadian historian Joan Sangster stressed the importance of seeing oral evidence as reflective of both constructed historical memory and lived experience:

While an emphasis on language and narrative form has enhanced our understanding of oral history, I worry about the dangers of emphasizing form over context, of stressing deconstruction of individual narratives over analysis of social patterns, of disclaiming our duty as historians to analyse and interpret women’s stories. Nor do we want to totally abandon the concept of experience, moving towards a notion of a de-politicized and “unknowable” past. We do not want to return to a history which either obscures power relationships or marginalises women’s voices. Without a firm grounding of oral narratives in their material and social context, and a probing analysis between the two, insights on narrative form and on representation may remain unconnected to any useful critique of oppression and inequality.92

Using oral history with awareness of the mediated knowledge of oral evidence can act to make this process more transparent and strengthen the production of historical knowledge. Canadian historian Ruth Roach Pierson cautioned oral history scholars to look beyond the task of recovering lost voices to enrich the historical record by contextualizing oral evidence:

It has, after all, never the job of the historian only to reclaim voices. That would result in naïve empiricism. No, the task has been equally, and just as importantly, to contextualize the individual voices, to reconstitute the “discursive” world which the “subjects” inhabited and were shaped by.93

American historian Ronald J. Grele suggested a multi-layered approach to the contextualization of oral evidence:

It is the oral historian’s task, through research, to understand the history of these tellings and then to explore the contradictions within the story, contextualize the telling, and thereby help the narrators create the fullest narrative possible at this moment in time.94

Questions of theoretical legitimacy are not isolated to oral evidence. Historians recognize the mediated nature of conventional historical sources, suggesting they should be subject to the same rigorous analysis and contextualization as oral testimony.95

In this thesis, I look to a range of historical, social science, professional, and popular sources on Ontario midwifery in order to contextualize the oral history narratives of the midwife interviewees, in addition to evidence on parallel midwifery movements in other regions of North
America. I also review historical evidence on the changing conditions of women’s lives in twentieth century Canada, given the divergence in the interviewees’ ages, to reflect on and contextualize the interviewees’ personal history narratives. In my exploration of the midwives’ oral histories, I highlight areas where their narratives contradict, enhance, or support theoretical understandings of midwives and their inspirations to practice in modern revivals of midwifery in Ontario and elsewhere in North America.

1 Midwifery in the United States, as in Canada, was a central form of domestic health care prior to the modernization and professionalization of health care in the late nineteenth and early twentieth centuries. American midwifery declined in similar patterns to those in Canada in the first half of the twentieth century, a time when midwifery was professionalized in other high resource countries. In some regions of the United States, however, nurse-midwifery was established as a distinct specialty of nursing, unlike in Canada where social reform campaigns advocating nurse-midwifery were unsuccessful in securing midwifery legislation. Although nurse-midwifery has since evolved to be recognized in many American states, the number of nurse-midwife-attended births has remained marginal and largely isolated to women underserved by physicians until recently. Social movements for childbirth reform based on home birth and midwifery emerged in early 1970s America, pre-dating and influencing similar movements in Canada. For a comprehensive overview of the evolution of midwifery in the United States, see Judith Pence Rooks, Midwifery and Childbirth in America (Philadelphia: Temple University Press, 1997). For a discussion of the parallels and divergences of Canadian and American midwifery, see Ivy Lynn Bourgeault and Mary Fynes, “Integrating Lay and Nurse-Midwifery into the U.S. and Canadian Health Care Systems,” Social Science & Medicine 44, no. 7 (1997): 1051-1063.


4 For a discussion of historical theorizing using the category of gender, see Joan W. Scott, “Gender: A Useful Category of Historical Analysis,” The American Historical Review 91, no. 5 (December 1986): 1053-1075.
Historian Adrian Wilson examines childbirth from “the mother’s point of view” in seventeenth century Europe and provides a contrasting portrait to dominant historical narratives characterizing midwives as unsafe and socially marginalized. Wilson provides scholarly evidence that childbirth was predominately under female control prior to the rise of “man midwifery” and that midwives were “distinguished members” of the “ceremony of childbirth.” See Adrian Wilson, “Ignorant Midwives - A Rejoinder,” *Social History of Medicine* 32, no. 1 (April 1983): 46-49; and “Participant or Patient? Seventeenth Century Childbirth from the Mother’s Point of View,” in *Patients and Practitioners: Lay Perceptions of Medicine in Pre-industrial Society*, ed. Roy Porter (Cambridge, UK: Cambridge University Press, 1985), 129-143. Scholarship on North American midwifery of the eighteenth and nineteenth centuries provides a similar portrayal of childbirth as a female domestic activity. See, for example, Ulrich, *A Midwife’s Tale*; and Connor, “Minority Medicine.”


Ehrenreich and English, *Witches, Midwives, and Nurses*.


For a critical analysis of these early histories of childbirth and midwifery, see Monica H. Green, “Gendering the History of Women’s Healthcare,” *Gender & History* 20, no. 3 (November 2008): 487-518.

See, for example, the historical account of midwife Martha Ballard who practiced in the eastern United States in the late eighteenth and early nineteenth centuries in Laurel Thatcher Ulrich, *A Midwife’s Tale: The Life of Martha Ballard, Based on her Diary, 1785-1812* (New York: Vintage Books, 1991).


See, for example, Ivy Lynn Bourgeault, “Delivering Midwifery: An Examination of the Process and Outcome of The Incorporation of Midwifery in Ontario” (PhD dissertation, University of Toronto, 1996).


In a 1965 special issue of the medical journal of The University of Western Ontario entitled “Cults, Marginal Medicine and Midwifery,” M.C. Hickey presented an historical overview of midwifery from ancient to modern times. Hickey’s article provides an example of folkloric and stereotypical interpretations of midwifery history. See “Midwifery,” *The University of Western Ontario Medical Journal* 35, no. 2 (January 1965): 63-66. Biographical and autobiographical accounts of nurses’ experiences providing primary health care in remote and rural regions in Canada were published in the postwar period. See, for example, Elliott Merrick, *Northern Nurse*

19 Buckley, “Ladies or Midwives?”


21 Biggs, “The Case of the Missing Midwives.”

22 Mason, “A History of Midwifery in Canada.”

23 Ibid., 12.

24 Ibid., 17-20.

25 Midwives Coalition, “First Submission to the Health Professions Legislation Review” (December 1983); Midwives Coalition, “Second Submission to the Health Professions Legislation Review” (June 1984); and Midwives Coalition, “Third Submission to the Health Professions Legislation Review” (October 1985).


27 In the 1990s, the Historica Foundation of Canada produced a series of one minute audio visual vignettes depicting historically significant events and figures that were televised in Canada. One of these vignettes portraying a midwife as a heroic frontier figure was broadcast at the time of Ontario’s landmark midwifery legislation. See, “Midwife: From the Heritage Minute Collection,” The Historica Dominion Institute, accessed June 13, 2012, https://www.historica-dominion.ca/content/heritage-minutes/midwife?media_type=41&. Margaret MacDonald examines the symbolic role of this vignette in “Tradition as a Political Symbol in the New Midwifery in Canada,” in Bourgeault, Benoit, and Davis-Floyd, *Reconceiving Midwifery*, 46-47.

Jutta Mason’s historical narratives of the “neighbour midwife” and the “popular birth culture” and Barrington’s interpretation of midwifery’s modern re-emergence as a “grassroots” and “feminist” social movement have informed future scholars and popular writers of Canadian midwifery. They are frequently referenced by social scientists who have published widely over the last several decades, such as Cecilia Benoit, Ivy Lynn Bourgeault, Robbie Davis-Floyd, Margaret MacDonald, and Sheryl Nestel. For a recent example of how these narratives continue to inform researchers and writers of Canadian midwifery, see Mariel Angus, Patrik Marier, and Stephanie Paterson, “The Politicization of the Dutch Model: The Creation of the Ontario Midwifery Model” (paper, Learning in Politics and Public Policy Workshop, European Consortium for Policy Research Joint Sessions, St. Gallen, Switzerland, April 15, 2011), accessed June 13, 2012, http://www.fabriziogilardi.org/ecpr2011/papers/files/paterson.pdf.


Cecilia Benoit, “Midwives & Healers: The Newfoundland Experience,” Healthsharing (Winter 1983): 22-26; and Benoit, Midwives in Passage.


For example, see Mary Crnkovitch, ed., ‘Gossip’: A Spoken History of Women in the North (Ottawa: Canadian Arctic Resources Committee, 1990); J. O’Neil and P. Gilbert, eds., Childbirth in the Canadian North: Epidemiological, Clinical and Cultural Perspectives (Winnipeg:


40 Rushing, “Market Explanations.”

41 Young, “‘Monthly’ Nurses, ‘Sick’ Nurses, and Midwives.”


49 Brian Burtch, Trials of Labour, 159.


52 Van Wagner, “With Women.”


54 Mason, The Trouble with Licensing Midwives.

55 American sociologist Barbara Katz Rothman is credited with formulating distinct childbirth models of care for midwifery and medicine in 1982 in In Labour, 23-25. American anthropologist Robbie Davis-Floyd is leading scholar on the construction of “wholistic” (midwifery) and “technocratic” (medical) models for birth that infuse narratives of North American midwifery, including scholarship in Ontario modern midwifery. See “The Technocratic and Wholistic Models of Birth Compared,” table 1 in Robbie E. Davis-Floyd, Birth as an American Rite of Passage (Berkeley: University of California Press, 1992), 160-161.

56 Critical scholarship on Ontario midwifery regulation increasingly characterized the community of midwives as polarized into a binary of “elite” and “non-elite.” See, for example, Mary Sharpe, “Ontario Midwifery in Transition: An Exploration of Midwives’ Perceptions of the

57 Biggs, “Rethinking the History of Midwifery in Canada,” 18.

58 Ibid., 19.

59 Ibid., 18-19.

60 Davis-Floyd defines the postmodern midwife as “one who takes a relativistic stance toward biomedicine and other knowledge systems, alternative and indigenous, moving fluidly between them to serve the women she attends. She is locally and globally aware, culturally competent, and politically engaged, working with the resources at hand to preserve midwifery in the interests of women.” See Robbie Davis-Floyd, “Daughter of Time: The Postmodern Midwife (Part I),” *Revista da Escola de Enfermagem da USP* 41, no. 4 (2007): 705-710. Margaret MacDonald refers to Ontario midwifery as a postmodern practice in, “Postmodern Negotiations with Medical Technology: The Role of Midwifery Clients in the New Midwifery in Canada,” *Medical Anthropology* 20, no. 2/3 (January 2001): 245-276. Davis-Floyd added a “humanistic model” of childbirth to her dichotomous models of medicine/technocratic and midwifery/wholistic. Social science scholars of midwifery have recently suggested a hybridization of these models contributes to improved outcomes in maternity care. See, for example, Davis-Floyd, Barclay, Daviss, and Tritten, *Birth Models that Work*.

61 Davis-Floyd, Barclay, Daviss, and Tritten, *Birth Models that Work*, introduction, 1.

62 Margaret MacDonald and Ivy Lynn Bourgeault, “The Ontario Midwifery Model of Care.”


64 Bourgeault, *Push!,* 286.


67 The professional association for Ontario practicing midwives, the Association of Ontario Midwives (AOM), has materials from the pre-legislation period of practice that, until recently, had not been catalogued. In 2012, the AOM initiated a project to create an archive for these materials, as reported by Kelly Stadelbauer, Executive Director, Association of Ontario
Midwives, in person communication with author, May 17, 2012. These materials include newsletters of the pre-legislation provincial associations for midwives, the Ontario midwifery consumer organization (the Midwifery Task Force of Ontario), and government briefs submitted to the HPLR by midwifery related organizations. Some materials, however, remain inaccessible or are lost. During my recruitment for this research study and in the interview process, I was informed by interested participants and interviewees that they had “boxes” materials from the pre-legislation period of practice in their “basements” that they would like to donate for preservation. The Michener Institute for Applied Health Sciences that sponsored the upgrading and assessment program for Ontario practicing midwives to qualify for registration with the College of Midwives of Ontario included a “biographical letter” from applicants in its admission process. (See Ivy Lynn Bourgeault, “The Michener Institute Midwifery Pre-Registration Program Application Instructions,” appendix 24 in “Delivering Midwifery.”) These letters, along with all records of the Pre-registration Program for Midwifery, were destroyed by the Michener Institute in the late 1990s as reported by Diana Schatz, Executive Director, Michener Institute of Applied Health Sciences, in person communication with author, March 22, 1998.


70 Tyson, Nixon, Vandersloot, and Hughes report that sixty-two of the seventy-four Ontario practicing midwives admitted to the Michener Institute’s Midwifery Pre-registration Program successfully completed the program and were eligible for registration with the College of Midwives of Ontario in “The Re-emergence and Professionalization of Midwifery in Ontario,” 172. Nestel reports seventy-two midwives were admitted and sixty-four graduated from the Midwifery Pre-registration Program in Obstructed Labour, 96.

71 See notes 2 and 24 above in the Introduction.

72 The first midwives registered by the College of Midwives of Ontario on January 1, 1994 were those who had successfully completed the Michener Pre-registration Program. The number of these registered midwives is variously reported in the range of fifty-eight, for example by Sharpe in “Ontario Midwifery in Transition,” 205, to “less than seventy” by Bourgeault in Push!, 146.

73 The clinical practice requirements for admission to the Michener Institute’s Midwifery Pre-registration Program are detailed in appendix 23 of Bourgeault, “Delivering Midwifery.”
For evidence of Ontario practicing midwives not admitted to the Midwifery Pre-registration Program, see Trish Hennessy, “New Legislation Puts Well-Established Midwife out of Work,” *Kingston This Week*, February 23, 1994, 20A. Hennessy reports eighty of the 150 people who applied to the Ontario government’s assessment program for Ontario practicing midwives were accepted and seen to meet the program’s entry criteria for current Ontario practice. This article features the story of a midwife practicing in the Kingston area whose clinical experience fell slightly below the entry cut off. Margaret MacDonald reports that some of those not admitted to the Midwifery Pre-registration Program formed the Committee for More Midwives to lobby the Ontario government for a special route of entry to regulated practice that recognized their Ontario clinical experience in *At Work in the Field of Birth*, 39. Sheryl Nestel critiques the exclusion of non-practicing midwives with international credentials from the program, as well as the loss of livelihood for rural Ontario practicing midwives who did not meet clinical standards for admission. See *Obstructed Labour*, 98.


British sociologist Ann Oakley challenges the neutrality and objectivity of the traditional scholarly interviewer as the gatherer of objective and quantifiable data from research subjects. She envisions the feminist interviewer in a relationship of equality with the interviewee and the interview as a conversation facilitating dialogue and disclosure by both the interviewee and the interviewer in “Interviewing Women: A Contradiction in Terms,” in *Doing Feminist Research*, ed. Helen Roberts (New York: Routledge & Kegan Paul, 1981), 30-61.


82 Alessandro Portelli refers to silences in oral testimony as “the most precious information may lie in what the informants hide (and in the fact that they hide it), rather than in what they say” in “The Peculiarities if Oral History,” *History Workshop Journal* 12, no. 1 (January 1981): 102. Luisa Passerini also recognizes the discursive meaning of silences in oral evidence in “Work, Ideology and Working-Class Attitudes to Fascism,” in *Our Common History: The Transformation of Europe*, Paul Thompson, ed. (London, UK: Pluto Press, 1982), 54-78.


84 Valerie Yow suggests the use of “critical reflexivity” by interviewers to be self aware of personal and ideological biases, monitor emotional reactions to interviewees, and consider alternate lines of enquiry to predetermined questions. See “Do I Like Them Too Much?: Effects of the Oral History Interview on the Interviewer and Vice Versa,” *The Oral History Review* 24, no. 1 (Summer 1997): 79. American folklorist Katherine Borland examines some of the complexities of interpretive authority for feminist researchers using oral narratives in trying to balance “interpretive respect” for those speaking with the researcher’s responsibility to interpret narrators’ stories and experiences. She recommends a reflexive and negotiated process for interpretive authority in “‘That’s Not What I Said’: Interpretive Conflict in Narrative Research,” in Gluck and Patai, *Women’s Words*, 63-76.


Gluck, “Women’s Oral History,” 381.

Sangster, “Telling our Stories,” 22.


Chapter 2

Before Midwifery:
Who Were Ontario’s Pre-legislation Midwives?

The artwork on the front cover of the Report on the Task Force on the Implementation of Midwifery in Ontario displays the Oxford English Dictionary definition of the word midwife:

mi’dwif/fe n. (pl. ves pr. –vz). person (usu. woman) trained to assist others in giving birth; hence mi’dwifERY (2) (-fri) n. [ME, prob. f. obs. prep. mid with (OE; cf. G mitt) + WIFE woman, in sense ‘one who is with the mother’]¹

The prominent display of this definition made a dramatic statement about the need to educate policy makers, health care professionals and the public about the concept of midwifery. It also asserted to readers accustomed to medical hegemony in childbirth that a codified understanding of midwives existed. The definition notes that the term “midwife” is derived from Old English and German meaning “with woman.” This literal meaning gives figurative form to the midwife as a childbirth attendant. The etymological roots of the English word do not denote gender; however, the definition does note that a midwife is usually a woman. Historically and cross culturally, childbirth attendance has largely been considered women’s work.² Terms for midwife across languages are commonly gendered female, such as the French “sage femme” and the Dutch “vroedvrouw” meaning “wise woman,” and the Danish “jordemoder” meaning “earth mother.”³

The members of the Task Force on the Implementation of Midwifery had to look outside Canada to learn about midwifery in formal systems of education and health care to see how a midwife was defined in practice. They investigated international midwifery models to determine how best to structure a sustainable and effective midwifery profession. They held public hearings to consider the interests of Ontario health care consumers and professionals. They also studied alegal practices of midwifery that were occurring in Ontario. In most countries of the world, midwifery has a continuous history from ancient to modern times and midwives are recognized as primary health care providers for normal pregnancy and childbirth. An international Definition of the Midwife was developed in 1972 by the International Confederation of Midwives that formalizes a common understanding of recognized midwifery practitioners as trained and skilled childbirth attendants.⁴ The original definition was created in collaboration
with the International Federation of Gynecologists and Obstetricians and was later adopted by the World Health Organization. This definition has been modified several times to emphasize changing priorities for the role and responsibilities of the midwife. In 2011, the definition was revised to strengthen the role of midwifery in the promotion of normal birth in response to rising rates of medical and surgical intervention in the management of childbirth.\(^5\)

Despite longstanding historical traditions of midwifery in Canada, midwifery has only recently received comprehensive legal recognition in many of the countries’ provinces and territories. Prior to Ontario’s landmark legislation, understandings of midwives were limited by their lack of a cohesive professional or social identity. The North American revival stimulated renewed growth and organization of midwifery, and yet midwifery continues to have diverse meanings in both Canada and the United States. American sociologist Barbara Katz Rothman’s reflections on the disparate practices and ideologies of modern American midwifery capture a methodological complexity in the study of midwives who do not share a singular identity: “…‘midwife’ is not a self-evident, all-inclusive term. A midwife is…very much in the eye of the beholder.”\(^6\) Rothman’s analysis of the varied and subjective meanings of the term midwife is relevant to the study of Canadian midwifery, as Canada and the United States share a history of diverse practices of midwifery with limited official recognition. The potential for interpretive subjectivity in the study of midwives who lack a common identity highlights the relevance of the research question: Who were Ontario’s pre-legislation midwives? It also underlines the value of midwives’ oral testimony to inform the discussion of their lives and their work in the absence of a formal or standardized identity.

Knowledge about Ontario pre-legislation midwives is informed by several major representations that dominate the literature of the North American midwifery movement and its particular expression in Ontario. Womanhood and motherhood underlie the most pervasive and persistent representations of midwives. Counterculture and feminist discourses defined the “new” North American midwife by her female gender and by her status as an “outsider” to prevailing systems of institutionalized maternity care.\(^7\) Midwives were configured in early midwifery revival literature as caring mothers empowering other mothers in natural childbirth alternatives to medicalized childbirth directed by male medical professionals.\(^8\) There was muted acknowledgement in this literature that non-mothers could make suitable midwives if they embodied exceptional caring qualities.\(^9\) Nurses’ suitability for midwifery practice was similarly
viewed with hesitation, despite nursing’s ideological roots centered on an ethic of caring. Nursing’s subordinate position within official health care was considered incompatible with the philosophy and practice of grassroots midwifery and its autonomy from medicine. The profession of nursing was seen to be aligned with institutionalized medicine and its view of childbirth as a pathological event requiring technological intervention. The ability of some nurses to redefine themselves as midwives and support women in natural birth choices was seen as exceptional.10

As midwifery practice expanded across North America in the latter decades of the twentieth century, critical analysis of the new midwifery based on class and race emerged in Canada. The inability of pre-regulation midwifery to reflect the diversity of Ontario’s population was variously used by social scientists, midwives and their supporters to critique and to forward midwifery’s legal recognition. In the 1980s, recognition that home birth and midwifery outside formal health care were accessible mainly to women of privilege contributed to a view of midwives as middle class and well educated. Midwives’ middle class status was interpreted in contradictory ways. In regions where midwifery was contested, it was held up to advance the social and legal legitimization of midwifery.11 At the same time, it was interpreted as a limiting the relevance and accessibility of midwifery for diverse women.12 In the mid-1990s, critical scholarship on the lack of racial diversity in Ontario midwifery entered the discourse on midwifery’s changing legal status. As feminist theory and practice in the late twentieth century increasingly incorporated the analytic category of race, critics from within and outside the midwifery movement highlighted the predominance of white women in the midwifery community and its inaccessibility for racialized women as recipients and providers of care.13 “White” became fused with “middle class” and “well educated” to form a common triad that is used to describe Ontario pre-legislation midwives within these debates.

Many of the midwife interviewees spoke of the influence of these representations of gender, class and race in informing their understandings of who took up the practice of midwifery on the margins of health care and of how they were perceived by others once they became midwives. The examination of the interviewees’ personal histories before they entered midwifery practice that follows adds to these understandings by providing a detailed portrait of the interviewees’ personal backgrounds before becoming midwives.
THE WHITE, MIDDLE CLASS, WELL EDUCATED ONTARIO MIDWIFE

Interviewee Helen McDonald reflected on the community of midwives who practiced in Ontario before legal recognition: “The diversity? I didn’t think there was any. Well I’m white. I didn’t see anybody pre-regulation who wasn’t...They’re all what I would characterize as middle class. They’re all what I would characterize as pretty well educated.” McDonald’s reflections highlight the concepts of “white,” “middle class” and “well educated” that have come to dominate the representations of practicing midwives in modern Canadian midwifery discourse. Her comments reflect both her personal awareness of the homogeneity of pre-legislation Ontario midwives, as well as how they have been portrayed by others. While gender is missing from this portrait, it is likely taken for granted as midwives are also commonly assumed to be female, as well as wives and mothers.

Eleanor Barrington’s 1985 *Midwifery is Catching* was the first major Canadian publication describing the “new” midwifery of late twentieth century Canada. It appeared in the early decades of a growing Canadian midwifery movement at a pivotal juncture of state, professional, and public interest in public policy about midwifery. It was designed to educate the general public about the re-emergence of Canadian midwifery, as stated by Barrington in the introduction: “I felt that people deserved better care and more caring than they were getting; that babies deserved better beginnings. I wanted to spread the good news that midwifery was happening again in this country, that there was a viable alternative to hospital birth and a more satisfying way to give birth in hospital as well.” *Midwifery Is Catching* presented an historical overview of midwifery and the law, and it detailed the evolution of modern practices of midwifery in Canada.

*Midwifery is Catching* makes a valuable contribution to the record of the late twentieth century revival of midwifery in Canada. It was the first major publication to document the modern midwifery movement in Canada. It featured portraits of twelve midwives practicing in a variety of regions in the early years of the Canadian rival, touching on their motivations to practice, their training, and their practice philosophy and structure, as well as the larger political context of their working lives. *Midwifery is Catching* helped to raise public awareness about the historic and modern traditions of midwifery in Canada. In giving voice to midwives’ daily experiences, Barrington’s approach is unique among the large body of Canadian social science literature that is preoccupied with midwifery’s changing legal status. *Midwifery is Catching* has
continued to play an influential role in informing discourse on the Canadian midwifery revival. Its portrayal of midwives’ lives and their work is deeply embedded in future research and writing on Canadian midwifery; the book has largely been seen as the authentic narrative of pre-legislation midwifery.19

*Midwifery is Catching* has also been influential in informing a lasting representation of who took up unregulated midwifery practice in Canada.20 Barrington provided a compelling portrait of highly capable and intelligent midwives to counter what she identified as a series of common “Myths and Misconceptions” that characterized midwives as ill prepared and irresponsible.21 She appealed to midwives’ maturity, their privileged social position and their educational status to bolster her argument for the social and legal acceptance of midwifery: “...by 1980, the majority of midwives and their clients belonged to the middle class. Today’s ‘wise-woman’ is likely to be about 35, raised in a suburb, and university educated.”22 Barrington concluded that, although there was “no prescribed career path” to midwifery, her “informal survey of a dozen practising midwives reveals a curious array of past lives: one actress, three nurses, two journalists, a teacher, an occupational therapist, a weaver, an X-ray technician, a massage therapist, and a bookkeeper.”23 She described midwives as typically coming to midwifery as “a second career, a discovery of ‘right livelihood’ that comes after post-secondary education, some other occupation, and usually parenthood. Few women take it up before the age of 25.”24 Barrington’s portrait of modern Canadian midwives reinforced the prevailing assumption that motherhood was a natural precursor to midwifery practice.25

*Midwifery is Catching* appeared at a time when ambivalence about motherhood as a feminist issue was shifting. With growing recognition of the personal and political significance of mothering in the lives of women, feminists across a range of theoretical orientations embraced midwifery as a feminist issue. Some feminists viewed midwifery as an essential feminine activity supporting childbearing women’s empowerment, whereas others interpreted midwifery as integral to women’s reproductive rights, particularly the choices of when and how to give birth.26 Barrington uncritically embraced midwifery as a maternal and feminist practice that supported the empowerment of women, while recognizing ideological tensions in the midwifery community among traditionalists and feminists.27 The book’s portrait of pre-legislation midwifery is celebratory. Critical analysis of midwives’ social privilege is lacking in Barrington’s account. She did not problematize midwifery as an elitist movement of women of
privilege, as emerged in future discourse on Canadian midwifery. Barrington also did not address race, despite the absence of diversity in stories of pre-legislation practice. The books’ photographs provide an image of the midwives and the women they served, and they all appear to be white. Essentialist assumptions of motherhood and nurturance as key prerequisites for midwifery are left unexplored.

Following *Midwifery is Catching*’s publication in 1985, developments in feminist theory and practice contributed new critical perspectives on North American midwifery revivals. Critiques of second wave feminism’s class and racial homogeneity and its universalizing of women’s experience within a rhetoric of shared “sisterhood” emerged in the 1980s, both from within and outside the women’s movement. In Canada, these critiques were increasingly seen to have relevance to the analysis of the modern midwifery movement. As late twentieth century feminist scholarship incorporated a focus on identities, difference and intersections of sites of oppression, critical scholarship on Ontario midwifery began to integrate class and race analysis. Growing recognition of the limitations of the midwifery community’s ability to reflect and serve diverse women consolidated a discourse of homogeneity regarding midwives and the women they served. The image of white, middle class midwives in a “monoracial social geography of the Ontario midwifery community” entered popular, professional, and academic discourses by the mid-1990s. Analysis of sexuality in the midwifery revival still largely remains under explored, as does an analysis of gender through the lens of essentialism.

The midwife interviewees spoke of the barriers of unsanctioned midwifery for women without privilege, both as providers and as recipients of care. They saw resonance in the ways Ontario midwives have been portrayed in the midwifery literature; and they saw dissonance. They offered their personal history narratives to add their voices to current understandings of who took up practice in Ontario in the two decades prior to midwifery legislation. While their oral testimonies reinforce the dominant discourse of homogeneity in race, class and gender, the midwives spoke of complexity and difference in their personal stories and in their stories of pre-regulation midwifery.

Heather Burton noted a contradiction in her recollections of the community of pre-legislation Ontario midwives that unsettles the dominant portrait of homogeneity: “I think what interested me, even at the time I was aware, everybody was so varied… We were this group of highly driven, pioneer minded originals, all strong willed, all highly driven by one common cause…”
We were all different and all the same.” While Burton’s reflections do not address race, class or gender, they do suggest a possibility for more complicated understandings of Ontario midwives than is evident in existing theories of alegal midwifery practitioners.

**Personal Backgrounds**

In many ways, the interviewees’ narratives of their personal backgrounds largely reinforce the dominant understanding of Ontario pre-legislation midwives as a uniform and privileged group. All of the interviewees are white.33 The majority are Canadian born and are predominantly of western European descent, with English as their first language. Most described their socio-economic backgrounds as middle class. The majority are currently in their fifties and entered midwifery education and practice while in their twenties and thirties. Many were mothers living in heterosexual nuclear families when they began practicing midwifery. At the same time, the midwives’ narratives also convey subtle differences within and beyond the categories of white, middle class, well educated, and female.

There are variations of nationality in the interviewees’ personal histories. Fourteen of the twenty-one interviewees were born and raised in Canada. Of the twelve interviewees born in Ontario, eight spent their childhoods in the Toronto area, two grew up the Kitchener-Waterloo region, one lived in the southwestern Ontario town of Brantford, and one lived in various army bases in Canada and the United States as her father’s work led to regular relocation of her family. Jane Kithei grew up in Saskatchewan; MaryAnn Leslie spent much of her childhood in Montreal, although she lived for a time in Victoria. Three of the midwives were American born and raised. Judy Rogers grew up in rural Iowa and urban California, Larry Lenske in Minnesota, and Jan Teevan in Maine and other areas of the northeast United States. Four of the midwives were born outside of North America. Mary Sharpe was born in India to white parents of British and Canadian heritage. Her family subsequently moved to England and then settled in Toronto when she was four years of age. Rena Porteous was born in Scotland. She lived part of her childhood in Thunder Bay before returning to Scotland. Linda Moscovitch was born and grew up in South Africa. Helen McDonald was born and raised in rural Australia.

Many of the midwives identified the socioeconomic profile of their families of origin as middle class. The majority of interviewees were born in the postwar baby boom and raised in new suburban communities of North American cities. Most were raised in traditional nuclear
families. The interviewees identified their fathers’ occupations, including lawyers, professors, teachers, engineers, farmers, an army colonel, an automobile mechanic, and a banker. Many identified their mothers as homemakers, some of whom had previous post-secondary education or professional backgrounds. Those raised on farms indicated their mothers’ work extended beyond childrearing and domestic work to include farm labour.

Not all of the midwives’ family backgrounds fit this picture of the normative North American middle class family. Several of the interviewees lived in extended family households or were parented by single mothers. The mother of one interviewee worked outside the home as a physician. Several interviewees identified their backgrounds as working class. Katrina Kilroy and her five siblings were raised by their mother following their father’s premature death. Her family lived in an economically disadvantaged community in Scarborough, a growing suburb of Toronto, and they were financially reliant on her mother’s social welfare income. Kilroy expressed frustration with the ways in which the dominant image of midwives as middle class excluded her:

I always had this little bee in my bonnet about some of the contexts. People would always say when they were talking about diversity, “Well we’re all white, middle class women here.” And I did not consider myself a white, middle class woman. I mean I was white. But I didn’t consider myself a middle class woman by any stretch of the imagination. I wasn’t raised in the middle class. I’d never had…I mean I had a university education. That was getting you part way there. But I didn’t identify myself as a middle class person. And the assumption that because we could all sit around and articulately critique the health care system or whatever, that we were all middle class. I found it offensive. I certainly felt like my class background was…I don’t know what to say about it. I mean it set me apart…I mean there were other midwives who came from similar backgrounds to myself…different from the kind of definition of mainstream that was being handed out.

Vicki Van Wagner was born in the 1950s baby boom and raised in the new Toronto suburb of Etobicoke. Her father was an automobile mechanic and her mother a homemaker. Van Wagner identified her family’s socioeconomic status as undergoing a transition from working class to the new middle class that emerged in Canada under the influence of postwar affluence. She and her sister were the first members of their family to attend university. She noted the significance of her university education: “I come from a working class family. I was a young woman entering university. My sister and I are the first generation of my family to enter university, which is usually taken as a marker of class status.”
When asked to describe their personal histories, few midwives commented on their cultural or religious backgrounds. Those who identified their backgrounds fell outside the dominant cultural and religious norms of the Ontario midwifery community. Two interviewees identified themselves as Mennonite; two others noted their Jewish backgrounds. Wendy Katherine remembered the impact of her “secular, not religious but dominantly Jewish” middle class background on her decision to become a midwife in an unregulated context. She described how her decision to pursue work that was not socially recognized or valued did not sit well with her family:

My background would not have lent itself to supporting a non-regulated health care provider. Choosing to even learn about midwifery was seen very negatively by my family. They hoped it would be temporary. They situated it as a kind of a phase. I remember my family and my extended family, my friends having all kinds of...sort of irrational fears about what I might be doing as I was learning more about midwifery. They thought that midwives were abortion providers. They thought that I might be working in situations that could be unsafe to me. They thought that they would certainly prefer me to have a more what they saw as a professional job if I was going to be in health care, something that was more predictable, remunerative, something that they could be proud of, that they knew more about. So they discouraged me. But I’m pretty stubborn and they knew that too and so it didn’t last very long. Before long I was already into trying to take some steps to get informal education, and at every stage that they saw me taking those steps they could see that the step itself seemed harmless. Learning to be a prenatal teacher was harmless. Learning to do well-women care seemed harmless. Learning physiology, that kind of thing, seemed harmless. They just didn’t quite understand how it all fit together or what it would amount to and whether it would ever become more formal in the system here. They sort of saw me as potentially doomed to, I guess in some ways similar to what I might be doing as an artist, sort of just a little bit unspecified. And I might be poor, and I might not be able to amount to anything that they would be able to understand…

Not all of the midwives who practiced in the early Ontario midwifery movement were women. One of the interviewees, Larry Lenske, is male. In his narrative, Lenske described the ways he negotiated his work in a female dominated occupation as the only man known practicing midwifery in Canada during the pre-legislation period. In a review of the literature on North American revivals of midwifery, there appears to be documentation of only one other man practicing as a “lay” midwife. Men in midwifery remain an exception nationally, despite male dominance in the Canadian medical work force. Men began to enter the midwifery profession in the 1980s in countries where midwifery is integral in the maternity care system, much like
men’s entry into the nursing profession in Canada at that time. Nevertheless, men continue to represent a small minority of midwifery practitioners worldwide and midwifery remains a largely feminized profession internationally.36

The midwives’ ages at the time of interviews ranged from mid-forties to mid-eighties, with the majority concentrated in their fifties. Thirteen of the twenty-one interviewees were between ages fifty and fifty-nine; two were in the age range of forty to forty-nine; two were between ages sixty and sixty-nine; and one was in her eighties. Three of the interviewees did not disclose their age; however from biographical information provided in their interviews it is likely that two were in their fifties and one was in her sixties.

The literature on midwifery for this period generally argues that women became midwives following post-secondary education, occupational work, and their own personal experiences of giving birth. This portrayal of midwives assumes they entered midwifery practice in their childbearing years and after some life experience. While most of the interviewees began their midwifery training and practice in their twenties and early thirties, the age when they entered midwifery education or practice varied from nineteen to fifty. Nearly one quarter began their midwifery education in their late teens or early twenties. Not all of the interviewees were mothers when they began their midwifery work: six midwives were not parents prior to learning or practicing midwifery; three became mothers during the pre-legislation period after they became midwives; and three did not become mothers. One interviewee was a father. Those who were parents had various family sizes that ranged between one and six children, with the average number being three.

Few of the interviewees overtly disclosed their marital status or their sexuality when asked to describe their personal backgrounds. It is evident from their narratives, however, that the majority lived in heterosexual nuclear families when they began their work as midwives, mostly within a middle class context. The occupational categories described for their partners included university professor, engineer, and financial professional. This lack of overt disclosure of marital status and sexuality by many of the interviewees may reflect their internalized assumption of normative discourses about family and sexuality. However, other family patterns were evident in the narratives of the midwives. Some interviewees were single and several continue to be. Some were single mothers or became single sometime within the two decades prior to midwifery legislation. Three of the interviewees disclosed they are lesbian, and all three
are mothers. One woman identified as lesbian prior to taking up midwifery education; another identified as lesbian after becoming a mother and a midwife. The third woman had children in a heterosexual relationship when beginning her midwifery work and has more recently “come out” as lesbian.

**Educational and Occupational Backgrounds**

Most of the interviewees’ educational backgrounds are consistent with the representation of midwives as well educated. Many had university education and professional backgrounds prior to taking up midwifery. Like Barrington’s portrait of Canadian midwives, the interviewees’ occupational backgrounds were varied. Analysis of their narratives suggests that not all interviewees followed a path of higher education and a professional life prior to taking up midwifery. The roots of midwifery interest are evident in the personal history narratives of some of the interviewees, whereas for other interviewees their paths to midwifery are less straightforward.

The midwives’ educational backgrounds fall into several broad categories. The majority attended post-secondary education prior to studying midwifery, primarily within a university setting. The fields of study for those who attended university ranged widely, including biology, business, education, English literature, journalism, music, political science, psychology, and women’s health. Several interviewees pursued graduate degrees prior to taking up midwifery, and several others entered graduate programs in the decades prior to midwifery legislation while they were practicing midwifery. Just over one third of the interviewees had training and practice experience as professional nurses that preceded their work as midwives.

While most of the interviewees attended post-secondary education directly following high school, several worked in a variety of jobs after high school prior to pursuing further education. Carol Cameron recalled her entry into the work force before attending university:

I worked right out of high school. I don’t even know, I just did various stuff. I mean I was sort of drawn to sales and marketing. I went back to school, to university, to York. I did some business and commerce, that kind of thing. And then again, sales and marketing. I thought I was pretty good at sales. And I liked it.

Cameron described her enduring interest in sales and marketing as something she later applied in her midwifery work. She recalled her business knowledge and skills were relevant in public
education and promotion campaigns for midwifery legislation, as well as following regulation when midwives were required to establish group practices in a self-employment, small business model. Vicki Van Wagner worked as a dance and yoga instructor while living in a variety of small Ontario communities for several years in her late teens and early twenties. She began teaching English courses at a Toronto alternative high school that she had attended, despite not having formal teaching credentials. She described her life circumstances when she enrolled in university at age twenty-three:

…I was going to university and I was teaching as a part time teacher/resource person. I hadn’t gone to teacher’s college but I was assisting in a high school, an alternative high school in Etobicoke. I began my university education when my daughter was six weeks old. That’s when I enrolled in university.

Not all of the interviewees who attended university completed their degrees. Several described dropping out of university in the 1960s, feeling disillusioned or disinterested and searching for meaning outside of institutionalized education. Jan Teevan framed her decision to leave university in the social context of sixties American counterculture:

I went to high school and, you know, it was the late sixties and I became a hippie. I tried to go to university and had to drop out and went to live with my boyfriend. And then decided I wanted to live on a commune and went back to the land. Bought some land in Oregon and moved there with my sweetie of the time. You know, just wanted to see what was out there as opposed to just wanting to get a job and settle down.

Larry Lenske explained his decision to leave university was similarly influenced by American counterculture ideologies and practices:

I grew up in Minnesota, Minneapolis suburbs. Spent my first twenty years there. Went to University of Minnesota for a couple of years after high school in kind of a science, undecided, major. Then in 1970 at the age of twenty ran away from home and became a hippie in San Francisco and spent five years there mostly working in alternative education. Then I went and lived for seven years in an intentional community in Virginia, probably the closest thing to a kibbutz in North America, an egalitarian community and that’s where I got my real education.

Several of the interviewees dropped out of high school, pursuing post-secondary education later in their lives. Michelle Kryzanauskas left high school at age sixteen and became a bank teller. She worked in the banking industry for over a decade, where she advanced to managerial positions specializing in computer technology. She later applied to a new community college
program in computer technology with her employer’s support. Kryanauskas remembered her surprise when she was assessed as having high school equivalency when she applied to community college:

I am a high school dropout. I left high school in grade eleven. I had moved from a private school situation where my classes were tiny, an all-girl situation, into North Toronto Collegiate. I was completely overwhelmed and had a terrible term...I always had the notion that I was going to go back to school sometime but I quickly rose through [bank] management...I went back to Georgian College, had myself assessed to figure out what I had to do to get a high school degree and they actually granted me the diploma at the testing. And I took a micro-computer specialist program in an apprenticeship model...

Holliday Tyson left high school to pursue international midwifery training. She explained her decision to completed high school by correspondence course and enter university while waiting to meet the age requirement for entry a European midwifery school:

I didn’t really want to stay in high school. I left home when I turned seventeen and I still had some high school to do. I went off to Europe and applied to be a midwife but I wasn’t old enough to be eligible. I hadn’t finished high school then anyway, so I finished high school by correspondence and worked at a bunch of jobs. I went to university for a year because I thought I should while I was waiting...

Tyson later completed her baccalaureate degree at Lakehead University in Thunder Bay, following her graduation from a British midwifery school and a period of international midwifery work.

Many of the interviewees did not have professional backgrounds in health care prior to their work as midwives. Carol Cameron worked in marketing and sales. Michelle Kryzanauskas combined work in banking with a small family business, run with her partner, that manufactured wood stoves. Jan Teevan’s varied background included working as a house sitter, fire tower lookout, waitress, and health food store clerk. Jane Kilthei worked as a writer and an information officer in the various government positions. Several interviewees worked as teachers, although none had formal teaching credentials. Mary Sharpe taught in public and private schools at the junior high and high school levels at a time when a specialized degree in education was not the requisite credential. Judy Rogers, Vicki Van Wagner and Larry Lenske worked in public or private “alternative schools” of the 1970s in Canada or the United States. Like Sharpe, they did not hold formal teaching credentials.
Several interviewees developed an interest in natural childbirth reform initiatives prior to becoming midwives. These interviewees trained as childbirth educators in programs founded in the 1960s and 1970s under the influence of natural childbirth and consumerist reform movements. Jane Kilthei sought training in childbirth education following the birth of her son. She also became interested in the emerging women’s health movement of second wave feminism. Her interest in women’s health and self-help led her to work as a “gynaecological teaching assistant” in a newly established program designed to train medical students in pelvic and breast examinations.

The proportion of nurses in this study sample, nearly one third, is consistent with the profile of Ontario midwives practicing in the pre-legislation period. It also challenges assumptions in midwifery revival literature about the exceptionality of nurses’ suitability to become midwives. The institutional setting of the interviewees’ nursing education varied, including programs at the community college or university level and hospital-based professional training programs. Six of the nine interviewees with nursing backgrounds trained in Ontario. Patty McNiven’s narrative of her hospital-based nursing training was typical of the interviewees who studied nursing in 1970s Ontario. Nursing education was undergoing a transition at this time, as hospital-based nursing training programs were being integrated into a newly evolving system of community colleges. McNiven described the pedagogical structure of her nursing training at Toronto Western Hospital: “It was a three-year program, two years that you went through the summer... it was at the hospital, not at the college, but it would have been coming under George Brown.” Of the three nurses who trained outside of Canada, one trained in Scotland, one in South Africa, and one in Australia. Five of those with nursing backgrounds also pursued recognized midwifery education and practice outside of Canada, whereas three of the interviewees with nursing credentials pursued informal midwifery training in Ontario. Two nurses entered Ontario midwifery practice through a hospital-based “midwifery project,” one with formal midwifery training outside Canada and one without previous midwifery training or experience.

Most of the interviewees with nursing backgrounds did not study nursing as a career path to midwifery, but instead discovered midwifery later in their lives. Kathy Penczak, for example, linked her desire to study nursing with her occupational experience working as an ambulance dispatcher in a small Ontario hospital:
I was working in a hospital doing ambulance dispatching at the time. Because it was a small hospital and there were people walking in off the street and I had to deal with the emergencies that walked in off the street as well as police, fire, ambulance, I thought, “You know what? I really like the patient care aspect of it.” So I thought, “Well I better, if I’m going to work here at night all alone before I can page somebody to come down to help somebody who had a heart attack in front of me, I better take CPR.” So then I took CPR and that got me interested. I did that for probably four or five years and then I decided I did want to get into that work, so I applied to both the RNA and RN courses. I got accepted into the RN course and a year later got called by the RNA course but I’d already been in the RN course for a year and said, “Thanks but no thanks.” Became a nurse...

Others took up nursing as a pathway into midwifery, such as MaryAnn Leslie who left university to pursue her interest in childbirth and midwifery. She entered a nursing program at Seneca College in Toronto with a plan to go on to formally study of midwifery. Leslie recalled:

I grew up in Quebec so CEGEP was just starting and I didn’t want to go to CEGEP. I wanted to go straight to university, and so you graduated out of grade 11. I went away to university in New Brunswick and started a Bachelor of Arts degree doing biology... and a double major with English literature...In 1974 I had my first daughter [at eighteen] and decided I didn’t really want the kind of academic science career and got interested in birth and midwifery...We were living in Toronto and I decided that I would go to nursing school here with the eventual goal of going to the UK somewhere to do midwifery and possibly work there or work in the north in Canada, something like that because these were the sort of options I knew about at the time. And so I went to nursing school here in Toronto at Seneca...so I did that and graduated and then worked as a nurse for a couple of years in downtown Toronto at Toronto General Hospital.

Patty McNiven, like Leslie, had an early interest in midwifery. Despite her aspirations to be an artist, she chose to study nursing for practical reasons. She described her desire to access a career that would facilitate her desire to travel:

I had two dreams. One was to be an artist... the other was to be a riding instructor...I got to thinking about what is a midwife and I looked into it and there was no midwifery. So I went into nursing. I was accepted into the Ontario College of Art and I didn’t go because I realized that I would only ever be a mediocre artist... it’s not like there’s lots of work for mediocre artists. You need to be exceptional. And I thought at the time, well nursing. I might be able to get into midwifery but I could also travel around the world and be a nurse.

Colleen Crosbie similarly saw nursing as a valuable credential to support travel and financial independence and she was attracted to its flexible work style:
…as I got older it fit in because I knew it was a transportable job and I was always a traveller and I knew you could work part time, full time and have shift work. I never saw myself as an office girl…I never saw myself as a nine-to-five person.

Many of the nurses, including those with formal midwifery credentials, worked as obstetrical or postpartum nurses in Ontario hospitals when midwifery was not a formally recognized profession. Linda Moscovitch described her surprise when she discovered she was unable to work as a midwife in the Ontario health care system following her graduation from a nurse midwifery program in Cape Town, South Africa:

I just worked for a few months and then I came and lived here and discovered…I hadn’t done a lot of homework around it...discovered that I really couldn’t work as a nurse midwife and so I worked as an obstetrics nurse at Toronto General [Hospital].

The educational and occupational backgrounds of the interviewees were influenced by their level of social awareness of midwifery, and by their access to midwifery training and occupational opportunities. Several of the midwives were born and grew up in countries where midwifery was an established and formally recognized profession within the health care system. For these women, the concept of the midwife was familiar and becoming a midwife was an acceptable and available career path for women within existing formal education programs. Most of the interviewees who had formal training as midwives entered nursing programs following high school. Midwifery education was most commonly available as a postgraduate specialty of nursing in their countries of origin and a midwifery certificate was often required for advancement in nursing.46 Moscovitch explained the role of midwifery training following basic nursing preparation:

I did a three year program at Groote Schuur Hospital in Cape Town...if you wanted to do any other speciality – peds, OR, whatever – you had to do midwifery. So you had to finish up so you were a sister as it was called and then you had to become a midwife and then you were allowed to do any other speciality...I think the idea was that you couldn’t be a fully rounded nurse if you didn’t know how to deliver babies.

The concept of the midwife was unfamiliar for most of those interviewees who were born and raised in the North American context where formal midwifery systems were limited or absent.47 Few North American born interviewees pursued post-secondary education in midwifery. Without easy access to midwifery training and given its tenuous legal situation in Canada and the United States, even those interviewees with aspirations to become midwives followed other
educational and work paths and took more circuitous routes into midwifery. The social profile and organization of the midwifery community in Ontario evolved over the two decades prior to midwifery’s legal recognition. Opportunities for midwifery training and practice inside Ontario were more accessible to aspiring midwives by the late 1980s and early 1990s. The number of practitioners grew along with demand for their services. A provincial organization for midwives was founded in 1981 that later developed standards for training and practice.48

The interviewees’ narratives of their family, educational and occupational histories add important new dimensions to the homogeneous representation of Ontario midwives as white, middle class, and well-educated. Similarity in their personal histories is not surprising given their relative uniformity in class, race, culture, and gender. Their educational and occupational backgrounds are largely reflective of the group they represent, white, middle class women of mainstream English Canada. Their narratives also reveal variations in age, gender, sexuality, class, culture, and religion that enhance understandings about Ontario midwives practicing in the midwifery revival period.

MORE THAN COUNTERCULTURE MOMS AND FEMINIST ACTIVISTS

Midwives’ identities were not only shaped by class and race, they were also shaped by gender. Representations of midwives as countercultural wives and mothers, and later as feminists across a spectrum of feminisms, dominate the literature of modern practice revivals. These representations both reflect and construct normative ideas of gender that persist in the understandings of the roots of modern North American midwifery movements. Counterculture ideologies shaped the new North American midwife as a caring maternal figure. Popular and scholarly critiques of mainstream childbirth practices that first appeared in the 1970s envisioned alternative approaches to modern scientific obstetrics based on the traditional practices of home birth and midwifery. These publications defined midwifery in opposition to medicine and constructed midwives as normal birth specialists in contrast to interventionist medical practitioners, as expressed by Susanne Arms in her 1972 *Immaculate Deception*:

> There have always been midwives, just as there have always been babies, and traditionally this birth attendant has been a woman, often a mother herself. As a trade, midwifery arose from the needs of pregnant women to have a sympathetic and experienced woman sit with them during the birth of their children. The midwife is nothing more nor less than a skilled
specialist in normal birth... By contrast, the science of obstetrics is a very recent development, a profession made necessary by the advance of civilization and its introduction of new problems into birth... the midwife begat the obstetrician, as it was the midwife who practiced for thousands of years in a world where birth was regarded as a natural and normal function of the human body... She has merely had to attend nature and watch and protect the normal process from interference. It is out of respect for the natural process that the midwife has traditionally worked with only her hands and the simplest of tools... I call the midwife the protector of normal and the conscience of the doctor...  

Arms’ claims to midwifery’s superiority that rely on nostalgic interpretations of childbirth history, both historically and cross culturally, are typical narratives in the literature on midwifery’s modern re-emergence in North America. Dichotomous models of midwifery and medicine that juxtapose caring midwife-mothers against scientific medical professionals permeate modern midwifery discourse. Midwives’ support of mothers in community-based natural birth alternatives are commonly set against medical and surgical management of childbirth within impersonal systems of institutional and scientific medical care. In her 1990 critical examination of “licensing” midwives in Ontario, Jutta Mason emphasized the non-professional oppositional stance of “counter-culture” midwives’ to mainstream institutional maternity care providers:

Sometime during the 1970’s, on the continent which had been the birthplace of twentieth-century medical obstetrics, a renaissance began. The neighborly midwife reappeared – the uncredentialed, undiploma-ed woman who went into the houses of her friends and sat with them as their babies were being born. She turned up in the cultural centre of technology-based obstetrics: she was the counter-culture midwife. During the same years the European midwife was becoming a specialized technician, the North American counter-culture midwife sat in the bedroom of her friends, knitting, telling stories, chanting, rubbing, drinking tea. To find out what she needed to know, she read books, talked to other women doing the same thing, and watched the laboring women. Her work and her very existence ran completely counter to obstetrical logic... these midwives were marginal by choice, and besides, who would ever invite them into the medical halls of power? People who chose non-medical birth wanted to have the freedom to be attended where they wanted, by whom they wanted, and that would be enough.  

Midwifery manuals written by practicing midwives that appeared in the 1970s and 1980s also relied on gendered binaries of midwifery and medicine. They envisioned the reclamation of midwifery as a childbirth reform alternative to normative maternity care and, as such, they constructed midwifery as a counter practice to medical obstetrics. Midwives’ lived experiences
as women, wives and mothers were promoted in the texts as fundamental prerequisites to sensitive and skilled midwifery practice, as described by midwife Elizabeth Davis in her 1981 Guide for Midwifery: Heart and Hands:

...the potent lesson of natural childbirth is the revelation of essential feminine force. The experience of birthing calls on a woman to shed her social skin and discover a definite feminine power in flowing, accepting and surrendering to natural forces. Ultimately, giving birth to her child will transform her, renew her, strengthen her faith and deepen her identity. Her ensuring change in perspective (so appropriate for becoming a loving mother) is revolutionary because it is antithetical to that of our outwardly focused, control oriented society...most practical midwives are mothers who have experienced just such an “awakening” themselves. So evolves the practice of midwifery as an art of service – recognizing, responding and cooperating with natural forces.51

Female midwifery was seen to facilitate women’s ability to give birth “naturally,” whereas male medicine was seen to subvert the natural process of childbirth. Medical statistician and childbirth consumer advocate David Stewart asserted an essentialist distinction between midwifery and medicine in his introductory remarks to Davis’ midwifery guide:

Midwifery is an art, not a science; and childbirth is an experience, not an experiment... Today’s obstetrics is an attempt to apply science to a process that is beyond science – the process of childbirth. It tries to reduce to masculinely objective routines the management of a process that is femininely subjective and which defies management. Unlike science, childbirth is a process where personal involvement is inevitable; the choice is not whether to be involved, but whether to be involved positively or negatively, actively or passively...Midwifery is an art; its basis, feeling and intuition. Midwifery is personal attunement by a caring professional and heartfelt concern for the only true observers and experiencers of the birth process – mother and baby.52

Historical theories of midwifery also played a role in constructing and reinforcing a gendered dichotomy of midwifery and medicine. Historical evidence of the long history of female childbirth attendance challenged prevailing assumptions of the superiority of medical maternity care. Early historical theories established heroic grand narratives of midwives that saw linear expression in the discourse of the late twentieth century midwifery movement. Modern midwives working on the margins of health care saw resonance in Barbara Ehrenreich and Deidre English’s historical figure of the midwife as a powerful female healer struggling to resist the male medical takeover of childbirth, as illustrated in the opening page of Heart and Hands:
Midwifery is probably the world’s oldest helping profession. Since time immemorial these helping women have been around at birthing time...However, midwives have a history of incredible persecution. Those practicing in Europe during the sixteenth and seventeenth centuries were tortured and burned at the stake as witches. The women headers were all lumped together in this convenient category, enabling the patriarchal medical profession to rise and conquer.53

Jutta Mason’s historical narrative of the “neighbour midwife” working in a distinct female “alternative birth culture” under threat of a rising medical profession echoed these historical portraits of midwives under threat and closely resembled her depiction of the late twentieth century “counter-culture midwife.”

Many of the interviewees remembered publications of the early North American midwifery movement as informing their understandings of who midwives were and inspiring their personal desire to become midwives. Some interviewees felt an affinity with the women they saw portrayed in these writings. However others, like Holliday Tyson, did not see themselves represented. The essentialist constructions of midwives left some interviewees feeling alienated and excluded. Tyson’s memories of the North American midwifery revival provide insight into the ways in which gender and sexuality were configured in early midwifery discourse. Tyson recalled women’s suitability for midwifery practice was predicated on their maternal and heterosexual status:

I remember that once I decided when I was fifteen that I wanted to be a midwife, I knew I couldn’t do it in Canada. And I started to know a little bit about lay midwifery in the States and I can remember thankfully not going down that route because I knew... I say thankfully because it would have been a complete dead end for me because I picked up really quickly that I just couldn’t have fit in at that time. You know, it wasn’t the right thing. I mean it was very much about women who had already had babies and their own experience leading them to a whole lot of amazing learnings and challenging the system through their own experience and I was not ready to have kids at that point. To be honest I have to say that I had not yet figured out that I was gay, but that was definitely a part of it. My personal take on what I read about the early days of The Farm in the United States and of The Birth Book with Raven Lang and about Elizabeth Davis in the United States, everything I read was always so... now I’d say heterosexist or heterosexual. I wouldn’t have had the words for it then. I just knew it was about men and women who were married or together forever and it was all about their groovy love between each other and them making their families together and I just knew somehow that wasn’t me and I didn’t fit into that. And I also knew that none of those people would be vaguely interested in an eighteen year old. And I could respect that completely. I mean I
completely got it. I just somehow felt that it was the right place for me in midwifery. But I guess I knew from an early time that I’d have to make my own place in it.

Tyson refers to several foundational texts of the North American midwifery revival that constructed and promoted the figure of the midwife as a countercultural wife and mother. She also makes reference to The Farm, a Tennessee spiritual community formed in 1971 that began a midwifery service led by now prominent “lay” midwife and childbirth author Ina May Gaskin. Tyson’s narrative reinforces the dominant understanding of the early midwifery revival as rooted in countercultural social movements of 1960s America. Tyson’s decision to pursue midwifery training outside of North America suggests the limited access to midwifery practice for individuals who strayed from this idealized counterculture figure.

As second wave feminism found common ground with midwifery’s ideological commitment to woman-centred childbirth, alternate representations of midwifery and midwives found expression in midwifery literature. Midwifery ideology diversified beyond the counterculture valorization of natural birth and maternalism to encompass feminist principles of empowerment and self-determination in childbirth. Feminism gave new meanings to the North American midwife that were both compatible and divergent from the counterculture figure. Dual representations of feminist midwives appeared in midwifery discourse that reflected ideological and political tensions and differences within midwifery communities. A maternal feminist midwife embodying traditional femininity was conflated with the counterculture midwife. In contrast, a feminist midwife that conceptualized childbearing as integral to women’s reproductive rights was seen to challenge the maternalism inherent in the counterculture figure by supporting women’s right to choose abortion or by pursuing the “mainstreaming” of midwifery.

While the counterculture and second wave feminism may have provided the social milieu for the emergence and growth of childbirth reform movements in North America based on home birth and midwifery, these social forces did not alone define midwives. Representations of midwives as counterculture mothers and feminists both inform and constrain understandings of midwives who practiced without official status in late twentieth century North America. Although counterculture and feminist ideologies and practices played key roles in informing, inspiring and shaping midwifery, midwives did not spring out of these social movements untouched by other significant social influences. Analysis of the interviewees’ narratives
suggests that these representations do not sufficiently reflect the complexity of midwives’ lives. It is evident that the social forces at play in the lives of the interviewees before they took up midwifery were more diverse than what is understood from the midwifery literature.

The divergence in age of the interviewees adds a significant dimension to the discussion of their social histories, despite the relative uniformity of their social positions. The midwives were born anywhere from the mid-1920s to the mid-1960s. The conditions of women’s lives in mainstream Canada changed dramatically over this forty year span due to changing opportunities and shifting gender expectations. Women’s participation in higher education and the paid work force rose steadily over the course of the twentieth century, and women experienced growing freedoms to direct their own lives. Despite these advances, education and work opportunities remained divided along traditional lines of gender throughout much of the twentieth century. Discussion of the interviewees’ narratives of their lives before midwifery in generational categories is considered in relation to these changing conditions in the lives of women in mainstream English Canada.

**Mennonite Missionary Nurses**

Elsie Cressman was one of the early practitioners in the Ontario midwifery revival. Her personal history is uniquely shaped by her age and by her religious-cultural background. Cressman was born in 1923 to a conservative Mennonite family.\(^{61}\) She is considered to be the oldest midwife practicing in pre-legislation Ontario. She was among a small group of Mennonite nurses who took up midwifery in the Kitchener-Waterloo region in the two decades prior to midwifery regulation.\(^{62}\) Cressman recalled that women sought her out to attend their home births because of her experience delivering babies as a missionary nurse in Africa. While the counterculture and women’s movements may have provided a social context for the resurgent interest in home birth and midwifery in Kitchener-Waterloo, Cressman’s Mennonite background fundamentally influenced her life history and her compulsion to respond to women’s desire for childbirth alternatives.

Cressman was born in the interwar years in Waterloo County at a time when the transition from an agrarian colonial society to an industrial modern nation was well underway in Canada. The lives of Canadian women were dramatically altered by the social transformations of a modernizing society beginning in the late nineteenth century. In the mid-1920s approximately
half of the Canada’s population was living in towns and cities, and by the early 1930s the population was more urban than rural. Birth rates declined and more women remained single. Women’s education and employment patterns were changing in response to urbanization. Political activity within an emerging “first wave” women’s movement among English Canadian middle class women in the late nineteenth and early twentieth centuries focused on women’s suffrage and expanding women’s opportunities in the public sphere. Women’s entry into the labour market steadily rose through the early decades of the twentieth century, primarily within a growing service sector and the ‘new professions’ for women. While small numbers of women entered law and medicine, women’s education and employment were primarily focused in areas deemed suited to women’s nurturing capacities such as teaching and nursing. The profession of nursing was increasingly formalized in the early twentieth century with the development of specialized training programs and the expansion of hospital-based care. The professionalization of domestic health care and the evolving role of the professional nurse were important developments in the modernization of society and emerging movements for social reform.63

These changing trends in women’s lives followed different trajectories in the lives of Mennonite women. The values and social norms of Mennonite farming communities were not dissimilar to those of farming communities in mainstream society; they also, though, are reminiscent of traditional values of pre-modern agrarian Canada society of the nineteenth century. According to historian Marlene Epp, Mennonite communities remained relatively isolated from the effects of the modernization of Canadian society until well into the twentieth century. These communities effectively separated themselves from the outside world by living out their religious beliefs within a community rather than within an individual context.64 The family was the central social unit for organizing Mennonite life until well after the mid-twentieth century.65 Mennonite women played essential roles in the domestic responsibilities of the farm. In this context, they could have substantial influence, given the centrality of the family to the Mennonite community. The farming economy dictated social expectations for Mennonite women to become wives and mothers. Mothering dominated women’s lives, as women married early and families were generally large. Childbearing and homemaking were considered women’s life calling. Women who did not marry or have children were seen as departing from cultural gender norms.66
Despite the high value placed on Mennonite women’s roles as wives and mothers, there were other opportunities for women to assume other valued and important roles. Some women were able to pursue the caring occupations in teaching or health care to meet the needs of separatist Mennonite communities. As in mainstream society, these caring occupations were seen as an extension of women’s roles in the domestic sphere. Epp has detailed longstanding traditions of organized women’s health care work within Mennonite communities in Canada. She found evidence that trained and skilled midwives played a vital role in the provision of health care in Mennonite communities and that midwifery declined much later than in mainstream Canadian society. By the middle of the twentieth century, Mennonite leaders increasingly recognized skills that women could offer outside the home. Mennonite women were supported to pursue post-secondary education and entered the work force in increasing numbers. Educational preparation for professional roles was highly valued and was available in private Mennonite educational institutions, such as Goshen College in Indiana where Cressman studied in the 1940s.

Women with specialized education contributed to the wider Mennonite community, both locally and globally. Women’s work in nursing and teaching was particularly valued by Mennonite missionary organizations. Overseas mission work under the auspices of the Mennonite church offered also women independence within the context of an extended Mennonite community, as well as structured and financially supported opportunities for education, work, travel and adventure. Mission work was seen as a socially acceptable career option for Mennonite women. The number of Mennonite women choosing mission work as a vocation increased dramatically after the middle of the twentieth century. Many turned their work into long term careers. As pacifists, Canadian Mennonites did not engage in wartime activities of World War II, a time when women’s participation in the work force surged to over one third of all Canadian women. In postwar Canada, a renewed spirit of relief work among Mennonite leadership stimulated growth in volunteerism and missionary work. The focus of mission work shifted from evangelism, which was traditionally seen as men’s work, to areas traditionally seen as women work, such as social programs, teaching and health care.

Elsie Cressman’s narrative of her early life tells the story of an unmarried Mennonite woman coming into adulthood in the immediate postwar period. She spoke vividly about her early life growing up in a traditional Mennonite farming community and her work as a nurse in Mennonite
missions in several regions of Africa.\textsuperscript{73} Cressman’s family was a member of the Eastern Mennonite Conference.\textsuperscript{74} Her father was a Conservative Mennonite church pastor and a farmer, and her mother was a homemaker and farm wife. One of three children, Cressman was raised with the expectation of working on the family farm and becoming a farm wife and mother. She expressed surprise that her parents supported her to continue her education beyond elementary school. She speculated that her father’s educational background as a minister and her mother’s valuing of education contributed to their commitment to higher education. She described her parents’ efforts to overcome practical barriers to facilitate her primary school education beyond an age when girls typically focused their work on the family farm. She related stories of travelling by horse and buggy to school with a teenage neighbour girl and learning how to navigate along icy winter country roads.

Cressman’s childhood narrative conveyed an early spirit of adventure and a keen desire for learning. She recalled her older brother remaining on the farm while she and her sister pursued high school education at a Mennonite boarding school in the Niagara region. She described her experiences working as a domestic helper for non-Mennonite families after completing high school as fostering an independence that grew with her decision to enroll in a nursing program at St. Mary’s Hospital in Kitchener. Following her graduation from nursing school, Cressman completed a natural sciences degree for nurses at the Mennonite Goshen College in Indiana. The Eastern Mennonite Missionary Board offered Cressman a nursing position at a Tanzanian leprosy mission following her graduation from Goshen College in 1953.\textsuperscript{75} Her desire to use her nursing knowledge and skills in mission work resulted in a twenty year commitment to this community. Cressman provided primary care to women having babies in this setting, an experience that sparked her lifelong passion for childbirth. When the local community took over the mission hospital in the early 1970s, she enrolled in a midwifery training program for nurses in England. She subsequently relocated to Rusinga Island on Lake Victoria in Kenya where she participated in the creation of a health centre. Cressman worked for a total of twenty-three years in Mennonite missions in Tanzania, Kenya, and Somalia.

Although Cressman’s narrative conveyed personal agency in her long term devotion to mission work, it is also evident that her choices were made within the social parameters of the wider Mennonite community. She recalled her disappointment when the local community assumed responsibility for the mission hospital in Tanzania, rendering her nursing role obsolete.
She explained how she re-oriented her passion for “birthing babies” by deciding to pursue formal midwifery training in her late forties. She was able to secure the support of the Eastern Mennonite Mission to attend midwifery school in England:

When I came home from Africa after twenty-three years I was expecting to go back...Very few missionaries were left. I thought I’d always be the last one because nobody wanted to do leprosy work. And when I got ready to go back the secretary of our mission called me to have dinner with him and told me they had a letter from the bishop that said I didn’t have to come back. And I said, “Well I was expecting that but I’d like to go to England and do midwifery.” He said, “Well that’s fine with us. You can do that.” Because I got paid for doing it, it wasn’t any expense to them except they might have paid my fare. So I went to England and spent a year doing midwifery.

These comments suggest the ways in which Cressman’s work life was negotiated within the authority of the Mennonite Missionary Board, albeit within a framework of practical and financial support.

Cressman expressed a deep personal satisfaction in her work as a mission nurse that is shared by other Mennonite missionary women. She proudly shared photographs of herself posing with her co-workers and the women and children she cared for. Her recollections of her connections with those in the mission community conveyed a sense of home and family. Her experiences also conveyed a degree of independence, adventure and freedom that seem incongruous with the dominant social norms for Mennonite women and women in mainstream postwar Canada. Cressman related stories of learning to shoot a gun, participating in big game hunting, and travelling extensively through the countryside by motorbike. When her mission work ended, Cressman was able to find new opportunities to play valued roles in Canada, first as a nurse and increasingly as a midwife. She did not recall experiencing feelings that have been described by other returning missionaries, such as loneliness, alienation and frustration at the loss in personal autonomy or professional freedoms.

Cressman’s narrative of her experiences as a mission nurse supports Marlene Epps’ analysis of the fulfilling opportunities mission work could offer Mennonite women who did not conform to the roles of farm wife and mother. It was also evident in Cressman’s narrative that medical advances in the treatment of leprosy offered within mission clinics contributed to the health of the individuals in the communities in which she worked. In 2009, Cressman returned to Kenya to visit health clinics in the regions where she had worked. Her travel experiences, as well as her
past experiences as a missionary nurse in Africa, were documented in a film produced by an independent media production company located in Waterloo, Ontario.78 Valerie Hill reported in the local Kitchener-Waterloo newspaper that Cressman was received by health care workers and by members of the community with gratitude for her contribution to the health of the community and individuals with leprosy.79 However, the wider context of colonialism within which missionary work took place and the meaning this held for Mennonite women and for women of colonized regions remain under explored by Epp in her examination of Mennonite missionary women, as well as by Cressman in her narrative. There is a growing body of scholarship of Canadian and “overseas” mission work from the perspectives of race, class and gender that, according to Margaret Jones, “left an ambiguous legacy.”80 In her research on the relationship between nursing and colonialism, sociologist Sheryl Nestel asserted European nurses in the African colonial setting “unquestionably contributed to the establishment and stabilization of the racialized order of colonial rule.”81 These multi-layered interpretations of women’s missionary work highlight the complexity of individual experiences within the broader political and social context of colonialism.

Despite being over thirty years younger, Evelyn Cressman’s educational and occupational backgrounds are similar to those of her aunt Elsie. As a result of continuity of Mennonite religious and cultural values and practices, expectations and opportunities for Mennonite women remained relatively constant throughout the first two thirds of the twentieth century. According to Epp, Mennonite women’s roles began to shift dramatically by the 1970s as Mennonite leaders accepted women’s vocational aspirations beyond marriage and motherhood to a greater extent.82 Evelyn Cressman trained as a nurse at the Kitchener Hospital in the 1970s. Following her graduation, she worked as a registered nurse in a small local community hospital where she enjoyed providing care to childbearing women. This experience led her to assist in her aunt’s community midwifery practice in Ontario. She subsequently sought formal midwifery training in England. Later, she took up Mennonite mission work in Paraguay for several months prior to returning to Ontario and beginning her midwifery practice in 1990.

Elsie Cressman’s and Evelyn Cressman’s stories of their family, educational and occupational backgrounds provide a counterpoint to the categorizations of midwifery revival practitioners as counterculture mothers and feminists. Although midwifery literature recognizes the appeal of home birth and midwifery to both traditional and progressive women across a spectrum of
political, cultural and religious ideologies, the narratives of these Mennonite missionary nurses and midwives find little expression in Canadian midwifery revival literature. Recent historical scholarship has uncovered longstanding traditions of midwifery practice in Canadian Mennonite communities that were interrupted by the transition of maternity care into hospitals and the professionalization of medicine and nursing, albeit at a later time that in mainstream society in some instances. The narratives of Elsie and Evelyn Cressman offer valuable contributions to the historical record of the Canadian midwifery revival and to the history of Canadian Mennonite women.83

Postwar Wives and Mothers

Rena Porteous and Mary Sharpe were born in the 1940s. They grew up and came into adulthood under the influence of postwar middle class ideals of domesticity and womanhood. While Porteous and Sharpe did not speak directly about the impact of postwar ideologies on shaping their life experiences and aspirations, their narratives reflect patterns that are consistent with postwar gender norms. Dramatic demographic, social and economic changes in postwar Canada reshaped the everyday lives of women. Patterns that had previously dominated women’s lives were altered by increasing prosperity, urbanization and modernization of mainstream society. Women’s life cycles shifted significantly over the period 1945 to 1960, with changes in timing of leaving home, age of marriage, age of motherhood, and family size.84 As well, the growing affluence of mainstream society resulted in the expansion of the middle class and the evolution of a suburban landscape in Canadian cities.85

In her study of the “normal” family in postwar Canada, Mona Gleason described how the destabilizing effects of the Depression and World War II led to a desire for security among Canadians where the family was viewed as an important source of social stability and personal well being.86 Postwar public and professional discourses promoted a family ideology based on domesticity, pronatalism, and heterosexuality. The ideal family was seen to consist of a father who worked out of the home to support a dependent wife and children. Marriage was envisioned as a companionate relationship between a benevolent husband and an attentive wife.87 Rates of marriage rose significantly after the World War II and the average age of marriage fell. Women were having more children and at an earlier age, resulting in a postwar “baby boom,” as birth rates increasing steadily until 1956.88 There was little discrepancy between the idealized image
of women as wives and homemakers and the lives of middle class women in mainstream English Canada in the immediate postwar period. However, growing prosperity in the postwar period also enabled greater independence and autonomy for women in directing their own lives. It was increasingly common and acceptable for young women to leave home to complete education or to work prior to marriage. By 1957, the Canadian birth rate fell as women were having fewer children over a shorter period of time. Despite prevailing social norms stressing the primacy of women’s role as wives and mothers within the home, rates of women’s participation in the Canadian work force increased in the postwar period. The orderly and distinct sequence of work, marriage and motherhood was disrupted, as these events became increasingly intertwined in women’s lives.

The steady rise in women’s work force participation throughout the first half of the twentieth century shifted during World War II with the dramatic entry of women into the labour market. Wartime employment for women had peaked in 1944, with an estimated one third of women over the age of fifteen participating in the paid labour force. In the immediate postwar period, reduced employment opportunities for women with the return of men from military service and renewed emphasis of women’s role in the home resulted in a temporary decline in women’s work force participation. However, women’s employment rose steadily from the 1950s onwards, reflecting an increasing gap between gender norms and the conditions of many women’s lives in an increasingly consumer-oriented society. This rise in women’s employment was primarily the result of the increased work force participation of married women who were childless or whose children were school age or older. Expanding employment opportunities for women were available in the growing service and clerical sectors of the post-industrial economy of postwar Canada. Notably, younger women showed lower work force participation rates as a result of prolonged education, and earlier age of marriage and motherhood.

With the rise of women’s work force participation in the 1950s and early 1960s, social norms shifted toward increased tolerance for women’s post-secondary education and paid employment prior to marriage and motherhood. There was also growing acceptance for mothers’ return to the work force once their children became school age. Employment patterns reflected an earlier age of women’s completion of childbearing, as increasing numbers of women were completing their families by age thirty and childcare responsibilities were reduced once children were attending school. Work force participation for mothers with preschool children, however, remained
controversial until several decades later. By the early 1960s, married women had become a permanent part of the paid labour force and increasing numbers of families came to depend on two incomes. Married women worked in order to maintain their family’s standard of living in an increasingly consumer oriented society and to improve their material circumstances following years of economic depression and war. Despite the significant rise in women’s paid employment over the postwar period in Canada, their work remained concentrated in low paid, low status occupations. Traditional gender expectations also persisted and influenced post-secondary education and career opportunities for women. While women’s university attendance steadily rose after 1951, their areas of study remained largely confined to areas considered compatible with traditional gender roles. As in earlier decades of the twentieth century, women’s access to university education continued to focus on the female professions of nursing and teaching, as well as the new profession of social work.

Rena Porteous’ and Mary Sharpe’s educational and work backgrounds fall within this general picture of white middle class women’s lives in postwar English Canada. They grew into adulthood with the expectation of earning an independent living in the paid labour force before marriage. Their educational and work experiences were focused in the teaching and nursing professions. They married and had children in their mid-twenties. Their life cycles reflected the pattern of paid employment until the birth of the first child, childrearing in the home, and re-entry into the paid work force once their children reached school age. They both spoke of collaborative decision making with their male partners regarding significant life decisions, ones that reflected the postwar social ideal of companionate marriage.

Rena Porteous trained as nurse and a midwife in a hospital-based program in Scotland in the late 1950s and early 1960s. She pursued a nursing career in her late teens at a time when women’s occupational aspirations in health care were relatively limited to the nursing profession. She worked as a nurse and midwife in Scotland and England prior to relocating to Canada for her partner’s work. Porteous discontinued work when she became a mother and returned to paid employment when her children were school age. Unable to work as a midwife in Canada, she took employment as a maternity care nurse in a hospital in south western Ontario. Porteous explained that she took a position as a home visiting nurse with the Victorian Order of Nurses (VON) as a result of her dissatisfaction with how childbirth was organized in the Canadian
health care system. She spoke of her “culture shock” at the technological management of childbirth that she witnessed and the lack of primary care responsibility of the obstetrical nurse:

I came over to Canada with my husband and stayed at home with my children...I had two children. I stayed at home with them for a number of years and then I decided to go back to work. Of course there was no midwifery here at that time. So I went back to work as a nurse and just at that time it was very hard for nurses to get positions. I was lucky to get one, but once I was in the hospital I managed to get moved into labour and delivery which was a shock. The culture shock was huge and I was there for about a year, a year and a half and then decided that I preferred to do something in the community so I joined the VON. I worked in the community with the VON...

She remarked on her satisfaction with the independence of her work as a VON nurse that resembled the community midwifery work that she subsequently pursued: “I loved the independence. I loved being out in my own car and visiting people in their homes and making that one on one connection.”

Mary Sharpe pursued university education at the beginning of the 1960s with family expectation and support. Sharpe commented, with ambivalence, on the influence of her banker father’s expectations in her decision to take up the teaching profession: “…he wanted us all to become teachers and I’m sort of ashamed to say that most of us did…I don’t know how he did it really. Just continued support.” Sharpe attended the University of Toronto. She did not study education, but rather completed a degree in English prior to working as an editorial assistant at the Canadian Law Book Review. Looking for a more flexible and “interesting” work lifestyle, Sharpe subsequently pursued what she remembered as a deep seated passion for teaching. She worked at a variety of schools in Toronto and in the eastern United States where she moved to follow her partner’s academic career, teaching a range of courses that included English, theatre, social studies, physical education and health. She described her pathway into teaching at a time when a baccalaureate university degree rather than a specialized education degree was sufficient qualification for a teaching career:

I didn’t go to teacher’s college but there was a really strong need for a teacher in an extremely difficult high school. And I’d always done teaching in my life as a counselor and as a swimming instructor from a very early age. I always took on that sort of girl guide captain, those sorts of roles, and so I actually really, really enjoyed teaching.

Sharpe discontinued her teaching work when she gave birth to her first child in 1970, focusing on her role of mother within the home. As a new mother, she engaged in volunteer activities that
facilitated her transition back into the work force. Her interest in alternatives to the prevailing technological management of childbirth while pregnant with her first child brought her in touch with emerging initiatives for the reform of normative medical practices related to childbirth and breast feeding. Sharpe applied her interest and her expertise in teaching to women’s support work that was compatible with and accommodating to her mothering role. She trained as a childbirth educator in an organized teacher training program in New York City in the formative years of childbirth education, and she became a volunteer “leader” in the breast feeding support group, La Leche League.

Sharpe’s re-entry into the paid work force followed several years of volunteer activities related to her mothering role. Her activities gradually expanded from volunteer breast feeding support to incorporate support and education for childbearing women. She began to receive payment for her work as a “labour coach” and later as a midwife beginning in the mid-1970s, a time when her older children were school age but her younger children were infants. This period represents a time when social norms began to shift toward increased tolerance for employment of middle class women with pre-school children. Sharpe recalled that she envisioned her midwifery work as compatible with and as an extension of her mothering role into the community, and she remembered the early years of midwifery revival as a rewarding time of her career. She also spoke with reflection on the challenges placed on her young family by the 24-hour on call midwifery lifestyle and the presence of her midwifery clinic in her home.

Not all women who became mothers during this period conformed to postwar middle class ideals of companionable marriage and domesticity. Colleen Crosbie’s experiences as a pregnant teenager in the mid-1960s illustrate the ways in which conservative attitudes towards female sexuality, adolescence and motherhood constrained growing social freedoms of the sixties. Crosbie grew up on a military base in south western Ontario during the postwar period. She became pregnant at age fourteen in the mid-1960s when access to birth control was tightly restricted, abortion was illegal, and women of mainstream society experienced intense social pressures to conform to postwar social values. Her experiences of giving birth and putting her baby up for adoption were typical of young unmarried pregnant women from white middle class families in 1950s and 1960s North America. She was sent away from her family and her community to a “home for unwed mothers” to give birth in “secrecy.” As a young, single mother, she was expected to give up her baby up for adoption, return home and resume her life
as if she had never had a child. Crosbie spoke of sadness and regret at relinquishing her infant son for adoption, feelings that she carried with her for several decades until she had “the good fortune” to reunite with her adult son in the early 1990s. Crosbie’s narrative of her experience becoming a mother in the postwar period reinforces a growing body of evidence of the devastating and long lasting consequences experienced by women who felt coerced into relinquishing their babies.¹⁰⁰

The Sixties Generation

The majority of the interviewees were born in the late 1940s and early 1950s. They grew into adulthood during the period popularly known as “the sixties.” This period is well known for the evolution of progressive “counterculture” social and political movements that had a powerful impact on mainstream North American society. The narratives of the interviewees of the “sixties generation” provide a deeper understanding of how the ideologies of sixties counterculture and a resurgent women’s movement touched their lives beyond their interest in midwifery.

The late 1960s and 1970s were a time of profound social change and unrest in North America, as mainstream institutions and societal norms were called into question.¹⁰¹ Growing political activity was organized within movements for civil rights, peace and social justice in the United States and Canada. The sixties generation advocated new ways of organizing relationships that influenced changing ideas about sexuality, marriage, and the family. Young women’s increased autonomy in directing their lives resulted in delayed marriage and motherhood. Not only was the necessity of marriage and motherhood questioned, the traditional structure of the family was also challenged. Rates of co-habitation rose dramatically, as marriage was no longer viewed as a necessary prerequisite for committed intimate relationships. The development of the birth control pill in 1966 created the possibility for women to be sexually active without becoming pregnant. The 1969 amendments to the Canadian Criminal Code regulating abortion and contraception offered women new reproductive choices. Improved access to birth control facilitated new sexual and social freedoms for women, as fertility rates declined. Motherhood no longer represented the central and defining feature of women’s lives.¹⁰²

Patterns of women’s education were also transformed during the sixties.¹⁰³ The Canadian educational system rapidly expanded under the influence of postwar economic prosperity and the baby boom of the late 1940s to the mid-1950s. The growing affluence of youth in mainstream
society enhanced their personal choices and freedoms. New ideas about education promoted an ideal of equal opportunity for the sexes. The number of women entering Canadian universities climbed steadily in the sixties and seventies. Accessibility to university education was facilitated by lowered fees and increased availability of student loans and grants. As accessibility grew, universities became sites for wide scale political activity within student led movements.

The majority of the interviewees of the sixties generation entered undergraduate education following high school without clear direction about career goals. Judy Rogers’ description of her university experience suggests the evolution of new priorities in higher education based on personal interest rather than a proscribed career path:

…once I got out of high school I wasn’t sure of my career path. I was planning to go to university and actually went to a community college the first year because my funding kind of fell through at the last minute to go to the university that I’d planned to go to. I was basically kind of dabbling and taking whatever interested me so in the first year I think I took courses like literature, art for elementary school teachers, Spanish, sociology, political science. I was quite a political person, and the next year when I went to UCLA I basically took things like children’s literature, history of India, philosophy, psychology courses. I got into developmental psychology and basically was pursuing an interest in I would say was a combination of a joint degree of psychology and education.

Rogers completed a baccalaureate degree in psychology and education; however, despite receiving a scholarship for graduate studies, she decided not to pursue higher education. She remembered her growing interest in alternative education brought her to the west coast of Canada in the late 1960s, where she lived and worked in alternative school community:

I got very interested in alternative education, things like Summerhill and free schools and started volunteering at a free school in the Los Angeles area. Prior to that I had worked for Head Start, which was a pre-school program for underprivileged children. My interest in alternative education and my volunteer experience led me to meet a teenager who had gone to an alternative school in Vancouver which he thought was a lot better than the one he was attending in LA where I was volunteering. So I decided to go up and visit it and went up in the spring break and met some really nice people who were working there. That was 1969. And really kind of liked the feel of Vancouver and Canada generally. I was encouraged by some of the people I met to join them for a brief trip out to the west coast of Vancouver Island and went out to Long Beach and, for want of a better word, fell madly in love with the landscape and the land, the rainforest and the ocean and decided I had to live in Canada. And so I went back home, got rid of my scholarship, sold my car, got a van, and moved to Canada.
And basically that was the summer of 1969. I applied for citizenship the following fall and got in by the skin of my teeth. I lived on the west coast for quite a while… I got a job at the Saturna Island free school on the Gulf Islands where I worked for about two and a half years…

Despite a steady rise in women’s university attendance in the sixties, their fields of study continued to be concentrated in service oriented fields traditionally considered appropriate for women. At age seventeen in the late 1960s, Helen McDonald entered nursing school in New South Wales, Australia at a time when nursing was still the normative health care field for women. McDonald planned to work as an emergency room (ER) nurse following graduation. She entered post-graduate nursing training in midwifery because it was a prerequisite for ER nursing in New South Wales. She described her attraction to the demanding environment of the ER:

I really liked emergency room work. I really, really liked it. I found it really challenging…to be a good emergency room nurse you have to know a lot, you have to be quick on your feet. You have to be quick. You have to think quickly, you have to be able to do really rapid assessments. You have to like the potential for disaster. You have to be one of those people who likes a bit of edginess in their work.

McDonald’s description of the role of the ER nurse reflects her desire for a high degree of autonomy and agency in her work. Opportunities for this kind of primary health care responsibility and autonomy were rare in nursing practice as nurses continued to largely work in a support role under the authority and supervision of physicians. Had McDonald entered post-secondary education a decade or two later when educational opportunities and expectations for women had expanded into the male dominated profession of medicine in greater numbers, she might have considered entry to medical school.

Trends in women’s work shifted in the sixties as a result of changing social and economic realities for women in Canada. In 1967 women’s work force participation rates surpassed the previous peak level of over thirty percent of women in 1944. Women with pre-school children were entering the work force in unprecedented numbers. New initiatives in organized day care assisted some mothers with young children to work outside of the home. Marital breakdown was increasingly common in Canadian society by the late 1960s and also contributed to women’s increased work force participation. Women’s work force participation, however, was still largely bound by traditional gender expectations. Despite significant educational advancements
for women, a substantial gap persisted between their educational opportunities and the reality of the labour market.108

While the sixties “sexual revolution” gave women new freedoms in organizing their lives, it did not significantly alter traditional gender roles within the family.109 Women continued to play a central role in domestic labour within the home resulting in a “double work day” for those who also worked in the paid labour force.110 Women were still largely expected to withdraw into the domestic sphere when pregnant. Heather Burton described how her educational and occupational plans were interrupted by her first pregnancy:

I was going to university. I was specializing in an English specialist degree at the University of Toronto and I was accepted to a very prestigious place called the Pontifical Institute to do my Masters in Medieval English and I was just ecstatic. At the same time I was offered a very good job in a corporation. And so this all came about along with my graduation from university. At the same time I found out I was pregnant and was horrified because my life plans had just been put aside...

Women’s entry into non-traditional occupations that arose during World War II resurfaced again in the early 1970s under the influence of emerging second wave feminism; however, progress remained slow.111 Michelle Kryzanauskas secured employment prior to the professionalization of the Canadian banking industry. She entered banking work in the feminized position of bank teller at age sixteen. She linked her advancement to managerial positions typically held by men to her occupational success and hands on experience. Kryzanauskas felt that although her advancement through the hierarchy of positions in the bank was not initially impeded by her lack of educational experience or her gender, it did become limited by a growing credentialism within the industry:

It was just when there had been a number of bank robberies in Toronto and I somehow managed to get a job with a bank just before they stopped hiring people younger than eighteen because I would have been sixteen...There had been this huge rash and they made a rule that you couldn’t hire people any younger than eighteen at that point and by then I already had my job...in the bank I quickly rose through management and sort of ended my career in a small savings and loan company in the rural community that I finally moved to. I went all the way up to bank manager, foreign exchange trading manager, and then found my niche in auditing. I became a manager just before they started hiring international graduates that had degrees, so I was sort of in this cycle in the bank. They had stopped hiring young people and then they stopped hiring people that didn’t have degrees. So I by then had secured the management
position so it wasn’t that it particularly threatened it but it began to limit how far I could go then in the bank.

Larry Lenske’s career aspirations also challenged prevailing gender norms. He entered university with an interest in health care. He enrolled in a pre-medical undergraduate program, a normative course of study in terms of his gender and middle class background. He subsequently dropped out of university under the influence of the countercultural ideologies. He pursued his interest in health care by studying massage therapy and developed interest in alternative ways of living. Lenske lived in an “intentional community” for seven years where he was exposed to home birth and discovered his interest in pregnancy and childbirth. He decided to pursue the female dominated profession of midwifery within a social context where men’s professional role in childbirth was largely isolated to medical practice. Jane Kilthei, Lenske’s partner, described how he attempted to find opportunities to study midwifery:

…he was very captured by childbirth as well and I think he was probably the one who said first that he wanted to be a midwife…He didn’t figure there was any way as a man that he could become a midwife unless he became a nurse first. So I remember he had hair almost down to his waist. I remember cutting his hair short so he could go to a nursing school entrance interview…Larry and I had been doing all this exploring and he’d looked at nursing school in the States. He’d looked at nursing school in Kingston. And I was just trying to figure out what I would do. And then we saw this magazine and it had a one page article, an interview with [a midwife] who was in Toronto. So I phoned her. And I said, “This is what we’re doing. Nothing is quite falling into place.” In the article she talked about taking apprentices and she said, “Oh. I’ve got somebody finishing up.” And so we said, “Well can we come and meet you?” And within a very short period of time we met with her. And the other thing was she wasn’t completely negative about a man being involved in childbirth, wanting to be a midwife. Like it didn’t seem like an odd idea to her. I mean Larry’s background, Larry has studied massage. He didn’t seem like somebody who was trying to sort of take over. I mean he dropped out of his pre-med course because he knew he didn’t want to be a doctor although he couldn’t figure out what he wanted to be. So anyway we both met with her and she said “I don’t know how it would go. I don’t know how you would be accepted” but at that point there were physicians who were attending [home] births who were all men. And so she said, “I’m willing to take Jane on as an apprentice and we’ll just sort of see” and she offered that we could both be involved in teaching childbirth classes with her. So it seemed like it was worth the leap.

Many of the interviewees spoke of their involvement in progressive social movements of the late sixties and early seventies, particularly student political movements on university campuses. They fit the typical profile of young social activists of the time as coming from white, middle
class homes and rejecting their class privilege and social expectations to take up alternative lifestyles, often with accompanying “voluntary poverty.” Jan Teevan, the daughter of a university professor, worked in a variety of jobs after dropping out of university to raise money to “live on the land” she had bought in Oregon:

...I would kind of do whatever work. I was a waitress for a really long time and worked in a health food store. Then I was part of a live-in couple in LA just taking care of rich people and their stuff and their kids and their gardens and what not. I was saving money to go live on the land that I had bought in Oregon...as I mentioned I was a fire tower lookout.

Jane Kilthei linked her awakening political consciousness to her desire to “go back to the land.” Countercultural movements of the 1960s and 1970s envisioned alternative lifestyles that were seen as healthy for individuals and for the planet. Critiques of capitalist political and economic systems contributed to the emergence of movements committed to sustainable, ecological ways of life. “Back to the land” movements combined anti-authoritarian ideas about communal living and a return to traditional ways of living off the land. Kilthei’s disillusionment with her undergraduate studies and her subsequent employment in the civil service contributed to her decision to move to a rural community. Her narrative reflected feelings of alienation from mainstream society and a spirit of non-conformity typical of 1960s countercultural youth. She remembered finding living communally more educational than her years at university:

I came east to Ontario to study journalism at Carleton University. So I went to Carleton and I worked in some government information officer positions. I actually exited Carleton with an English degree because of differences with the head of the School of Journalism. And I think that as a nineteen, twenty year old that was one of my early encounters with systems that were more powerful than I was. I ended up working in journalism in a way writing and doing various jobs in government as an information officer and writer but I wasn’t very happy doing that and I was somewhat involved in politics and but just really hadn’t found my place or passion in the world. I ended up spending a year living rurally in the Laurentians in Quebec in a log cabin. I don’t know that we were going to do that for the long term but it was a way of kind of stepping out and looking at my life and then ended up being part of a group that started an intentional cooperative community that was somewhat structured like a kibbutz where I lived for the next seven years. And I think I learned more in that living experience than I ever learned at university just in terms of what it takes to make collective decisions and try and live congruently with values with a whole group of people and with no two people seeing anything the same way exactly and learning to sort of work with that as well as
learning to do various physical skills. And that was where I got interested in women’s health issues.

Judy Rogers’ narrative of her young adult life in rural Nova Scotia conveyed a similar interest in alternative ways of living and learning. Her memories of living rurally with limited resources and skill reflect experiences of hardship, determination and resourcefulness that were common in back to the land living. Rogers and her partner bought an affordable piece of land far from their friends and family when she was pregnant with her first child and worked tirelessly to prepare a space in the property’s dilapidated farmhouse for the imminent home birth of their first child. Rogers’ reflections on her experiences as a back to the land wife and mother suggest some of the complexities of the position of women in sixties counterculture that have been discussed and debated by scholars. Canadian sociologist Jeffrey Jacob, for example, noted that although back to the land communities had egalitarian ideals about gendered divisions of labour, the demands of every day rural living reinforced women’s traditional roles of housewife and mother. In her analysis of counterculture women, however, American historian Gretchen Lemke-Santangelo asserted that women who embraced traditional roles were empowered by a revalorization of women’s domestic and productive labour. Rogers valued the self-sufficiency she and her partner required to meet the challenges of rural living. She assumed the role of farm wife and mother in a gendered division of labour that was reminiscent of an earlier agrarian economy. She pursued traditional domestic activities that were integral to the simple lifestyle she and her partner were seeking, such as gardening, canning, bread making, sewing, and clothes making. While Rogers reflected with amusement about the pre-feminist values embodied in counterculture ideologies and lifestyles, she remembered her role as equal and complementary to her that of her male partner.

**Coming of Age with Second Wave Feminism**

The interviewees who were born in the mid-1950s to mid-1960s encountered new freedoms in directing their lives and changing educational and occupational opportunities. Many of these changes were influenced by progressive social movements of the sixties and the impact of the second wave feminism. Growing dissatisfaction with women’s unequal position in society in the sixties stimulated a resurgence of feminist activity in North America and other western countries. By the late sixties and early seventies, the “second wave” or “modern” women’s movement emerged as a distinct activist movement, largely among white, middle class women in
mainstream Canada. Feminist activity highlighted and fought to correct discriminatory institutions and practices that reinforced gender inequality. The impact of sustained efforts by Canadian women’s organizations to change laws, public policy, and social attitudes regarding women’s position were evident by the end of the twentieth century.

Access to education and paid work were seen as key strategies to support women’s independence. Changing trends in women’s education and work in the 1970s and 1980s reflect steady increases in women’s entry to post-secondary educational institutions and the paid labour force and the beginnings of enhanced female participation in areas formerly dominated by men. When the Report of the Royal Commission on the Status of Women in Canada was published in 1970, women represented 38.6 percent of Canadian university undergraduates. By 1982, women students were in the majority in Canadian community college and undergraduate university programs. Professional education for women expanded in fields traditionally dominated by men, such as medicine, where forty-four percent of medical graduates were women in 1981 as compared to six percent in 1951.

Women’s entry into the paid labour force in the late 1970s and early 1980s was unprecedented. Despite economic recessions in this period, women’s labour force participation rose steadily. Dramatic increases were seen in employment levels for women with young children. By 1985, over half of Canadian women were working and the majority combined employment and childrearing. Despite employment equity legislation introduced by the federal government in 1986, though, the majority of women continued to work in occupations in which women were traditionally concentrated.

Increased access to contraception, together with the reproductive rights movement, continued to undermine assumptions about the inevitability of women becoming wives and mothers. “Mandatory heterosexuality” was also called into question by feminism and a growing gay rights movement. The average age of first marriage among Canadians increased by over five years between 1975 and 2003, and rates of marriage in Canada decreased steadily beginning in the early 1970s. Women were also delaying childbirth, as the average age of mothers giving birth rose steadily from the mid-1970s. Family size also steadily declined. More diverse family structures were evident by the early 1980s, as the number of two parent families declined and the number single parent and common law households proportionately rose.
The attitudes, opportunities and experiences of the midwife interviewees born after the mid-1950s reflect these changing social norms for women. Their narratives conveyed independence and autonomy in directing their lives. MaryAnn Leslie, born in the mid-1950s, commented on the value of making educational and career choices to support her personal independence:

Don’t always count on other people to know what’s best for you, especially as a woman. I grew up the oldest of six kids, and I’m the oldest of five daughters. It was very much my mother at least, and my mother’s family, was very strongly, “A woman should be able to support herself. She should have an education and a career.” My grandmother, my mom’s mother, had a university degree from Mount Al[liison]. She was one of the first women graduates in the early ‘20s. Definitely coming from a sort of not wealthy but upper middle class kind of existence where it was my father’s family more, my dad, who said I should marry well. I should be taken care of...it’s like, “I’m sorry, don’t be taking care of me.”

Holliday Tyson’s narrative of her determination to enter midwifery school as a teen reflects an attitude of self-assuredness. When Tyson dropped out of high school at age seventeen to pursue overseas midwifery training, she was not deterred by the rejection of her initial application to midwifery school because she fell below the minimum age requirement of eighteen. She was not dissuaded by the notice that she would not qualify as an overseas applicant until age twenty-one, but instead travelled to England to apply in person at nineteen:

When I was eighteen, I got back a notice from England saying that they weren’t taking any people from overseas who were under the age of twenty-one. Well for me at eighteen, twenty-one seemed like just completely forever so when I was nineteen. I left my apartment and my job and I just went over to England. I had a list of all the schools. There were seven of them at that point I think. Seven. Yeah. Nine but two of them had closed so there were seven. And I had rail pass, so I was just living on the trains. I didn’t have any money and so I started going around to them and the first five said no and then I had two more on my list. Number six and number seven, and the sixth one was this one in Oldham near Manchester and it was on a Friday afternoon I arrived and the director of the program was, I guess she was really surprised. She remembered. They still had my application there and she said “Oh you’ve applied twice already but you’re too young.” And I said “Yeah, I know.” She said “Well what are you doing here in England?” And I said “Well I’m just here to get into the program.” So she said “Well if you’re willing to go find something to do over the weekend.” Actually they found me a room like in a broom closet or something because I didn’t have any money to stay over the weekend. She said “If you’re still here on Monday I’ll talk to you and we’ll do an interview.” So they did an interview, her and a couple of other midwifery instructors on the Monday and then they called me in on the Tuesday and told me that I could start in the program a month later. So then I worked for a while, just for the month before I
started, unpaid, like a nursing auxiliary or something just around the place and then I started midwifery.

Most of the interviewees born during this period entered post-secondary education or the work force following high school with the goals of personal fulfillment and a desire for financial independence. Their educational experiences were influenced by educational reforms of the 1970s based on progressive social ideas of sixties that emphasized student autonomy. While Judy Rogers and Larry Lenske worked as educators in independent schools of the early alternative school movement, Vicki Van Wagner was able to attend a newly established alternative school in the public school board in the early 1970s. Van Wagner also attended an innovative educational program at the University of Waterloo based on student directed learning. She was able to design her curriculum to focus her studies on her interests in women’s health and midwifery: “When I was in university, I studied a lot of health science and health studies kinds of topics, and I wrote my undergraduate thesis on midwifery.” Katrina Kilroy’s search for a meaningful area of study based on her commitment to sixties ideals of social justice led her to program in international development at Trent University:

I went to high school in Scarborough...I worked as a bank teller and travelled internationally. And then when I went back to university. I wasn’t sure what I was going to study. I thought maybe I’m interested in psychology but of course Psych101 taught me immediately that wasn’t what I wanted to do. And I got interested in a course that they had at Trent University where I attended that was international development studies. I think that was about the kind of social justice component.

Most of the interviewees who entered post-secondary education or the work force as young women in the 1970s and 1980s were not yet contemplating marriage or motherhood. Some chose to live in common law relationships, while others contemplated their sexuality within the context of an emerging gay rights movement. Those who had children, were married, or living in common law relationships saw their family life as intertwined with their education and work lives. Patty McNiven continued to work as a nurse after her children were born, specializing in the care of childbearing women and newborns:

I got pregnant and moved back to Toronto and went to work at Women’s College [Hospital] where I wanted to work in labour and delivery and they said, “Oh, you have intensive care [experience]. You can work a respirator.” They put me in the nursery, the neonatal intensive care nursery. But Women’s College did let me work in labour and delivery, so I worked. I had one baby, and then another and they let me work in labour and delivery.
Several of these midwives had babies while in their teens or early twenties. For these women, their education and work plans were not interrupted by motherhood. Vicki Van Wagner began undergraduate university education just after her daughter was born, in addition to working part time as a teaching assistant.

Some of the midwives of this “post-sixties” generation were able to contemplate alternatives to the traditional educational and work opportunities for women. While the normative health care occupation for women during the 1970s and 1980s was still largely nursing, rates of women’s entry into medicine were increasing. Patty McNiven persisted in her nursing training despite ambivalence about the nursing role:

When I went into nursing though I don’t, I didn’t like it at all. I stuck with it and finished my degree but I did not like it. The first time I had to give a needle to someone I realized I didn’t think I could do it. I actually almost thought of dropping out. And I had a teacher who was a nurse who taught us philosophy and she asked to meet with me and said “I don’t think you’re going to like nursing. You should drop out.” And I said “Why?” And she said “Because I think you’d like something more creative.” Anyway I didn’t drop out...I did stick with nursing. And nursing was very...I wore a cap. Like we wore nursing caps and hair up and the whole darn thing.

MaryAnn Leslie also spoke of her ambivalence about nursing but recognized the impact of feminism on shifting the structural subordination of the nurse’s position. She saw nursing training as a route to midwifery training:

I went to nursing school and it was actually pretty good though I hated the nursing part of it and the hierarchy and all that stuff…but nursing was at a point where it was starting to change and starting to take on some power and the feminist movement was having some impact on at least how nursing education and nursing theory and philosophy was going. So it was a little better…

Several of the interviewees spoke of medicine as a career option they had considered, but none pursued medical training. Leslie entered a “pre-med program” at the University of Toronto but left, finding it too “mainstream”:

I was also thinking about going into medicine at one point. I got accepted into pre-med program at U of T. That’s why we moved to Toronto and then I decided it was going to be too, not me...It as a philosophical thing. I got accepted into the program. I actually did a couple of courses the first year we were here to go into it that next year which would have been maybe ’76. Then decided I was going to go to nursing school and do midwifery. It was too mainstream.
Linda Moscovitch described the alteration of her plans to enter medical school by family circumstances:

…after graduating from high school I was at a crossroad in my life because my parents got divorced and I was supposed to go to medical school and didn’t go because I didn’t want to live with one or the other. So I went to nursing school instead because you got paid to be a student...So I became totally autonomous at seventeen and became a registered nurse.

Holliday Tyson also contemplated entering medical school after doing international midwifery work in Africa and India following her midwifery training in order to broaden her health care role:

...there was this one woman who died of appendicitis while I was there and that made me start to think if I want to work in other countries maybe I should actually try to go to medical school and come back and combine my midwifery...So I decided to go back home to Canada and to finish up my BA or BSc up in Thunder Bay with the thoughts maybe that I would go into medicine instead. But then when I was back I mean I found midwifery so compelling...

Some of the interviewees grew up with the presence of an active women’s movement and were directly influenced by and attracted to feminism. Vicki Van Wagner first identified as a feminist in her teens in the mid-1970s, under the influence of a burgeoning Canadian women’s movement. Her interest in women’s health as an “emerging feminist,” together with her personal experience of home birth in her early twenties, influenced her decisions to study the social science and history of midwifery at university and to take up an offer to apprentice with a midwife who had begun practicing in the Toronto area. Katrina Kilroy credited her interest in women’s health and feminism to her mother’s “early feminist” attitudes about sexuality:

My mom was kind of an early feminist. She had very strong opinions about childbirth. She was a natural birther in the late fifties and early sixties, really into the Lamaze method and used the method for the last four of her six children. She talked openly about sex, sexuality, birthing, all those kinds of things when I was a child, openly and opinionatedly. So...the seeds were sown back then.

Kilroy’s interest in midwifery influenced her decision to seek volunteer work at a women’s health centre. She found paid work at a free standing abortion clinic in the 1980s. She explained the ways her learning encompassed not only women’s health issues, but also feminist politics, that helped prepare her for her entry into midwifery training and practice. Wendy Katherine, the
youngest of the midwives practicing in the pre-legislation Ontario, was born in the mid-1960s. She reflected on the influence of feminism on her sense of autonomy as a young adult:

…I was questioning a lot of things generally. I think at that time, both in history and in my life, things that were new to me were generally very exciting. Feminist principles were new and very exciting at that time. I think I was becoming more independent as a person in general, learning to live on my own, seeking independence from my family, becoming more self-sufficient economically. I was looking for a job that fit...my own principles.

Organizing this discussion of the midwives’ backgrounds into generational categories allows comparison of the narratives of a group whose lives span more than three quarters of a century. Their lives before midwifery reflect changing social norms and opportunities for women, and yet they were not static within these categories. They continued to be influenced by changing social beliefs and conditions that catalyzed their decisions to become midwives and practice on the margins of official health care. Despite variation in their life choices and experiences, both within and across these generational divides, these women and one man all found a path to the unrecognized practice of midwifery in the period of 1974 to 1994, united by a common commitment to the revival of midwifery and offering women alternatives to the medically-managed childbirth that had come to dominate North American maternity care.


2 The English word midwife has not been used exclusively to refer to female childbirth attendants. Early male medical practitioners who attended women in childbirth in seventeenth century England were called “man midwives.” In early twentieth century North America as childbirth increasingly came under the purview of the male-dominated field of medicine, male medical practitioners were also called man midwives and midwifery was formally defined as a part of professionalized medicine. For a discussion of men’s entry into the care of childbearing women in Britain, see Adrian Wilson, The Making of Man-Midwifery: Childbirth in England, 1660-1770 (London, UK: University College London Press, 1995). For a discussion of the inclusion of “midwifery” into the practice of medicine in late nineteenth and early twentieth century Canada, see Jutta Mason, “A History of Midwifery in Canada,” 207.
Farah Shroff provides a list of fourteen multilingual terms for midwife and their meanings in the introduction to her anthology on the late twentieth century renewal of Canadian midwifery in “Midwifery - from Rebellion to Regulation,” 15.


Rothman, In Labour; and Mason, The Trouble with Licensing Midwives.


Davis, Heart and Hands, 2-4.

In one of the first late twentieth century critical examinations of the technological management of childbirth in America, Suzanne Arms portrayed nurses’ subordination to medicine and socialization to medicalized childbirth in opposition to midwives’ “faith” in and support of normal birth. Arms also featured portraits of “exceptional” nurse midwives whose style of care she presented as consistent with midwives. See Immaculate Deception, 155-162.

Barrington, Midwifery is Catching, 16.


Sociologist Sheryl Nestel is a prominent critical scholar of Ontario midwifery from the perspective of race who has published extensively on race and representation in Ontario midwifery in the pre-legislation and early post-legislation contexts. See the Bibliography for a listing of Nestel’s work.


15 See, for example, Barrington, *Midwifery is Catching*, 13; and Mason, “*The Trouble with Licensing Midwives*,” 1.

16 The term “new midwifery” has been used to refer to the modern revival of midwifery in Ontario. Barrington used this term in 1985 in *Midwifery is Catching*, 13. This term has continued to be used by scholars and popular writers when referring to this period of Canadian midwifery. Farah Shroff titled her anthology on Canadian midwifery *The New Midwifery*, explaining the meaning of her use of this concept on the opening page of her introduction, 11.

17 For a discussion of the multifaceted events of the early 1980s that culminated in the Ontario government’s announcement to legalize midwifery, see Fynes, “The Legitimation of Midwifery in Ontario.”

18 *Midwifery is Catching*, 10.

19 *Midwifery is Catching* is frequently referenced as an evidentiary source for the pre-legislation period of practice in subsequent scholarship on Ontario midwifery.

20 For example, Sheryl Nestel states “how unusual it was to encounter women who differed in any way from Barrington’s description of midwives” which she interprets as “code words for white racial identity” in *Obstructed Labour*, 23.

21 Barrington identified a series of stereotypes of midwives that are widely discussed in midwifery literature, including the dirty, dangerous midwife, the hippie midwife, the spiritual midwife, the nurse midwife, the home birth midwife. See Barrington, *Midwifery is Catching*, 16. These stereotypes have become infused in popular, professional and historical narratives on midwifery. See, for example, Brian Burtch, *Trials of Labour*, 55; and Kitzinger, “Why Women Need Midwives,” in *The Midwife Challenge*, 7-8. A number of Canadian midwifery scholars have called for a critical reading of these “myths and misconceptions,” particularly the assumption of a dichotomous and adversarial positioning of doctors against midwives. See, for example, Connor, “‘Larger Fish to Catch Here than Midwives’”; Mitchinson, *Giving Birth in Canada*, 69-70; and Biggs, “Rethinking the History of Midwifery in Canada,” 37-38.

22 Barrington, *Midwifery is Catching*, 16.

23 Ibid., 41.

24 Ibid.
Ibid, 13, 41-42.

Barbara Katz Rothman refers to midwifery “feminist praxis,” largely in reference to its woman-centred philosophic orientation, in *Recreating Motherhood* (New York: W. W. Norton, 1989), 169. A range of feminist interpretations of midwifery have been articulated according to different theoretical orientations to feminism. For a discussion of feminist ideological interpretations of midwifery in the Ontario context, see, for example, Beth Rushing, “Ideology in the Reemergence of North American Midwifery,” *Work and Occupations* 21, no. 3 (February 1993): 57-60; and Tracey L. Adams and Ivy Lynn Bourgeault, “Feminism and Women’s Health Professions in Ontario,” *Women & Health* 38, no. 4 (January 2004), 82-86.

Barrington recognized traditionalist and feminist ideological tensions in the Ontario modern midwifery revival; however, she argues the principles of control and empowerment embodied in emerging women’s health movements were increasingly embraced by Canadian midwives and their supporters with traditionalist perspectives on midwifery. Barrington did also note that women’s reproductive right to abortion remained a divisive issue in Canadian midwifery in *Midwifery is Catching*, 151-153.


Patricia Hill Collins, *Toward a New Vision: Race, Class, and Gender as Categories of Analysis and Connection* (Memphis: Center for Research on Women, Memphis State University, 1989).


There is limited discussion of lesbian women as care recipients and a virtual absence of reference to lesbian midwives in Canadian midwifery literature. Ford and Van Wagner refer to their interviews with lesbian women in “Reflections on the Ontario Equity Committee Experience,” 250-251. In her comments on diversity of Ontario midwifery practitioners, Margaret MacDonald refers to “sexual orientation” in addition to age, marital status, motherhood, and family arrangements, in *At Work in the Field of Birth*, 61. Pamela Klassen acknowledges the presence of lesbian midwives in her study of the interrelationship between religion and home birth in America in *Blessed Events*, 60.

Canadian sociologist Helen Lenskyj critically examines essentialism in Canadian midwifery in, “A ‘Natural’ Calling? Issues of Choice and Diversity for Midwives” (unpublished paper, University of Toronto, 1996), used with permission of the author. For a discussion of essentialism in the evolution and codification of the Ontario midwifery model and philosophy of
care, see Mary Sharpe, Annette Rudel, and Michelle Turner, “Essentialism as a Contributing Factor in Resonance and Dissonance Between Women and Their Midwives in Ontario, Canada,” Canadian Journal of Midwifery Research and Practice 8, no. 2 (Summer 2009): 15-28.

33 While all the midwives in my research were white, not all midwives practicing in Ontario in the two decades prior to legislation were white. Nestel reports there was one woman of colour among the first seventy-two midwives registered with the College of Midwives of Ontario prior to the first 1996 graduating class of the Midwifery Education Program in Obstructed Labour, 4.

I am not aware of the systematic collection of information regarding the personal backgrounds of individuals practicing midwifery in Ontario, either prior to or since the passage of midwifery legislation. The collection of information about those who were practicing midwifery in Ontario prior to legal recognition is hampered by the lack of any formal mechanism to identify or track these individuals. The systematic collection of biographic details of practicing midwives is an area for future research investigation to understand the profile of midwifery practitioners in Ontario.


35 Despite an increasing trend in feminization of the Canadian physician work force over the last several decades, men continue to represent the majority of medical practitioners. The Canadian Institute for Health Information reports that 34.7 percent of the physician work force was female in 2008 compared to 11.1 percent in 1978. See Canadian Institute for Health Information, Supply, Distribution and Migration of Canadian Physicians, 2008 (Ottawa: Canadian Institute for Health Information, 2009), 34. Obstetrics continues to be a male dominated specialty of medicine; however, the gender balance is also shifting, as reported by Warren H. Pearsen, William H. J. Haffner, and Aron Primack. “Effect of Gender on the Obstetric-Gynecologic Work Force,” Obstetrics and Gynecology 97, no 5 (May 2001): 794–797. The first male student of the Ontario Midwifery Education Program graduated in 2012, as reported by James Bradshaw in “Breaking Barriers: Canada’s Only Registered Male Midwife Knew His Calling All Along,” The Globe and Mail, May 16, 2012.

certified nurse-midwife members of the American College of Nurse midwives were men in “Midwifery: A Career for Men in Nursing,” *Men in Nursing* (February 2008): 29-33.

37 Several of my interviewees are featured in Barrington’s *Midwifery is Catching*, including Elsie Cressman, Jane Kilthei (referred to as Jane Cocks), and Mary Sharpe.


42 See note 10 above in this chapter.


44 These nurses participated in the midwifery pilot project at McMaster University Medical Centre as described by Harvey, Kaufman, and Rice in “Hospital-Based Midwifery Projects.”

45 The nursing backgrounds of several of the interviewees will be further discussed in the following section, More than Counterculture Moms and Feminist Activists. The role that interviewees’ nursing backgrounds played in their decisions to become midwives will be explored in more depth in Chapter 3 in the section titled Nurses First.

46 For a discussion of models of midwifery education in western European countries and North America, see Cecilia Benoit, Robbie Davis-Floyd, Edwin van Teijlingen, Jane Sandall, and Janneli Miller, “Designing Midwives: Comparison of Educational Models,” in *Birth by Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe*, ed. Raymond De

47 Midwifery in the United States was not uniformly recognized throughout country in the twentieth century. Regulations varied state by state, with some states having no formal provisions for midwifery, others with recognition of nurse-midwifery only, and others recognizing a variety of formal and informal midwifery models of practice. For a discussion of historical and contemporary practices of midwifery in the United States, see Rooks, *Midwifery and Childbirth in America*.

48 See the three briefs on midwifery self-regulation to the panel of the provincial Health Professions Legislation Review in the early 1980s prepared by the Midwives Coalition that are listed in the Bibliography. The Midwives Coalition was working group with representation from three provincial organizations representing Ontario practicing midwives, midwifery consumers and nurse midwives. See also “International Definition of Midwifery & AOM Standards, appendices 5 and 6 and “AOM Document Core Competencies, September 1990,” appendix 22 in Bourgeault, “Delivering Midwifery.”

49 Arms, *Immaculate Deception*, 151-152.


51 Davis, *Heart and Hands*, 2.

52 Ibid., vi.

53 Ibid., 1.

54 The early American midwifery texts referred to by Tyson in this passage include, Lang, *Birth Book*; Gaskin, *Spiritual Midwifery*; and Davis, *Heart and Hands*. These publications are representative of those described by MacDonald as influencing Ontario midwives in *At Work in the Field of Birth*, 54-60.

55 A variety of terms are used by midwifery writers and practitioners to refer to midwives who did not have formal training or who practiced outside recognized systems of health care in North American midwifery movements, including “lay”, “independent,” “community,” “empirical,” “traditional,” and “direct entry.

56 Ina May Gaskin is the author of *Spiritual Midwifery* that provides a portrait of The Farm’s midwifery service, in addition to a teaching guide for midwives.

Ideological tensions between a traditionalist ideology emphasizing woman’s femininity and maternal role and a feminist ideology emphasizing woman’s autonomy and personal fulfillment have been described by scholars writing about midwifery revivals in North America and are reflected in Ontario midwifery discourse. See Ruzek, *The Women’s Health Movement*; Rothman, *In Labour*; Mason, *The Trouble with Licensing Midwives*; and Van Wagner, “Why Legislation?”

For example, Elizabeth Davis sees midwifery’s marginality in the American health care system as demanding a “revolutionary perspective” from midwives. She blends an essentialist portrait of midwives with their “political” position outside official health care to characterize midwives as feminist “rebel” figures. Davis interprets feminism in midwifery using an essentialist perspective, seeing midwifery as feminist for its “revelation of essential feminine force,” in *Heart and Hands*, 2.

See Van Wagner, “Women Organizing for Midwifery In Ontario”; and Mason, *The Trouble with Licensing Midwives*.

Barrington uses the term “conservative” to refer to Cressman’s Mennonitism in *Midwifery is Catching*, 94.

Ibid., 93-100.


Ibid., 61.

Ibid., 60.

For a discussion of Mennonite women whose roles diverged from the normative gender roles of wives and mothers, see “Wives, Mothers and ‘Others’: Women Within Families,” chapter 2 in ibid., 60-118.

Ibid., 78. Katherine Martens and Heidi Harms document midwifery practices in Mennonite communities in their oral history anthology of Mennonite women’s childbirth experiences, in *In Her Own Voice: Childbirth Stories from Mennonite Women* (Winnipeg: University of Manitoba Press, 1997). In her historical study of childbirth in Canada, Wendy Mitchinson also found
evidence that practices of midwifery persisted within cohesive communities that were culturally or geographically isolated from modernizing Canadian society. In *Giving Birth in Canada*, 92.

69 *Mennonite Women*, 153.

70 For a detailed analysis of Canadian Mennonite women’s role as missionaries, see “Preachers, Prophets, and Missionaries: Women in the Church,” chap. 3 in ibid., 119-178.


73 The rich detail of Cressman’s early life narrative is consistent with theories of memory in the practices of oral history with older people, such as Alessandro Portelli, “‘The Time of My Life: Functions of Time in Oral History,’” chap. 4 in *The Death of Luigi Trastulli and Other Stories: Form and Meaning in Oral History* (Albany: State University of New York Press, 1991), 59-79.

74 Marlene Epp notes there are approximately fifty identifiable Mennonite subgroups in Canada. See Epp, *Mennonite Women*, xi.

75 Cressman noted that Tanzania was called Tanganyika prior to its 1964 merger with Zanzibar.


77 Ibid., 151.


81 Sheryl Nestel, “(Ad)ministering Angels: Colonial Nursing and the Extension of the Empire in Africa,” *Journal of Medical Humanities* 19, no. 4 (December 1998), 258.


83 Elsie Cressman received extensive public recognition for her work, both provincially and locally, including the Order of Ontario in 1994 and, in February 2012, a Woman of Achievement Award from the Kitchener-Waterloo chapter of Zonta International, a global advocacy and service organization for the advancement of the status of women. See Valerie Hill, “Zonta Honors Four Incredible Women,” *Kitchener-Waterloo Record*, February 15, 2012. Cressman’s work has also been extensively covered in the public press, particularly in the Kitchener-Waterloo region, and her missionary work in Africa is the subject of a documentary film (see note 76 above). A biography of Cressman was recently published, Nancy Silcox, *Elsie Cressman: A Trailblazing Life* (Kitchener, ON: Pandora Press, 2012). Despite Cressman’s public prominence and the presence of other Mennonite midwives working in pre-legislation Ontario, the narratives of midwives as counterculture mothers and feminist activists continue to dominate the literature of midwifery revival in Ontario and elsewhere in North America.


86 Gleason, “Psychology and the Construction of the ‘Normal’ Family in Postwar Canada.”


88 Brandt et al., *Canadian Women*, 343.

89 Ibid., 324.
The proportion of married women in the paid work force rose steadily from 1 in 25 in 1941 to 1 in 5 in 1961, as reported in ibid., 325.

The massive influx of women into paid work force from 1951 to 1980 was primarily in the clerical and retail sectors and that in 1991 more that eighty-five percent of all working women worked in the service industries. See ibid., 443.

Ibid., 344.

Ibid., 440.


Brandt et al., *Canadian Women*, 348.


Childbirth preparation programs proliferated in North America beginning in the 1960s, as organizations to promote childbirth education and natural childbirth were formed in Canada and the United States. Growing concern for child health, and mental health in general, led to new psychological imperatives in parenting. The rising fields of psychology and psychiatry emphasized the importance of child mental health and advocated informed, healthful mothering practices for the prevention of mental health problems rooted in early childhood. In this social context, La Leche League was formed in 1956 by a small group of Illinois mothers to promote

100 For an examination of the experiences of young pregnant women in 1950s and 1960s North America who gave birth in secret from their families and communities and gave their babies up for adoption, see Anne Petrie, Gone to an Aunt’s: Remembering Canada’s Homes for Unwed Mothers (Toronto: McClelland & Stewart, 1998); and Anne Fessler, The Girls Who Went Away: The Hidden History of Women Who Surrendered Children for Adoption in the Decades Before Roe v. Wade (New York: Penguin Press, 2006). For an example of Canadian media coverage on recent public demand for a federal inquiry into coercive adoption practices of this era, see Mary Anne Alton, The 40 Year Secret, television documentary directed by Mary Anne Alton and Deborah Parks, first aired January 25, 2012 (Toronto: Canadian Broadcasting Company, The Passionate Eye); and Kathryn Blaze Carlson, “Curtain Lifts on Decades of Forced Adoptions for Unwed Mothers in Canada,” National Post, March 9, 2012.


102 For a discussion of demographic, life cycle and reproductive changes in the lives of women in the 1960s and early 1970s, see Brandt et al., Canadian Women, 477-492.

103 Ibid., 499.

104 Thirty-seven percent of all full time undergraduates in Canadian universities were women by 1970, as reported by Brandt et al. in ibid., 501 and 612.

105 Women represented over ninety-five percent of students in household science, nursing, secretarial science and occupational and physical therapy in 1969-1970. See ibid.


107 Brandt et al., Canadian Women, 438.


109 Adamson, Briskin and McPhail, Feminist Organizing for Change, 40.

111 Brandt et al., *Canadian Women*, 445-446.


115 Jacob, *New Pioneers*, 140.


117 The “ideological and material beginnings of a women’s movement” were evident in Canada in the early 1960s, according to Adamson, Briskin and McPhail in *Feminist Organizing for Change*, 43.


119 Brandt et al., *Canadian Women*, 501. The gender gap in education has continued to widen. John Intini reports in 2006 that Canadian university undergraduate programs have become feminized, with female students representing sixty-eight percent of students in social science and eighty-three percent in English. See “Two Girls for Every Boy,” *Maclean’s*, June 26, 2006, 54-56.


121 Women’s work force participation rose from thirty-eight per cent in 1970 to fifty-three per cent by 1983, as reported by Adamson, Briskin, and McPhail in *Feminist Organizing for Change*, 5.
In their study of the sex composition of the “professions” in Canada in the period 1971 to 1986, Pat Armstrong and Hugh Armstrong report pronounced patterns of sex segregation between and within professional occupations despite increasing rates of women’s entry into the professions. They conclude most professions were dominated by men in this period and men were concentrated in professions with the greatest autonomy, power and reward. See “Sex and the Professions in Canada,” *Journal of Canadian Studies* 27, no. 1 (Spring 1992): 118-135. Statistics Canada reported in 2005 that, while women were increasingly represented in the traditionally male dominated professions of medicine, dentistry, business, sixty-seven percent of employed women were working in teaching, nursing and related health care occupations, and clerical, sales and service occupations. See Statistics Canada, “Distribution of employment of women and men, by occupation, 1987, 1996 and 2004,” table 5.13 in *Women in Canada: A Gender Based Statistical Report* Statistics Canada Catalogue no. 89-503-XWE (Ottawa, 2005), accessed August 8, 2012, http://www.statcan.gc.ca/pub/89-503-x/2005001/tab/tab5-13-eng.htm.


While generalizing about the lives of twentieth century Canadian women is limited in representing the lives of women outside of mainstream society, this discussion is relevant to the lives of the midwives given the relative homogeneity of their personal histories as a group of white, middle class and well educated women of English Canada.
Chapter 3

Finding Midwifery:
Midwives’ Inspirations and Motivations

Our understanding of why midwives chose to practice on the margins of official health in late twentieth century North America is limited. Research that explicitly investigates the factors that inspired and motivated midwives to work in alegal or illegal practice settings in twentieth century North America is absent. The large body of literature analyzing midwifery’s modern re-emergence as a grassroots social movement for childbirth reform provides some evidence for understanding why midwives entered unofficial practice. Several Canadian publications that profile the working lives of pre-legislation midwives include discussion of factors that informed their decisions to practice. These publications present similar themes to those expressed in recent publications featuring the life stories of American midwives. Documentation and discussion of the principles and philosophies underlying emerging practices of midwifery in late twentieth North America provide another source of evidence for insight into what may have attracted the interest of aspiring midwives. The portrait of the ideal student midwife candidate contained in early American midwifery teaching manuals written by and for lay midwifery practitioners provide opportunities for understanding what motivated midwives to learn and to practice in without legal status. Critical scholarship on midwifery regulation and professionalization constructs understandings of pre-legislation practice through discussion of losses or gains to the model and philosophy of care, suggesting how unofficial midwifery was organized and valued by practitioners.

Essentialist and hetero-normative assumptions shape knowledge about why midwives practiced in North American midwifery revivals. Much like the theoretical understandings of who became midwives, midwives’ motivations are deeply entwined with their assumed status as women, wives and mothers. This may account for the absence of a clear articulation of midwives’ motivations in midwifery literature, as they are considered so obvious as to be rendered invisible. In the dominant portrait of midwifery’s revival as a grassroots, consumer led movement of mothers assisting other mothers to give birth outside official health care, midwives are commonly portrayed as mothers reclaiming the traditional practices of home birth and midwifery as a means to resist and redefine normative maternity care’s reliance on medical technologies. Their motivations to support other women in childbirth reform alternatives are tied
to their personal experiences of giving birth and becoming mothers. Women who experienced medically-managed birth are seen to be motivated to support other women to give birth without technological interference by feelings of dissatisfaction, whereas women who experienced “natural” births were assumed to be inspired to support other women to share in this natural experience.4

Feminine caring, or what Canadian anthropologist Margaret MacDonald calls “maternal nurturance,”5 is considered to have played a key role in women’s suitability to become midwives, as well as their pathways into practice. Midwifery is widely referred to in historic and contemporary writings as a “calling.”6 It is conceptualized similarly to other forms of women’s caring work, notably nursing and teaching, as a natural extension of women’s domestic caring and healing roles.7 However, professionalized female caring occupations are simultaneously viewed as incompatible with midwifery’s counterculture values and practices.8 Those suited to midwifery’s calling are represented as women, often mothers, who embody exceptional caring qualities and who are dedicated to the feminine ideals of service and altruism, as expressed by American midwife Elizabeth Davis in her popular guide for aspiring midwives:

The most common profile of the midwife is probably the mother with children (often home-born) who begins to be asked to births as a labour coach and works gradually into a position of greater responsibility…The service and self-sacrifice that are such a big part of midwifery cannot be overestimated. Many aspiring young women see midwifery as a “high” or “far out” thing to get into; in other words, their desire is more for ego gratification than for right livelihood...In order for person to stay with such demanding and responsible work, it should feel more like a calling.9

Metaphors embodying caring as the core value of midwifery are pervasive in midwifery revival literature, as well as in the rhetoric of modern midwifery public education and promotion campaigns.10 These metaphors depict women’s connections to one another in care giving and care receiving roles, emphasizing their shared gender as women and mothers. Women’s relationships to one another as daughters and as sisters are also used to describe midwives’ connections to one another, both historically and in the present.11

Ideologically diverse forms of midwifery that evolved in the North American revival broadened midwifery’s appeal to women across a spectrum of political perspectives, ones that ranged from conservative to progressive. Women who reclaimed the traditional practices of home birth and midwifery assigned them new meanings in a modern context in opposition to
medicine. Midwifery’s claims to qualities seen to be lacking in normative maternity care, such as spirituality, maternalism, and female empowerment, captured the interest and attention of many aspiring midwives. Self-trained American midwife Ina May Gaskin’s *Spiritual Midwifery*, a foundational text in the North American midwifery revival, constructed midwifery as a “revolutionary” spiritual practice honouring the sacredness of birth:

This is a spiritual book, and at the same time, it’s a revolutionary book. It is spiritual because it is concerned with the sacrament of birth – the passage of a new soul into this plane of existence. The knowledge that each and every childbirth is a spiritual experience has been forgotten by too many people in the world today, especially in countries with high levels of technology. This book is revolutionary because it is our basic belief that the sacrament of birth belongs to the people and that it should not be usurped by a profit-oriented medical system...We feel that returning the major responsibility for normal childbirth to well-trained midwives rather than have it rest with a predominately male and profit oriented medical establishment is a major advance in self-determination for women. The wisdom and compassion a woman can intuitively experience in childbirth can make her a source of healing and understanding for other women.12

Other American lay midwifery literature similarly configured midwifery as a nurturing female “art” in opposition to the “science” of male medicine. In the introduction to Elizabeth Davis’ guide for midwives, medical statistician and childbirth advocate David Stewart painted an essentialist portrait of midwifery that stood in stark contrast to his portrayal of medicine as impersonal and mechanistic:

Midwifery is an art, not a science; and childbirth is an experience, not an experiment... Today’s obstetrics is an attempt to apply science to a process that is beyond science – the process of childbirth. It tries to reduce masculinely objective routines to the management of a process that is femininely subjective and which defies management...Midwifery is an art; its basis, feeling and intuition. It understands the proper and beneficial role of subjectivity and does not try to avoid personal involvement. Midwifery is personal attunement by a caring professional and heartfelt concern for the only true observers and experiencers of the birth process – mother and baby. True midwives do not “deliver” babies as much as help mothers give birth by their own exertions and allow babies to participate in their own birthing. They are not here to “manage labor” or to “accomplish a delivery.” They are there to help mothers and babies do what God and nature meant for them to do for themselves.13

Dichotomous models of midwifery and medicine that infused North American midwifery discourse constructed midwifery as a “wholistic” alternative to “technocratic” medicine and posed female intuition as a key component to skillful midwifery practice.14 Davis’ compelling
portrait of midwives as female rebels remained true to midwifery’s countercultural roots while integrating a maternal feminist perspective. Davis, like Gaskin, saw the everyday act of midwifery practice as not only spiritual, but also as inherently political:

To understand the midwife we must appreciate her reality – living on the edge of the law, realizing that personal freedom may be at stake, but going ahead with it anyway. This takes strong character, independence and revolutionary perspective. Herein lies the secret of the midwife’s current notoriety: she is a rebel and a female one at that! So like it, or not, the midwife these days has a decidedly political position. She is almost invariably typed feminist. This, because the potent lesson of natural childbirth is the revelation of essential feminist force…Hence the midwife, essentially peace-loving guardian of the natural birth process, is thrown into political dichotomy for facilitating this awareness. This is an awkward position for many of the midwives I know. At most a midwife might consider herself an “evolutionary agent” (Timothy Leary’s phrase) or feminist in the sense of furthering the individual, non-violent awakening of each women’ spirituality.15

With the evolution and diversification of the women’s health movement, others embraced midwifery as form of social or political activism for women’s reproductive control and empowerment. Some feminist midwives and scholars not only recognized the transformative potential for women in how they gave birth, but also their choice to be pregnant, including safe access to abortion and contraception.16 Despite these philosophical variations in the conceptualization of modern midwifery, common principles underlay diverse practices that resonated for aspiring midwives. Midwifery discourse fundamentally asserted the normalcy of birth and women’s autonomy to direct their own care.17

Literature documenting and analyzing midwifery’s re-emergence in Ontario reflects and constructs similar understandings of midwives’ inspirations and motivations based on the concepts of motherhood and womanhood. Barrington configured midwifery as a calling predicated on female caring and community, an enduring motif in Canadian midwifery discourse. She referred to midwifery as a “calling, a “vocation of vigilance,” and a “discovery of right livelihood.” She identified motherhood and nurturance as essential qualities for midwifery practice: “All that the midwives have in common is motherhood. The only prerequisites are life experience, quick intelligence, a giving personality, and a passion for birth.”18 She noted the relevance of midwives’ personal childbirth experiences to their desire to become midwives: “The provocations to learn midwifery are particular to individuals, but there are a few recurring themes among midwives’ professional histories. The most obvious is the enduring impact of a
very good, or very bad, birth experience.” Barrington expanded her notion of a midwifery calling to incorporate neighbourliness and service to community, portraying midwives as chosen by other mothers in an informal network of neighbours supporting one another in childbirth alternatives:

The first “new midwives” emerged from among…questioning parents. Mothers, who explored and experimented first for themselves, shared their newfound skills and experience with their neighbours. They gave birth at home, and whoever knew more offered help. Most were reticent to accept the title of midwife until it was thrust upon them by others.

Jutta Mason’s representation of the early Ontario midwifery community in her 1990 publication, *The Trouble with Licensing Midwives*, closely resembles Barrington’s portrait of midwifery’s informal female network of mothers helping mothers, as well as her historical narrative of the “neighbour midwife” that continues to be influential in Canadian midwifery scholarship. Mason’s portrait of modern Ontario midwifery evokes historical understandings of midwifery as a universal and traditional female practice. She described the modern revival of midwifery as a “neighbourly venture, a gradually expanding net of womanly connections between friends” where “the link between midwife and labouring woman lay in the shared experiences of being female and being mothers.” Mason inferred that midwives’ motivations lay in their commitment to countercultural natural childbirth alternatives, ones that she saw as inextricably linked to their position outside official health care and the law. She perceived midwifery’s legal recognition as fraught with danger by shifting midwives away from the core values inherent in a counterculture model of maternity care. She also asserted that professionalization would undermine midwives’ non-authoritative, caring relationships with childbearing women and their respect for normal birth by aligning midwifery with medical authority and practices that it had once resisted and redefined. Mason’s analysis of the implications of licensing midwives reinforces the portrait of pre-legislation midwifery as a caring female calling. Like Barrington’s analysis of the re-emergence of Canadian midwifery, Mason’s critical analysis of midwifery regulation created a lasting impression of the early Ontario midwifery revival that continues to inform scholarship on Canadian midwifery.

The assumption that pathways into pre-legislation practice stemmed from women’s mothering experiences and caring qualities was further developed and reinforced in the large body of literature examining Ontario midwifery regulation that followed Mason’s work. The focus of this literature largely centres on the impact of midwifery’s professionalization on the model of
Critiques of legal recognition overshadow arguments for beneficial outcomes of a regulated system of midwifery. Like Mason’s analysis, critical scholarship on Ontario legislative reform identified core values that would be lost with midwifery’s “incorporation” into the official health care system. Midwives, midwifery clients, and scholars passionately voiced concern about the potential erosion of midwives’ caring relationships with childbearing women in the large body of literature published in the years surrounding enactment of midwifery legislation in Ontario. Accountability to health care and regulatory institutions that would accompany midwifery’s legal recognition were interpreted as potentially shifting midwives’ alliance away from the women in their care toward medicine and the state, by “wear[ing] away the ideal of the equal partnership around which midwifery was built and flourished.” Critical scholarship on midwifery regulation also predicted that erosion of midwives’ expertise in normal birth would result from pressures to conform to medical practice standards. Factors that inspired and motivated midwives to practice may be inferred from these contested debates about the implications of moving midwifery from outside to inside the health care and legal systems. The deeply held philosophic and practice principles of midwives’ caring relationships and their expertise in normal birth that permeate the discussion of midwifery’s changing status likely represent factors that inspired midwives to practice in Ontario’s midwifery revival.

Studies of midwifery’s relationship to official health care and its changing legal status provide other insights into what may have motivated midwives to practice, ones that go beyond their desire to offer a dichotomous model of care to medicine based on female caring and normal birth. Scholars and practitioners have interpreted midwifery’s oppositional stance to medicine as symbolic of social activism. It is widely assumed that the daily work of midwives contributes to social change by humanizing birth practices for mothers and babies, suggesting midwifery was appealing to those wanting to engage in meaningful social change work. Aspiring midwives may have also been attracted to midwifery as a political change project in regions of North America where midwifery lay outside official health care. Midwives’ engagement in political campaigns for legal reform has been interpreted in contradictory and contested ways, reflecting ideological differences about the value of “mainstreaming” versus “disengaging” midwifery. Midwifery scholars and practitioners who viewed legislation as strengthening midwifery and improving women’s access to childbirth alternatives interpreted midwives’ political activism favorably. Others, who saw midwifery’s integration into official health care as undermining midwifery’s autonomy and core values, interpreted midwives’ political involvement as
incompatible with midwifery’s political stance as an outsider to medicine and the law. Activist midwives’ aspirations for “insider” status were interpreted as a move away from the “outsider” maternal counterculture midwife figure and the caring qualities it represented toward a professional midwifery identity and medical model of childbirth.\textsuperscript{31} Ontario midwife and midwifery scholar Betty-Anne Daviss noted midwives interested in legal reform were more closely aligned with feminism as compared to the “radical fringe” who prioritized “spiritual enlightenment.”\textsuperscript{32}

According to Margaret MacDonald, “resistance to biomedicine” played a key role in identity formation for Ontario midwives in addition to the dominant narratives of “nature, tradition and home” that permeate midwifery discourse.\textsuperscript{33} Critical scholarship on Ontario midwifery regulation portrays the community of pre-legislation midwives as polarized by tensions about legal reform into a binary of urban political “elite” midwives allied with medicine and the state versus “other” or “non-elite” counterculture midwives working in partnership with childbearing women.\textsuperscript{34} Midwives in political leadership positions have been portrayed as skilled lobbyists controlling midwifery’s “professionalization project” that threatened to undermine midwifery’s core values and autonomy from medicine and the state. The dichotomy of caring midwives versus political activist or aspiring professional midwives mirrors the gendered dichotomy of midwifery and medicine that infuses Ontario midwifery discourse. Whereas the political implications of midwives’ daily work resisting and redefining mainstream maternity care was not seen to disrupt essentialist constructions of midwives and their motivations to practice, elite midwives’ pursuit of a relationship with the system was seen to sacrifice their caring relationships with childbearing women. Theories of elite Ontario midwives constructed understandings that they were not only less caring, but also less maternal. Some writers suggested that elite midwives were able to devote themselves to midwifery’s “professionalization project” because they had less domestic responsibilities or were childless.\textsuperscript{35} Elite midwives’ sexual orientation also came under scrutiny in ways that further reinforced their alignment with the gendered male constructs of medicine and the state. Midwives’ political activist and lesbian identities were conflated by some writers to bolster arguments about the dangers of midwifery’s legal recognition to the essence of Ontario midwifery.\textsuperscript{36} Alternative constructs of midwives’ engagement in campaigns for legal recognition also appear in midwifery literature. Midwives’ participation in political work has been interpreted as strengthening midwifery’s position in relation to medicine and the state. Some scholars linked midwives’
commitment to legal change work to their deeply held beliefs that midwifery’s autonomy, accessibility, and diversity would be strengthened by midwifery’s integration into the publicly funded health care system. The impact of midwifery’s legal recognition was also interpreted as enhancing midwifery’s core values of caring and respect for normal birth by formalizing midwifery as a primary health care profession and infusing midwifery’s values into mainstream maternity care.

Almost twenty years have passed since midwifery’s transition from an alegal to legal practice in Ontario. Uncertainty about the future of midwifery that influenced the literature published at the threshold of midwifery’s changing status in Ontario has diminished. Scholars who expressed concern about the loss of midwifery’s distinct professional identity by its “incorporation” into the medically dominated health care system have begun to publish accounts of Ontario midwifery as an international leader in creating a “birth model that works.” These scholars have increasingly offered more nuanced and optimistic understandings of the ways in which political activism holds meaning for midwives. Midwives’ interest in political and social change has been reinterpreted as more than a desire for personal gain and professional status. There is a growing body of literature on Ontario midwives’ commitment to social and political change through local and structural initiatives to improve the quality of maternity care. Scholars who were critical of midwifery regulation have more recently proposed a “hybrid” model for effective maternity care, one that blends caring and science.

Shared motherhood, female caring, and political activism may reflect authentic narratives of factors that influenced aspiring Ontario midwives; however, these concepts also overshadow other and more nuanced understandings of why midwives made the decision to take up practice under challenging legal and social conditions. Mothers’ suitability for midwifery practice is presented as self-evident in midwifery literature; however, the variety of meanings that midwives may have found in their personal birth experiences is often left unexplored. The experiences of non-mothers and the passion they felt about birth are rendered largely invisible, as are the experience of midwives who learned and practiced outside the North American midwifery revival or who became nurses’ first. An idealized caring midwife may not fully embody what aspiring midwives viewed as the essence of midwifery that attracted their interest. The construction of midwifery activism that dominates the literature on Ontario midwifery may also fail to capture how midwives viewed their work for social change of childbirth practices.
In their oral histories, the interviewees spoke evocatively about their inspirations to participate in the early years of the modern Ontario midwifery movement. Almost twenty years have passed since the legal recognition of midwifery in Ontario and anywhere from twenty to forty years since the interviewees entered practice. The endurance of their professional work within changing and challenging social and legal conditions and their dual experiences of working alegally and legally in Ontario likely influenced the depth of meaning and complexity that they assigned to their midwifery inspirations. The interviewees described multi-layered factors influencing their decisions to become midwives, ones that are simultaneously marked by individuality and commonality. Most highlighted several compelling factors that inspired and motivated their midwifery aspirations rather than a singular factor. Their memories of finding personal meaning in birth and midwifery through experiences that cross childhood, adolescence and adulthood will be explored further in this chapter. While these narratives reinforce the more common representations of midwives’ inspirations and motivations to practice embodied in North American midwifery literature, they also provide important counter narratives as well. In addition, their memories provide insight into the changing social conditions for childbirth in Ontario in the years they were “finding” midwifery.

CHILDHOOD ASPIRATIONS AND INSPIRATIONS

Many of the interviewees traced their interest in midwifery to early life experiences. They aspired to play a care giving role as midwives, a profession that was not always known or visible in their social contexts and one that offered greater occupational autonomy than the dominant Canadian female health profession of nursing. Girlhood aspirations to care for mothers and babies would have conformed to prevailing gender norms for the woman participants, even when considering the diversity in their ages.

*A Childhood “Calling”*

Heather Burton and Colleen Crosbie located the roots of their desire to care for childbearing women in childhood. The narratives of their childhood aspirations expand the notion of a “calling” to midwifery beyond its typical expression based on women’s personal childbirth and mothering experiences.
Burton’s mother was a German-trained physician practicing in Canada. Burton recalled her childhood insistence that she would become a care provider for childbearing women that differed from the North American maternity care model of the nurse-physician care team:

It’s as though I always knew. There wasn’t even a word for it. When I was a tiny little girl, the neighbour had a baby. I was about seven or eight and I had no idea about babies. I thought that they just simply showed up...And I said to my mother, “Where do babies come from?” And she said, “Well the lady goes to the hospital and the doctors get out the babies.” And considering my mother was a physician I thought that was probably God’s answer. And I said, “But what do you mean the doctors get out the babies?” And she said, “Well you go to the hospital and the doctor helps.” And I said, “Aren’t there ladies that help ladies have their babies?” And she said, “No.” I said, “But there must be ladies that help ladies get their babies.” I was a very bright and insistent child. And she said, “Oh. You mean a midwife.” She said, “No, we don’t have them.” She said, “We have midwives in other countries.” And I said, “Oh, well when I grow up I’m going to be a lady that helps ladies get out their babies.” And she said, “Well then you’d have to move to another country.” I said, “Well then I would. When I grow up I am going to be a lady that helps ladies get out their babies.” And then no more was said.

Burton did not articulate her aspirations using the concept midwife. Instead, she described professional aspirations that resemble the work of a midwife, as distinct from nursing or medicine. Although her mother was aware of the profession of midwifery from the German health care system, Burton’s narrative suggests she herself was unfamiliar with midwifery, which is not surprising given its absence in the Ontario context where she grew up.

Crosbie similarly linked her decision to become a midwife to a childhood desire to care for childbearing women. Living in Canada, midwifery was also unknown to her. She remembered articulating her aspirations using the normative occupational category of the maternity nurse. Like Burton, Crosbie’s memories of her aspirations were amplified by infusing her narrative with a child’s perspective: “All I ever knew in my heart, I never remember saying anything else except that I was going to be a nurse and I was going to work on the maternity ward. Always.” Crosbie fulfilled her childhood dream by becoming a maternity nurse. She related how her midwifery aspirations evolved in early adulthood when she was living in a rural “hippie” community in eastern Ontario in the mid-1970s. Childbearing women planning home births in her community requested her assistance because of her nursing background. She began to attend births as the most responsible care provider; during that period, a woman she was caring for called her a midwife. Crosbie looked into what a midwife was and it was then that she realized
her childhood desire to care for childbearing women was better aligned with the autonomous role of the midwife as a primary care provider, rather than the subordinate role of the nurse as an assistant to the obstetrician. The woman’s naming of Crosbie as a midwife gave her childhood aspirations new meaning and she reinterpreted her early life ambitions as linked to midwifery. Crosbie vividly recollected feeling called to midwifery: “I was meant to be a midwife. I was chosen. It was what I was meant to be from when I was born. That’s what I feel...I was put here to be a midwife...The rest is details.”

Childhood Stories

Childhood stories played a formative role in the midwifery aspirations of many of the interviewees. MaryAnn Leslie identified children’s literature as informing and inspiring her interest in midwifery. She remembered her attraction to heroic tales of frontier midwives that have become part of the folklore of North American midwifery.\(^{44}\) She described how stories of real and fictional nurses provided her with role models for women’s caring service to community:

...there was a novel, I can’t remember who the author is but the novel is called Christie and it was about a nurse who goes to somewhere in Kentucky or Tennessee, one of the very poor regions in the Appalachians. It was basically about helping look after the community. I remember all of the birth things about that book. I must have been nine or ten. I also had a book all about nurses in different nursing careers including like Florence Nightingale. I read about Mary Breckinridge who did the same kind of work, helping women in a compassionate caring way. So [midwifery] just appealed, always.

The story of Mary Breckinridge, an American nurse who founded the Frontier nurse-midwifery service in Kentucky in 1925, was particularly inspirational for Leslie.\(^{45}\) The travels of the nurse midwives by horseback into remote and mountainous regions of the Kentucky to deliver babies appealed to Leslie’s desire for adventure and left her with a vision of midwives as strong, independent and courageous.

Some interviewees related another form of childhood stories that inspired their attraction to birth and to midwifery. Several spoke of the deep and lasting impression of their mothers’ stories of their own childbirth experiences. These interviewees found inspiration in their mothers’ experiences of giving birth without technological interference in an era when childbirth was routinely managed using medical and technological procedures in North America.\(^{46}\) The
story of her mother’s “natural” twin birth in India in 1942 left a lasting impression on Mary Sharpe and inspired her longstanding interest in the mother-midwife relationship:

….when Caroline and I were about eight or nine, you know I have a twin, mom started to tell us stories about when we were born and she talked about this wonderful midwife. She was a British nurse and midwife in India who told her that she really should have a natural birth to save the second twin. That’s how she put it. And she stayed with my mother and walked around the bed with her and said between contractions, “With every pain god… brings your baby closer to you.” She inspired my mother. Her name was Jenny...she caught the babies…. it was just the story that my mother told me about how kind this midwife had been and how inspiring she had been to her. It was very, very evocative for me…

Vicki Van Wagner found inspiration in the story of her mother’s desire to resist the technological approach to birth that dominated medical practice in 1950s Canada. She described how her mother’s struggles to be conscious in childbirth in an era when women were routinely anesthetized informed her own confidence in the physiologic process of childbirth and her appreciation for female support in labour:

...a significant influence is my mother because my mother always talked about her own birth and she had, as she described it, been put to sleep even though she had fast, normal labours. In fact she talks about how in her second baby’s birth she felt like pushing in the elevator and she could hear as she went into the operating room them yelling, “Put her out. Put her out. She’s tearing.” Which of course means the baby is almost about to be born. And my mother was really mad about that. And she talked about it. And she struggled and fought as you would have had to in the mid-1950s to early ‘60s. My brother was born in 1960. And she said, “I went to a different hospital.” She went to Women’s College Hospital and she talked to a different doctor about staying awake for the birth. And those were the words that she used. She didn’t think of power or control or any of those things I might have been thinking about. She thought about staying awake and she really wanted to do that. And she always said to me as I was a kid growing up, “If it wasn’t for that young woman....a [medical] resident... who sat with me I couldn’t have done it.” So I wasn’t consciously thinking about that when I was deciding to become a midwife or even making my home birth plans...But I’m sure that influenced me in my idea of having a normal birth, a home birth, a natural birth as we called it then and the idea of a midwife being important and the person who is going to be there helping you to do it. I think that came from that story of my mom.

Jan Teevan took inspiration from her thirty-eight year old mother’s experience of a normal twin pregnancy and birth in 1960s America when twin pregnancy and birth were perceived as “high risk,” requiring medical surveillance and intervention. Teevan attributed her early fascination
with childbirth and babies to her experience as the big sister of twins and hearing how her mother had given birth vaginally without pain medication:

Well I think at the base of [my inspiration] is when I was eight years old my mother gave birth to twins and the first time I saw them they were just lying head to head on the sofa. And I thought that was pretty special. “Oooh. Two babies. Oh my goodness.” My mom was the classic kind of elderly multip, 47 thirty-eight. Gave birth to fraternal twins, a boy and a girl. And she told me that her obstetrician stopped yelling at her for gaining weight when he did figure out, “Oh, you’re carrying twins. Okay. You can gain some weight.” And the twins were 7½ and 8½ pounds. First one was head down, second one was breech. She gave birth vaginally. She said, “Oh yeah, the twins birth was the only birth that I didn’t have any pain medication because they were so fast.” So there we have it. That was 1960 that that happened. So, you know, just seeing those babies I think that gave me some kind of interest.

Teevan also noted her childhood fascination with pregnancy and childbirth was further reinforced by The Visible Woman, a plastic anatomical model of the female body with a detachable uterus that was introduced in America in 1960. This toy embodied a new interest in scientific education for children and offered an alternative to the highly popular and gendered Barbie doll that had appeared one year earlier: 48

And then when I was a preteen, maybe eleven or so, I got The Visible Woman, that model. She had a uterus that was roughly seven months pregnant and you could put it in, take it out, put it in, take it out. That was my favourite part of the model.

While The Visible Woman, like Barbie, reinforced traditional gender stereotypes, it inspired Teevan’s interest in an alternative to the scientific model of medicine that it was designed to teach.

Family heritage also played a significant role in inspiring a number of interviewees about alternative models of childbirth than those they were familiar with. Awareness of their grandmothers’ midwifery work seems to have reinforced a sense of continuity for these midwives, one consistent with perceptions in historical discourses and in popular imagination, that midwifery is women’s work handed down from one generation to another. In her examination of tradition in the Canadian midwifery revival, Margaret MacDonald noted the significant role that the valorization of tradition played in modern midwives’ identity formation. 49
Vicki Van Wagner also spoke of finding inspiration in family stories of her great grandmother’s work as a practicing midwife in Toronto. She noted the influence of the deeply rooted cultural traditions of home birth and midwifery from her Dutch heritage:

My family’s ancestry is Dutch and I had always thought that home birth was normal because I knew that it was normal in Holland. I remember thinking about having a baby when I was five years old. I remember the exact location where I was when I thought, “I will never have a baby in the hospital.” Not “I do not want to,” but “I will never”....When I was a young pregnant woman and I thought about having my baby at home, I knew that my father’s generation had been born at home in the west end of Toronto. And it seemed like a very normal thought to me.

She recalled that she first articulated her aspirations to become a midwife in her teen years:

For me the very first idea about being a midwife came when I was about seventeen when a friend said to me, “One of us better learn how to deliver babies because we’re going to want to help each other when we have babies.” And of course at that young age I wasn’t even thinking of having a baby, but that was the first memory I have of that idea. ... I have actually found an old journal from my teenage years that said “Maybe I would like to be a midwife.”

Holliday Tyson recalled learning about her great grandmother’s work as a rural Saskatchewan midwife gave her an historical role model and a family heritage in midwifery that sustained her commitment to midwifery in the face of her family’s disapproval. Her parents’ discomfort with midwifery and home birth was consistent with a more generalized societal view that formal systems of physician and hospital care were superior, modern forms of care:

I found out...that my great grandmother actually had been the town midwife in Maymont, Saskatchewan, between 1920 and 1945. She was actually well documented in all the historical notes of that town that some historian put together. Bizarrely it was in 1985 when the Toronto inquest was happening and I was on TV a few times that I suddenly got this package from this woman who said, “You don’t know me but I saw you on television and I know your family and did you know your grandmother Lafreniere was the town midwife in Maymont, Saskatchewan. She was a really good midwife and she went to almost four hundred births and here’s the documentation from this history of the town that she lived in.” And then I went and asked my father....and he just said, “Oh yeah. That was true.” But all that time they’d never told me because they were all sort of embarrassed by it. Strangely they thought it was really embarrassing. And of course it turns out my father had been born at home on the kitchen table but his mother was so embarrassed by it that she always said he was born in hospital instead. So it wasn’t like anyone in my family was happy that I was becoming a midwife.
Carol Cameron also noted that her great grandmother was a midwife. Her parents came to Canada from Scotland, where midwives were the lead care givers in maternity care. Cameron linked awareness of her great grandmother’s work to her normalization of midwifery:

My great grandmother was a midwife. I constantly knew that but it wasn’t until I started thinking about having children that I really thought, “What is a midwife, like what does that mean she was a midwife.” We didn’t talk about it but ever since I was little I knew that Grandma Hogg was a midwife, my great grandmother.

Childhood Passion for Birth

Holliday Tyson’s commitment to becoming a midwife in the early 1970s at age fifteen diverges from the common representation of midwives’ motivations that suggest they decided to become midwives as mature adults. While many midwives described an attraction to the process of birth in their early lives, Tyson found great meaning in the physiology of childbirth and breast feeding. She traced her desire to become a midwife to a series of childhood experiences that formed her passion for normal physiologic childbirth.

Tyson identified the experience of seeing a movie of a buffalo giving birth at age eight as a powerful and formative influence on her desire to become a midwife. Her fascination with the normalcy of the animal birth crystallized her vision of the ability of the body to work without technological interference:

...when I’m eight or nine years old I see a movie of a buffalo giving birth. And I think, “Oh, this is a beautiful thing. This makes sense.” I remember I was at a local movie theatre and I remember my mother tried to cover her eyes because she found it a bit obscene. And I remember it was the best scene I’d ever seen at a movie. I couldn’t believe it. Like, “Oh, this buffalo’s giving birth. That was so great.”

She similarly described witnessing a breast feeding infant as a young girl as a covert discovery of the wonders of physiology. She recalled her persistence in watching the experience unfold, despite her mother’s embarrassment:

I remember once this woman, the wife of an employee of my father, coming over to our house for dinner and her opening up her shirt and breast feeding her baby. And of course I’d never seen anybody breastfeed. I’d never seen a picture of anybody breast feeding. Certainly my mother did not breastfeed any of the four of us. And I remember just thinking, “That makes so much sense”... my mother was so horrified. She got up and left the table and never came back that night. And meanwhile I was using every excuse I could to stay at the table and
clearing the table trying to be helpful. I knew, because in our household you weren’t supposed to talk unless you were asked to talk, that I’d get booted if I asked too many questions but I was doing everything I could to just hang around the table because I was so fascinated.

Tyson’s mother’s discomfort with birth and breast feeding would not have been unique among mainstream women in middle class suburban Canada of the 1950s and 1960s. Female modesty and restrained sexuality were dominant social norms that reinforced secrecy surrounding childbirth and breast feeding. Childbirth was predominantly conducted within the confines of the maternity ward where women were routinely anesthetized and babies “delivered” using medical and surgical procedures including forceps and episiotomies and parenting was informed by new imperatives in scientific and educated motherhood. Bottle feeding of infants was promoted as a modern scientific and healthful practice, as mechanized and routinized infant feeding practices eclipsed the physiological process of breast feeding. The physiologic processes of childbirth and breast feeding held different meanings for Tyson. She contrasted her sense of comfort with physiology with her mother’s discomfort:

So those were my first two exposures to birth, a film of a buffalo and then this woman nursing her baby at our dinner table. Somehow those things were just hugely comforting to me. My mother definitely wasn’t someone who could relate to anything at all to do with her body or childbirth or anything and certainly didn’t want to talk about any of those kinds of things.

Tyson’s conviction to become a midwife was further reinforced by her exposure to an educational film on childbirth in junior high school. She related her feelings of outrage at the film’s representation of childbirth that she felt portrayed women’s disembodiment through technological interference in the physiologic process of birth:

...we had this biology class where we were all sitting behind those tables that had the Bunsen burners and everything and they go to show this birth film. And it wasn’t a normal birth at all. It was this draping of this set of legs in lithotomy position, up in stirrups and then this big slash of scissors and forceps. And I can remember being so upset and offended and even though I hadn’t even seen a woman give birth by that point I knew instinctively that that wasn’t right. Like I just knew it wasn’t right.

She remembered her impassioned insistence that the film’s representation of childbirth was not “real” landed her in the principal’s office:

And so I was really angry with the biology teacher saying, “That wasn’t a normal birth.” They should be showing us a normal birth and it didn’t even show the woman as a human
being. I remember it just showed her crotch and these legs in lithotomy and then the baby was hung upside down by a doctor. And the whole thing was so grotesque that I just knew. It was just hugely offensive to me. So I remember getting in trouble. I got sent to the principal’s office actually because I was really upset and saying that it wasn’t a real birth. It just wasn’t a real birth.

Tyson’s memory of the educational film suggest that she recognized as a young teen the conditions of medically-managed childbirth that were leading dissatisfied women in North America to seek out alternatives. Her attraction to the physiologic process of childbearing and her feelings that normative maternity care practices were subverting physiologic childbirth and violating women’s bodily integrity reflect emerging discourses critiquing medicalized childbirth and valorizing normal birth.56 Tyson’s story of her willingness to stand up for her beliefs in the face of authority also conveys a rebelliousness of spirit that foreshadowed the strength of conviction that enabled pre-regulation midwives to challenge hegemonic medical practices.

Tyson recalled an experience where she was able to find representations of childbirth that resonated with her belief in normal childbirth. At age thirteen, she babysat for a neighbour who had given birth outside of Canada with a midwife. When the woman told her she had home birth movies, Tyson requested to see these movies. To Tyson, her neighbour’s willingness to share these movies symbolized the woman’s comfort with the normalcy of childbirth. She described feeling an affinity with the style of birth she observed in these films:

… I was babysitting for these European people and they were talking about their midwife. They’d just come [to Canada] and they’d had a midwife and they had some films about birth. And I remember I was babysitting one night and I said, “Can I watch those films?” I couldn’t have been more than thirteen. And I watched these films and they were home birth films with a midwife from... I think one was from Holland. And so I saw these three or four births and it was just like, “Oh. Ah ha. That makes sense. Yeah, that’s what I want to do. That’s clearly what I want to do.”

At this time in the early 1970s, childbirth practices in mainstream Canada emphasized birth as a medical event conducted in an operating room attended by a professional physician-nurse team. Although hospital policies were beginning to shift to “allow” women’s “husbands” to be present in the delivery room for their babies’ births, childbirth was predominantly removed from the fabric of daily life.57 In contrast, the experience of Tyson’s neighbours revealed an alternative vision of birth as a social and family event. Midwives were primary childbirth care providers throughout Europe at this time and the process of childbirth was less dominated by technological
procedures than in North America. Home birth was common practice in countries such as Holland where children and family members were recognized as integral members of the experience as portrayed in the births Tyson viewed. Her exposure to films depicting home births would have fallen outside of social norms for a teen in suburban Toronto at that time.

Tyson’s depth of passion about the normal processes of birth and her new found knowledge of midwifery culminated in her determination to become a midwife at fifteen. She remembered the discouragement of her high school guidance counselor did not dissuade her:

So by the time I was fifteen I just knew I wanted to be a midwife. So I remember saying that in high school to the guidance counselor who thought I was completely crazy. It was like, “What’s a midwife?” or “What are you talking about? They only had midwives in previous centuries or decades” or something like that. So that’s when I first knew.

*Childhood Experiences of Home Birth*

Patty McNiven was also exposed to home birth as a teen in Toronto, although slightly later in the seventies than Tyson. She attended a home birth as a babysitter in the early years of the home birth movement in Ontario. She identified this experience as playing a key role in sparking her interest in midwifery:

When I was a teenager I had friends who I was a babysitter for and they had a home birth and I babysat the other kids at a home birth when I was about sixteen. So I thought that was pretty cool. And the mother had said, “Oh, I wish I’d been a midwife.” And then I got to thinking about what is a midwife and I looked into it and there was no midwifery so I went into nursing.

McNiven’s opportunity to attend a home birth and her memory that this was a “cool” idea reflects an emerging popularity of childbirth alternatives in mainstream Canada and a growing public consciousness of midwifery.

Wendy Katherine recalled the impact of being invited to attend two home births in the early 1980s. As a nineteen year old fine arts student at York University in Toronto, she was seeking direction in her life when she was invited to two midwife-attended births. She was asked to take photographs at one of these births and to provide childcare to the older child in the family at the other. She described feeling an immediate sense of clarity that she wanted to become a midwife when watching the midwives at work:
…when I saw what the midwives were doing, I was completely overwhelmed with excitement
and felt like I knew at that point that this was what I wanted to do. It was as clear as a bell to
me at that point. I asked them to explain what was happening at the birth, what they were
doing, what made them want to be midwives, how they did their work. I remember them
helping me examine the placenta. I had never touched or come close to any kind of blood
products of any kind, never close to even providing health care. I was awe struck by what
they did. Within a very short time afterwards I made contact with one of those midwives and
asked her what I needed to do to become a midwife at that time, to get more experience.

Katherine recalled feeling inspired by the midwives’ non-authoritarian and caring relationship
with the labouring women and the integration of the birth experience into the family’s daily life.
She subsequently investigated workshops on labour coaching and prenatal class teaching that
were offered by midwives in the growing Toronto midwifery community in 1985.

The degree of significance the interviewees ascribed to their childhood experiences and
aspirations was an unexpected finding. Many interviewees described their fascination with
pregnancy, birth, babies or breastfeeding as originating from a young age. Childhood
inspirations flowed from family stories and family histories, from books or films, and from
neighbours who had home births, and they influenced these future midwives to envision
themselves in the role of the midwife. They may not have known the term, as the title “midwife”
was often unknown or assumed to be an anachronism to Canadians of the era, but they
remembered being strongly attracted to a future career that involved helping women in
childbirth. Midwifery aspirations appear, for some, to pre-date and reach far beyond personal
experiences of motherhood.

BECOMING MOTHERS AND SUPPORTING OTHER MOTHERS

Almost two thirds of the interviewees had children prior to becoming midwives. Most of these
interviewees, although not all, linked their personal experiences of childbearing to their
midwifery aspirations. Those who spoke of the inspirational impact of childbearing were
exclusively women and while they all personally gave birth, not all were actively involved in
mothering as one interviewee gave her baby up for adoption. They ascribed a range of meanings
to their experiences of giving birth and becoming mothers and how these experiences catalyzed
their decisions to pursue midwifery. The conditions under which these interviewees gave birth
varied in terms of time and place and, as a result, they experienced a variety of maternity care
models and social practices of childbirth. The majority gave birth in Ontario, although some gave birth in other regions of Canada or in the United States, the United Kingdom or France. The settings for their births encompassed home, hospital and a maternity home. They were attended by a variety of care providers that included family physicians, obstetricians, nurses, nurse midwives, and midwives with or without formal recognition.

The interviewees gave birth sometime in the period 1960 to 1990, a time when mainstream maternity care in North America was undergoing a transition in response to growing public and professional dissatisfaction with the routine technological management of childbirth and interest in natural birth alternatives stimulated reforms both within and outside the system. International movements for natural childbirth reforms that promoted women’s conscious awareness at birth as foundational to infant well being and healthy mothering practices gained popularity in mainstream Canadian society during this period. Natural childbirth preparation programs designed to teach women techniques to cope with the pain of labour as alternatives to the routine use of pain relieving medications were increasingly incorporated into mainstream maternity care. While natural childbirth reforms did not alter institutional or medical authority, their challenge to routine technological interventions in childbirth was consistent with emerging professional and public interest in maternal-infant bonding and women’s satisfaction in childbirth.\(^{59}\) There was growing recognition of childbirth education and labour support as integral components of North American maternity care practices by the 1970s. The professional sphere of the delivery room was opened up to women’s “husbands” in North American hospitals and childbirth education programs proliferated.\(^{60}\) Natural birth ideologies were increasingly incorporated into mainstream childbirth practices under the banner of “family-centred maternity care.” In the 1970s and ‘80s, birthing rooms were re-designed to take on a more home-like appearance to replace the operating room, and women’s partners were expected to play a central support role in labour. Despite these innovations, rates of medical intervention remained high. Critics claimed family-centred maternity care ideologies and practices represented only a superficial challenge to medical hegemonic childbirth practices.\(^{61}\) Popular “grassroots” movements for home birth and midwifery that were emerging at this time, under the influence of the counterculture and the growing consumer and women’s health movements, more directly challenged institutionalized and routinized maternity care practices.\(^{62}\)
The interviewees’ narratives of their childbearing experiences reflect their desire to participate in creating alternatives based on a vision of childbirth as a healthy, normal process. Some of these interviewees gave birth at a time when natural childbirth alternatives were only beginning to surface and were largely inaccessible, whereas others gave birth within a context of active and well-established practices of home birth and midwifery. Some came to their own childbirth experiences with a vision of birth that typified the goals of the North American midwifery movement. Others formed a belief in normal birth through personal experiences of normal birth or in reaction to childbirth experiences that left them feeling dissatisfied.

**Personal Experiences of Childbirth and Mothering**

Mary Sharpe’s narrative of her personal inspirations centred on the resurgence of her childhood interest in childbirth and midwifery by her personal experiences of childbearing and mothering. Sharpe described giving birth to her first baby in 1970, a time when natural childbirth ideologies formed outside North America were beginning to have influence within pockets of American maternity care. Her desire to give birth “naturally” led her to seek out one of the new childbirth training programs that would prepare her to give birth without medical or surgical interventions. Sharpe noted her dissatisfaction with the local program she found in Connecticut as overly focused on preparing women for the use of medical procedures. Her sister recommended a Canadian program based on the teachings of French obstetrician and natural childbirth proponent Fernand Lamaze called the Canadian Association for the Lamaze Method, or CALM. Sharpe found this program more appropriately suited her goals. It provided training in physical and psychological techniques to cope with the pain of labour. She had a natural birth at the Yale-New Haven Hospital, one of the leading American institutions for natural childbirth practices of the time, making use of the techniques that she had learned. She named her daughter after her mother’s midwife who had left a lasting impression on her as a role model for caring support in labour. Sharpe recalled: “...that name is very sweet in my memory.”

Sharpe’s narrative of her early postpartum hospital experience highlighted her interest in the mother-infant relationship and foreshadowed her later passion for breast feeding support work and her engagement in social movements for home birth and midwifery. Sharpe spoke enthusiastically about the innovative postpartum unit at the Yale-New Haven hospital that she
felt eased her transition to new motherhood by creating a supportive community of care givers and other new mothers:

…the Yale-New Haven hospital was very modern in a particular way and that was the postpartum rooms. There were four women in each of two rooms and then there was a little room in between that was like a mini nursery for eight babies. I remember how I was supported with breast feeding. In this particular hospital they were very modern, or I would say proactive. The babies were taken to the nursery but I don’t remember being separated from Jenny right after the birth. I think I was with her right after the birth. But when she fell asleep after breast feeding, she went into this little nursery where there was one nurse looking after her. And in the middle of the night I remember the nurse coming to me and saying, “Mrs. Sharpe,” everybody was very formal in those days, “I think your baby needs you.” Now those words are very strong in my memory. Just the way she expressed that. She brought me the baby to me to be nursed, and then cared for the baby in between. So it was a very reasonable postpartum arrangement that actually could be considered to be incredibly supportive, even now especially if women are on their own and don’t have anybody else there. But also to have other women to talk to in the room. I liked the sort of communal atmosphere.

The design and philosophy of the postpartum program that Sharpe described was premised on new theories of the primacy of the mother-infant bond to healthy psychological child development and maternal adjustment. This arrangement facilitated ready access of mothers and babies, in stark contrast to the prevailing practices of routine separation of infants from their mothers into large specialized nurseries for extended hospital stays.65

Sharpe’s memories of her childbirth experiences provide insight into the varied and sometimes contradictory meanings and practices of natural childbirth. Sharpe recalled that her partner was left outside the delivery room where he could only observe Sharpe giving birth through a one-way mirror and communicate via a loud speaker, even though she had sought out a physician who would support her plans for an unmedicated birth with her partner in attendance,. While Sharpe commented that she had a “normal, unmedicated birth,” she also related how a nurse “strapped my hands down with these sort of padded leather bracelets on either arm.” She had difficulty recalling which of her first two births involved other routine procedures that were left uncontested in the nascent practices of natural childbirth, such as perineal shaving and enemas:
I was certainly shaved completely with the first baby, was I? Or was it the second one? Maybe at Yale-New Haven they didn’t shave me but certainly the next baby I had a complete pudendal shave which…I found that very bizarre and somewhat humiliating.

She noted the formative influence of later discovering Doris Haire’s 1974 critique of North American maternity care, *The Cultural Warping of Childbirth*, on her evolving belief in the normalcy of birth. Sharpe identified Hare’s article as playing a key role in politicizing her about institutionalized childbirth practices: “I kept that around sort of like a little bible.”

Sharpe had six children in a variety of models for childbirth. Her perceptions of the strengths and weaknesses of the care she received inspired her passionate interest in the caring connection between care givers and childbearing women. Her memories of her “hardest birth” left a lasting impact on Sharpe that informed her vision of the importance of warmth and attentiveness by maternity care providers to women’s individual needs. Her narrative of her experiences with midwifery care provides insight into the qualities that symbolized caring for Sharpe. They also offer insight into new priorities of interest to childbirth reformers. For Sharpe, the failure of her obstetrical nurse to recognize the personal and social significance of birth, as well as her midwife’s dismissal of her desire to avoid an episiotomy, signified an uncaring attitude:

We decided that we wanted to go to midwives so we went to a midwife group in New York and I learned that midwives are not all lovely. There were four midwives in this group and I met them all. I was going to be the first one in this sort of new birthing centre to have a midwife and three of them were lovely and one of them was very, very cold. That was very, a very difficult birth. That was probably the hardest birth in ways psychologically because there was a nurse standing at the end of my bed leafing through a girlie magazine and I was sort of reaching, wanting some kind of connection, some sort of acknowledgement that this was a really special central event for me. And saying to her, “Well it must be wonderful being around birth all the time.” She said, “Seen one, you’ve seen them all.” And the midwife that I was working with telling me that, “I’m going to do an episiotomy.” I said, “No, I don’t want an episiotomy.” “Well you’re going to rip.” This kind of talk.

She reflected on the ways her childbirth experiences informed her vision of compassionate care, one that transcended the profession of the care provider:

…there were different things that I was learning through my own personal birth experiences about what really felt right and didn’t feel right. And a huge message that I wanted to get across is that just because you have a midwife, you don’t necessarily have a compassionate care giver. And I would say that the home birth doctors that were at the two home births here
[in Toronto] were far more compassionate than the midwives that I had, one in New York and one in France.

Sharpe’s belief that her male home birth doctors provided more compassionate care than her female midwife care providers challenges binary models of midwifery and medicine embedded in midwifery discourse that attach caring to midwives.67

The experience of resisting medical advice and intervention in her first child’s birth in the mid-1970s motivated Heather Burton to become a midwife. She remembered feeling “horrified but happy” to find she was pregnant in her early twenties. While she had planned to attend graduate school or accept a managerial position she had been offered on completing an undergraduate degree at the University of Toronto, she set aside her future plans to focus on mothering. As the first person in her peer group “to marry and have children,” she felt she “knew nothing about having babies.” Her lack of knowledge about childbirth led her to “research everything I could.” She was able to easily access medical textbooks, but noted feeling inspired by her discovery of The Experience of Childbirth by British anthropologist Sheila Kitzinger, one of the first publications in a growing body of popular childbirth literature that promoted the transformative power of woman-centred, normal physiologic childbirth:68

...thankfully...accidently, divinely I came across Sheila Kitzinger’s The Experience of Childbirth and from that moment I was just revolutionized. I mean I was absolutely revolutionized. I had to really, really, really fight just to be allowed to have a baby without drugs. I didn’t care about the delivery room. I didn’t really care about the stirrups. I didn’t care about this and that. I just wanted them to leave me alone. And I was terrified at their intervention.

Burton’s desire to give birth without medical routines and technologies led her to seek care from a family physician in a Toronto who would support her plans to give birth without analgesia. When this doctor was not available, Burton found herself receiving a style of obstetrical care that influenced her conviction to have her next baby at home and to become a midwife in order to offer childbirth alternatives to normative medical care:

[My doctor] sent me to some horrible obstetrician who immediately announced that I had eclampsia and needed to be induced immediately and I refused induction. And then he didn’t even make it and I had a whole slew of people who sort of went off and came on. In a six hour labour I don’t know how many residents and obstetricians I finally saw. I had my first baby at North York Branson [Hospital] and on the delivery table I looked at my husband and
said, “I will never do this in a hospital again.” I said, “I will if there’s something wrong. But if not, I am never, ever, ever doing this again.”

Several years later, she was able to access midwifery care in her second pregnancy and had her baby at home. Burton described her subsequent decision to train as a midwife with the assistance of a local family physician:

And so before my son was even born in the early part of 1977 I had started to investigate midwifery training out of country or covert American offered midwifery training. I started to buy every medical textbook I could afford…then found someone through my doctor…to deliver my second baby at home…And from that moment on I just knew that that’s what I was supposed to be doing. So I never had any hesitation about it.

MaryAnn Leslie’s experiences of giving birth to her three children similarly inspired her interest in normal birth and her desire to become a midwife. She gave birth to her first child at age eighteen in the mid-1970s in New Brunswick. Leslie wanted to give birth without the medical routines and interventions that dominated maternity care at the time. She described what she saw as the contradiction between her personal desire for respect and the local regressive obstetrical practices, which she emphasized with the exaggeration of the local obstetrician’s age:

[I wanted] to be treated with respect because I was young. I wasn’t actually eighteen until a couple of months before she was born. And to be respected and to have my views respected. And I was in this very small town, Sackville, where Mount Allison was. The old obstetrician who did all of the births in that town and the surrounding area was still putting women to sleep, knocking them out and dragging babies out with forceps and that was 1974. And he was like 106 at least. So I went to see him for a visit and thought, “Okay, I’ve got to do something different. This is not going to work for me.”

Leslie was aware of home birth and midwifery revivals in the United States from newly published books by American practicing midwives and the women’s health movement. She met friends at university who had their two babies at home in the Gaspé region of Quebec on their own, without professional assistance. She learned that the partner of a house painter working in her neighbourhood was a British trained midwife. She approached this midwife to ask if she would attend a home birth, but the woman refused, because of the absence of legally sanctioned midwifery. Leslie also heard through word of mouth of an “elusive lay midwife” who was practicing in Nova Scotia who she attempted to track down without success. Her narrative of her efforts to find this midwife, or “just a person who would come,” provides insight
into the strength of conviction felt by women to seek out alternatives to mainstream medical care in the social context of 1970s Canada:

I tried to find this person, including going to Amherst which was the closest town, which was quite a big deal because we had no vehicle and absolutely no money. I mean I was young. I was only eighteen and could not find the person at all, any way, shape or form. No one would tell me or I just never ran into the right people to make that connection.

Leslie noted, with irony, that this midwife was her “dear friend Judy” Rogers, who later practiced in Ontario and is currently Leslie’s midwifery practice partner.70

Leslie was not comfortable to give birth at home without skilled assistance as her university friends had done. She managed to have a “normal” birth with her first child in a Sackville hospital under the care of local family physician, which she attributed to her personal determination and her fortune of having an efficient and uncomplicated physiologic labour. She tied her motivation to pursue midwifery with her desire to offer other women the respect for integrity and autonomy that she was seeking for herself but was unable to find:

...considering the times and the place and everything else I had a pretty uninterfered with straightforward labour and birth. People didn’t do too much to me that I didn’t want. And I came out of it feeling okay. There was some stuff but it was really pretty good. And then when you’ve had a baby and you talk to other women that have babies, they were all so unhappy with their experiences and they had been treated so badly. They had no say and they had no respect. They just didn’t get treated like human beings. It just made me mad...I was reading more and more books about midwives and where there was midwifery, still not aware that there was anything in Canada that would be easy to find.

Leslie’s birth experience confirmed her childhood aspirations to become a midwife and she decided to attended nursing school in Toronto as a route to midwifery. She was later able to locate an “elusive” midwifery practice in Toronto in the early 1980s when she was pregnant with her second child. Following her third child’s midwife-attended home birth, Leslie approached her midwife care giver to enquire about apprenticeship training.

Jan Teevan was similarly motivated to train as a midwife following the birth of her first child. She gave birth at home in Calgary under the care of a midwife who was practicing without legal status. For Teevan, home birth and midwifery represented counter practices to institutionalized maternity care that facilitated women’s ability to give birth informed and in charge of directing their health care decision making. Her interest home birth grew out of her experiences visiting
and living in several American counterculture communities that had active practices of midwifery. She also accessed early American midwifery and childbirth literature that critiqued mainstream medical practice as dehumanizing for mothers and babies. When some of her friends became pregnant, she considered studying midwifery:

I was living in Oregon in my middle twenties and some of my friends were starting to have babies. That’s when I became interested in midwifery. I read the two books that were available in 1977 which were *Immaculate Deception* and *Spiritual Midwifery*...They were available at the library and so I read them. They were my background information. And I knew people who had lived at The Farm in Tennessee and I had visited so I was aware of that whole thing too...[Midwifery in Oregon] wasn’t regulated at that time but there definitely were midwives serving the needs of women who wanted to give birth at home, to not be drugged and the baby dragged out and all of that stuff that was quite common in kind of late ‘70s obstetrical care in the States...And I had had that interest in the human body and that kind of thing from when I was younger. And I thought “Midwifery. Hmmm. Dealing with healthy people, not sickness. That could be good.” So I did talk to one of the local midwives and found out how she trained and if she would be willing to take an apprentice and what not and that was a good discussion. Then I met this guy who became my first husband and I moved to Alberta so nothing developed at that time.

Teevan noted her plans to study midwifery were interrupted when she moved to rural Alberta and became pregnant with her first child in 1979. She searched for a community to live where she would have access to midwifery care. She relocated to Calgary and gave birth at home with the assistance of one of the small number of midwives practicing in Alberta at that time. She reflected on her desire for a style of personalized and respectful care that she saw was lacking in mainstream maternity care: “I would have choices. I wouldn’t have stuff done to me. I would know what options, what reasonable things could be expected or asked for, and get them and not just be a slab of meat showing up at the hospital.” Teevan became active in a consumer group that promoted childbirth reform alternatives, the Calgary Association of Parents and Professionals for Safe Alternatives in Childbirth. While she had pre-existing interest in midwifery, it was following her experience of giving birth and becoming a mother that she pursued midwifery training:

...after my daughter’s birth I was kind of just taking care of her and feeling totally filled up with taking care of a baby and thinking, “Oh yeah, well maybe I didn’t really want to be a midwife. Maybe I just really wanted a baby.” So that was the first six months. And then after that I started feeling like, “No, I really do want to be a midwife.”
Kathy Penczak’s passion for women’s self-determination in childbirth was evident in her narrative of her personal childbearing experiences. Penczak married at age seventeen and had four children by the time she was twenty-two. She gave birth in hospital in the 1970s under the care of nurses and doctors who supported her desire to give birth vaginally despite the presence of medical complications. Penczak’s narrative disrupts notions of the interventionist practices of physicians and hospitals that are integral to feminist and midwifery critiques of modern obstetrics. She viewed her experience of having children when she was young as triggering her “deep maternal instinct” to help others that she carried into her professional life, as both nurse and a midwife. Penczak gave birth in a small city in southwestern Ontario at a time when medical routines and technologies in childbirth were coming under public and professional scrutiny, stimulating interest in humanizing childbirth. She contrasted her first three childbirth experiences in an “archaic” hospital with the more modern and progressive practices of the university health science centre where she gave birth to her fourth child. Despite facing significant complications in her third and fourth pregnancies, Penczak had vaginal births for all four of her children as she intended. She was grateful for the low intervention style of care that she received, even in the presence of unnecessary routine medical practices:

The first three were in Brantford and it was a little archaic. I thought, ‘I really don’t like this.’ You had shave preps, you had enemas, you know all the nasties that we know aren’t very beneficial…I had some complications. The first two were pretty uneventful except the second was breech and I had him turned. I had a NSVD [normal spontaneous vaginal delivery]. I had great experiences with labour and birth. I’ve never had a [cesarean] section…With my third one I had ruptured membranes for a week. At that time they put me on low dose antibiotics orally. I didn’t go into the hospital. She was breech and I had her, footling breech. No IV, no nothing. That was in ’75. Some things have changed a lot.

The support she received in her fourth pregnancy in the face of even more complex pregnancy complications solidified her commitment to offer a style of maternity care facilitated control in decision making for women facing “high risk” pregnancies:

My fourth one I had at Mac [McMaster Health Science Centre]. He’s microcephalic. I had a marginal placenta previa. I had a transverse lie. And I had ruptured membranes for two months. So it was huge and there was a reason for me being there. I had a vaginal birth and they supported me in my decision to have a vaginal birth even though they were set up to do a section if I needed it. So I thought this is where I want to work. They supported me in my decision. If I were somewhere else, they probably just would have sectioned me. So that’s
what swayed me into letting women have a choice and taking control. At least having things explained as to why or why not makes a big difference than just doing it.

Vicki Van Wagner’s memories of her motivations to practice midwifery reflect a common narrative in the literature written about grassroots social movements for home birth and midwifery in North America. She remembered her childhood interest in the birth process and her teenage desire to become a midwife resurfaced in her early twenties by her encounter with American publications promoting home birth and midwifery:

Before I was pregnant with my daughter, when I was about twenty-one, I looked at a book. I think it was called The Farm Book by Ina May and Stephen Gaskin. It had a bunch of health food recipes and countercultural ideas about the commune that that group of people had called The Farm in Tennessee. It told the story of babies being born within that community and of midwives attending the births. Even though the book wasn’t focused on midwifery, it made me really think about that idea again in my life and I was quite fascinated by it.

As Van Wagner contemplated her midwifery aspirations, her partner articulated a widely held assumption in midwifery revival literature that giving birth and becoming a mother were necessary prerequisites. She found herself pregnant with her first child one year later. Her difficulty accessing a home birth care provider consolidated her desire to learn midwifery:

I remember talking to my boyfriend at the time about the idea and he said, “Well you’d have to have a baby in order to be a midwife.” And interestingly enough within a year I was pregnant at the age of twenty-two with my daughter. That’s when I began to seriously look into the issues of midwifery, at first inspired by my own desire to have a home birth and looking for a care provider. I knew midwives existed but they didn’t exist in Ontario.

Van Wagner was aware of social movements for home birth and midwifery that were emerging in the United States and that pre-dated similar movements in Canada. She approached her family physician for a referral to a practitioner who would support her desire for a home birth. She was referred to an obstetrician who was known by her family physician to be “supportive of natural birth.” Van Wagner was hopeful he would agree to attend her home birth. She went to her first prenatal visit with a list of questions about his practice, but was “horrified” when he began to perform an ultrasound examination without her knowledge or consent. She discovered this doctor did not attend home births and Van Wagner was skeptical about his commitment to natural birth. She called the Toronto chapter of the International Childbirth Education Association (ICEA) to see if they knew of any home birth practitioners working in the Toronto area. They referred her to the Home Birth Task Force (HBTF), an organization of
health care consumers and professionals that had formed to lobby the Ontario government for the retention of nursing support services for home birth provided by the Victorian Order of Nurses (VON). Although the lobby efforts of the HBTF were unsuccessful, it was evolving into a home birth resource group that fostered resurgent interest in home birth in Toronto at that time. Van Wagner learned that midwives were not practicing in the Toronto area at that time, but that there were a small number of family physicians who offered home birth services. She called the offices of these physicians, but was disappointed to find they were on holiday for her late July due date. She ultimately managed to arrange care with an older Toronto home birth doctor who had a longstanding home birth practice that stretched back to the interwar years, a time when childbirth was not fully integrated into the hospital setting. As Van Wagner was living in a rural community outside of the city, she set out to find a birth location in Toronto. She met a Toronto childbirth educator who offered her home and was willing to provide labour support.

Van Wagner recalled that her home birth experience catalyzed her decision to learn midwifery in order to make home birth services more readily available to other women. The personal meaning she attached to home birth are reflected in the ideologies of late twentieth century North American social movements for home birth and midwifery. Van Wagner described feeling empowered and inspired by the opportunity to give birth the way she wanted rather than adapting to institutional policies and practices:

I had a very fast labour and I was virtually alone for most of it. I had the opportunity to labour and give birth on my own terms, a feeling that I was the central person and making the decisions and performing the incredible feat of giving birth. And to have done that when I was young. I was just barely twenty-three and it gave me a tremendous feeling of competence and power and all sorts of inspiration. It was meaningful on every level, from making me feel strong and independent to having the political meaning to feeling everyone should be able to do this and why can’t we? Why did I have to scrounge for this choice? I knew I was lucky. I moved to Toronto from out of town. I lived on a farm outside of Toronto. I moved because it meant so much to me to have my baby at home. I would not have gone to the local hospital. And the conditions under which women gave birth…that was in the late ‘70s. It was very medicalized at that time and the idea of having supportive people around or for women to give birth without pain relief, those ideas were very new.

Not only did she want to make home birth and midwifery accessible to other childbearing women, Van Wagner also wanted to see it become an “ordinary” option, as it was in other parts of the world:
I didn’t have a midwife at the birth but I did have a home birth physician and a woman who was a childbirth educator who had offered to come and help. She didn’t see herself as a midwife at all but she was involved in the movement to support home birth. I found my birth experience extremely meaningful and that was a major inspiration. I wanted to help other women to be able to have that same experience. It was very hard for me to find a care giver. I actually lied about my due date in order to get the only care giver that was available. I was thinking about Holland. If this was Holland it would just be ordinary to have a midwife and a home birth. And I was thinking about the reading I was doing about Raven Lang and the American midwives. It made me realize that midwifery should be ordinary. It should be normal. I drew together those ideas about the history of midwifery and how and why it was wiped out in Canada. I really wanted other women to be able to have that experience and feeling. It was wrong that there were no midwives for people like me who wanted them. That was probably the kernel of my inspiration.

Michelle Kryzanauskas linked her motivation to become a midwife to a similar desire to offer home birth services to other women in her community. Like Van Wagner, she envisioned home birth as facilitating the normal physiologic process of birth and woman’s control in health care decision making. Kryzanauskas was aware of home birth from family stories that fostered her familiarity and confidence with out-of-hospital birth. Her father was born at home in an era and locale where home birth was the norm, whereas her mother had unexpected home births for her three children due to the speed of her labours, including the birth or a stillborn premature infant that Kryzanuauskas was present for at age fourteen. Her inspiration for midwifery did not follow from her experience of giving birth at home; rather, it resulted from her inability to access home birth services in her first pregnancy. Kryzanauskas recalled coming across American home birth and midwifery literature that provided a vision of normal childbirth that appealed to her when she was contemplating having children in the late 1970s. She learned about active practices of home birth and midwifery that resembled those she read about when she travelled to Vermont to secure the rights to manufacture wood stoves for a business she and her partner were starting at their home near Stayner, Ontario. When she became pregnant in 1979, she knew she wanted to access a model of care like the one she had seen in Vermont. She located a small group of midwives that had started practicing in the Toronto area, but was unable to arrange for any of these midwives to travel to her community to attend her home birth. Kryzanauskas made an alternate plan to give birth in the local rural hospital under the care of a family doctor who she understood was supportive of natural birth. Soon after her daughter was born, she began to pursue a program of self-study in midwifery in order to make the option of home birth that she
had wanted for herself available to other women in her community. She remembered *Spiritual Midwifery* by Tennessee midwife Ina May Gaskin as particularly inspiring and instructive.\(^{77}\) She described how her confidence to take the step to practice midwifery was strengthened by arranging for backup medical support from a local family doctor:

> I read in entirety *Spiritual Midwifery* and just realized that there was something that wasn’t being offered in my community. And I had developed a pretty good relationship with my family doctor there. He was a young man. He was from the local area. My mother knew his wife and her family. So we sort of had this other relationship going on. And he always acted supportive of midwifery. So as I started evolving the notion that the way to have a midwife was to become a midwife and so that’s what happened to me is basically it became very evident to me that there wasn’t going to be midwifery in Ontario unless people started demanding it and started doing things towards it happening.

Carol Cameron found the experience of giving birth to her first child and becoming a new mother transformative and she was inspired to share in this experience with other women. Despite familiarity with midwifery from her Scottish heritage, where midwives are integral in maternity care, she did not seek out a midwife in her first pregnancy. She was living in the Durham area in the mid-1980s and was unaware that midwifery was being practiced in Ontario. Even though there were midwives visibly practicing in various regions of the province at that time, women often learned about midwives through word of mouth and access was restricted. Cameron wanted a natural birth and she was able to access care from a family physician who would support her desire to give birth in hospital without medical intervention. Following the birth, she read a newspaper article about midwifery and was struck by a compulsion to take up this work. She volunteered with a local chapter of a midwifery consumer lobby group that had formed in 1984, the Midwifery Task Force of Ontario.\(^{78}\) She contacted the local midwife in her community and pursued apprentice training with her. The midwife reluctantly took Cameron on as her first apprentice, and Cameron began attending births in 1988: “She took me on a little unwillingly. I had to really coax her a lot.”

Colleen Crosbie also found profound meaning in her experience of pregnancy and birth that reinforced her childhood desire to become a “maternity nurse.” This meaning did not centre on her experience of giving birth or becoming a mother, but on the loss of being a mother and the pain of giving a baby up for adoption. Crosbie was fifteen years old in 1967 when she gave birth to her son under medical care in a maternity home for “unwed mothers” in southwestern Ontario. Given the lack of social acceptance or support for teen motherhood at that time in mainstream
Canadian society, Crosbie recalled she was expected to give the baby up for adoption: “I didn’t really feel I had a choice. I can’t say I chose it. I mean it just was adoption, you know. There was no choice in my family in getting to keep him.” Her feelings of loss were left unacknowledged in the dominant social practices that normalized adoption in teenage pregnancy in postwar Canadian society: “I had the experience of birthing a child and giving him up for adoption which everybody was doing. I mean lots of women did it in those days, and it was sort of treated like the way you handled the situation. But it was a very deeply moving experience for me...So at a young age I had gone to a deep place and had to say goodbye to a baby.” Crosbie also wanted to acknowledge her fortune in reuniting with her adult son in 1992: “Also for the interview, I also know him now. I’ve had the joy of meeting him again. I’m that lucky person.”

*Mother Helping Other Mothers*

Participation in childbirth and breast feeding support activities played a role in inspiring and facilitating some interviewees’ entry into midwifery practice. The narratives of these interviewees conform to a common representation of pre-regulation midwives’ entry into practice through support work assisting other women within a community of new mothers in the midwifery revival literature. Some interviewees sought training as childbirth educators within structured programs developed by Canadian and American childbirth education organizations in the 1970s and 1980s that formed under the influence of natural childbirth and consumer health movements. Others were self-taught and accessed a growing body of instructional literature on childbirth preparation, home birth and midwifery. As prenatal class teachers, they found that women in their classes sometimes asked them to attend their births to provide emotional and physical support in labour in the role of “labour coach.” Several interviewees also described being approached family physicians who were offering home birth services in their communities to provide assistance in monitoring labour progress and helping at the birth, in addition to labour coaching services. These interviewees remarked on the significant contribution these opportunities made to their learning about labour and birth care. For some interviewees, their involvement in providing breast feeding support to other women similarly sparked their interest in expanding their role to include labour support and eventually deciding to pursue midwifery.
Mary Sharpe’s inspiration to become a midwife was founded on her interest in the relational aspects of women’s transition to motherhood. Sharpe’s engagement in breast feeding and childbirth support work as a new mother reinforced her childhood interest in midwifery through her mother’s stories of childbirth. Although she had “looked into” midwifery training while living in the United States in the late 1960s, it was during her first pregnancy and in her transition to new motherhood in 1970 that she became active in infant feeding and childbirth reform activities that took her on a path to becoming a midwife. Sharpe became a volunteer counselor in the breast feeding support organization, La Leche League following the birth of her first child. She described the dramatic impact of discovering the La Leche League’s *The Womanly Art of Breastfeeding* as a confused and tired new mother struggling to care for her newborn daughter:

> Somebody brought over *The Womanly Art of Breastfeeding*, which is sort of a funny name of a book, but I just opened it and I read, “Your baby is your teacher. Listen to your baby. Respond.” And that message was nowhere out there. And I remember bursting into tears and going and picking her up.

Much like the goals of childbirth reform movements to humanize childbirth practices through reclamation of “natural” birth, movements to reform infant formula feeding practices emphasized the recovery of the “natural” process of breast feeding. Mother-to-mother support networks, such as La Leche League, became a popular tool to promote breast feeding. Sharpe recalled her enthusiasm to participate in La Leche League was based on a personal conviction that breast feeding had the potential to empower women as mothers. In reflecting on her experiences as a La Leche League leader, Sharpe also remembered feeling ambivalent about the league’s proscriptive ideology of women’s role as stay-at-home mothers, particularly in relation to her interest in early second wave feminism that linked women’s oppression to motherhood. Nevertheless, Sharpe maintained an active commitment as a breast feeding counselor and leader with La Leche League when her children were young. Her experiences with La Leche League provided her with opportunities to engage in meaningful work that extended beyond the role of mother and breast feeding counselor. Sharpe recalled her work with the La Leche League offered “exciting” opportunities for public speaking, health education and promotion activities, and travel, both locally and at the national and international levels:

> So it was very exciting to find myself over those years, well really from probably ’71, ’72 to ’75, doing a lot of speaking at different places about breast feeding and then about childbirth
and just becoming more involved in different groups and organizations in New England that were interested in supporting women in having what they want. And so La Leche League became a very strong part of my life, doing a lot of breast feeding support on the telephone and leading meetings. And getting involved in different international things. For example, when we were in New York I was involved in creating a comic book in Spanish for Latin American women and families to support breast feeding. There were just all these initiatives. I used to speak for the Red Cross and for nutrition in schools and involved in different projects people were interested in. Anyway it was just a very active time…

Sharpe’s interest in support for new mothers evolved from breast feeding support to encompass childbirth education and labour support within a social context of growing interest in home birth and natural birth alternatives. She traced the expansion of her involvement from interested parent to childbirth educator, labour coach, physician assistant and finally to midwife. Her narrative of her gradually expanding role from support and educator to care provider in response to demand from childbearing women is commonly cited in the literature on the Ontario midwifery revival. Sharpe reflected on the importance of support for women interested in natural childbirth alternatives in the early home birth and midwifery movements, a time when confidence in normal birth was low. She vividly recalled the seeming novelty of an unmedicated vaginal birth in the hospital setting that she witnessed while attending a course on labour and birth at a New York City hospital in 1974:

I remember in New York in 1974 being just shocked by this woman having a natural birth that I was working with. There were I think probably about twenty people came in the room because it was such a rare event to watch this woman give birth, have a natural or normal spontaneous birth.

Living in Toronto in the mid-1970s, Sharpe was pregnant and interested in giving birth at home. She accessed care from a family doctor who had a longstanding home birth practice. She learned that she was eligible for government funded nursing services for home births through the community-based Victorian Order of Nurses (VON). The VON provided home birth supplies, nursing assistance to physicians during labour and birth, and home visiting postpartum care. These VON services were underutilized, as the demand for home birth was low at that time, and the government threatened to withdraw funding. Sharpe, like Van Wagner, became active in the Home Birth Task Force, an organization of parents, physicians, and childbirth educators that had become galvanized around the potential loss of funding for the VON home birth nursing services. When government funding for these services was cut and they were discontinued, a
“Midwives Support and Study Group” formed as an “offshoot” of the HBTF. Sharpe met other women who shared her interest in childbirth education and support. She began to combine prenatal class teaching with attending births, at home and in the hospital, as a “paid labour support person.” She recalled feeling compelled to focus her support work on the care of women in childbirth after witnessing the restrictive and “punitive” practices in Toronto hospitals:

There were very restrictive policies in hospitals at that time. I remember at the Wellesley Hospital women could have only the husband with them during birth. They couldn’t have a friend, a sister, a mother, a boyfriend, a girlfriend with them, any partner. It had to be a husband. And, you know, just very, very punitive socially. So I did a lot of labour support work in those days. In the hospital setting I was exposed to just horrific treatment of women...and that just really politicized me again further.

Sharpe’s narrative of the growing demand for her services suggests the evolution of interest from childbearing women for the kind of information and support she provided. She described herself as busy but energized by her childbirth support work:

I was very, very busy. I sometimes, you know, when I’d be on the phones I would speak to over thirty women in a day...I mean that’s one day I counted that. It was over the top actually. So then I was teaching childbirth classes and at one point when we moved here in 1977, I was teaching two childbirth classes a week, one childbirth class for women who were planning home births and one for women who were planning hospital births. And, so that was a very interesting time.

In the second half of the 1970s, demand for home birth services was growing in Toronto, as part of a burgeoning North American home birth revival. This demand was initially met by a small group of family doctors. While Sharpe first attended home and hospital births in a support role for women who attended her prenatal classes, she later formed a more formal relationship with some of the Toronto home birth doctors to complement their role as the primary care giver.

The provision of labour support and birth assistance was a common pathway into practice for midwives who lacked formal routes to education in late twentieth century North American midwifery revivals. Some unofficial midwives, like Sharpe, distinguished their support work from the responsibility assumed by physicians as the most responsible care providers at home births. Although there were no clear lines that demarcated labour support from midwifery, Sharpe went on to clarify that she was unwilling to publicly call herself a midwife in an uncertain legal context without some semblance of “formal” midwifery training. She recalled
that she began to call herself a midwife following her return to Toronto from an intensive midwifery training program she attended in El Paso, Texas in 1979. She remembered the event that precipitated her decision and that of her midwifery colleagues to offer midwifery services autonomously from the physicians they had been working with. In 1983, the College of Physician and Surgeons of Ontario issued a statement discouraging doctors from attending home births and cautioning them against cooperating with non-physician care providers. As physicians in the Toronto area largely withdrew from home birth services, Sharpe made the decision to take on primary care responsibility for the care she was providing to childbearing women. Not all of those who had been providing labour support and childbirth assistance to physicians were willing to take on this responsibility in an uncertain legal environment. Some interviewees shared stories of women who stopped attending births as a result of their husbands’ unwillingness to support them assuming primary care responsibility as midwives in an ambiguous legal context.

Michelle Kryzanauskas’ transition into midwifery practice similarly flowed from her volunteer breast feeding activities that followed the birth of her first child in 1980. She provided breast feeding support to other women in her community at a time when social and medical breast feeding information and support were lacking and rates of bottle feeding remained high. Unlike Sharpe, she did not participate in a formally structured breast feeding organization, such as La Leche League, but rather provided breast feeding assistance within an informal network of new mothers predicated on woman-to-woman support. Kryzanauskas’ interest in breast feeding was influenced by maternal feminist ideology that linked female empowerment to the valorization of women’s essentialist qualities. She envisioned the reclamation of breast feeding as empowering for women, both personally and in their role as mothers. She also interpreted the breast feeding support and promotion activities that she and other breast feeding mothers engaged in as an expression of social activism: “So it became sort of like a women’s network started happening, riding around with diapers on our aerials and breast feeding at McDonald’s just to piss people off.” She explained how her breast feeding support work merged into childbirth support, as she began to pursue her desire to become a midwife:

…I was sort of hooking up with women in the rural village where I lived who started to have interest in breast feeding. I was quite committed to breast feeding and I noticed while I was in the hospital that nobody was breast feeding. And so that became my first link within the community…helping women who couldn’t figure out how to get their babies latched or why
were they having trouble. And not that I knew. I mean I hadn’t studied breast feeding. I just sort of knew it was something we should do. I went on to do those studies but it was this sort of buddy relationship that started to develop among the women in the community. And it was those very women that let me deliver their subsequent babies in the community.

Colleen Crosbie’s inspirations to become a midwife were also tied to her experience providing labour support to other women; however, in her case this occurred in the maternity home where she lived as a pregnant teen. She explained that the maternity home functioned independently from the local community hospital and that the residents gave birth in a section of the home designated as the hospital wing. She recalled the conditions of childbirth in the maternity home were punitive and substandard, conditions that she attributed to social perceptions that the residents were undesirable mothers. Crosbie related how the women laboured and gave birth with minimal access to pain relieving medications that would have been more readily available in the nearby hospital and that they lacked access to emotional or physical support in labour. When she herself was transferred to the hospital wing of the maternity home because of pregnancy complications, she found herself drawn to assisting a number of the labouring women until they were taken into the delivery room:

I spent months in an unwed mothers home with other pregnant women. And they birthed. It was a birthing place before it was all moved into the hospital. It was a birthing home. There was like a little hospital section on one side and we all lived on the other side of this huge old building. Most of the girls who gave birth there were young women under twenty, mostly teenagers...I had hyperemesis gravidarum so I was vomiting all the time and I spent a lot of time over on the hospital side getting IV fluids and being treated for my nausea. So I labour coached those women, those girls in labour that were over there. They wouldn’t let me go into the delivery room but I was with those girls a lot. I mean many. When I say many I mean maybe about ten times in my four months there I labour coached girls until they went through the door and they found me helpful...They were getting Demerol but there were no epidurals. And then they gave birth. And the team that was attending the birth was like the medical students or whatever from the local hospital.

Crosbie’s narrative expands the notion of an alternative childbirth community that is commonly represented in the literature on North American home birth and midwifery revivals. She described the maternity home as a female childbirth community, one that had been lost in mainstream Canadian society. Before the evolution of hospital-based maternity care in early twentieth century Canada, it would have been commonplace for young women of Crosbie’s age to be present at childbirth. However, the professionalization and institutionalization of childbirth
eroded midwifery as a domestic female activity, isolating women from their social support networks. Crosbie’s experiences providing labour support to the maternity home residents were foundational to her future commitment to respectful maternity care. Her personal birth experience and those of the other residents sparked her critical awareness of obstetrical routines and interventions. Her motivation to assist other women without prior exposure to birth or specialized training flowed from her attraction to the childbirth process rather than from a particular philosophy or ideology about childbirth.

For many interviewees, their personal experiences of childbirth confirmed a previous attraction to pregnancy and birth work. Some described being transformed or empowered by their own births, feeling inspired to help other women find the deep meaning and power they had found in giving birth on their own terms. For others, difficult and unsatisfying birth experiences pushed them to want to create alternatives for other women. Many related their struggles to access the kind of maternity care they wanted and, whether or not they succeeded, they wanted to address what was for them a significant gap in prevailing systems of maternity care. They saw a compelling need for less medicalized care and for more control and choice for pregnant women. Many interviewees expressed feeling driven to take up midwifery to offer childbirth alternatives for other women. Without an organized system of midwifery in the province, they sought ways to become midwives and to practice on the margins of official health care and the law.

NURSES FIRST

Many of the interviewees who studied nursing prior to becoming midwives identified their nursing experiences as playing a pivotal role in their midwifery inspirations and motivations. Although several of these interviewees entered nursing school with aspirations to become midwives, the majority had no pre-existing midwifery ambitions. Their pathways into midwifery and their professional credentials vary in relation to their access to midwifery education and practice opportunities. Some had formal credentials in nursing and midwifery, whereas others held nursing credentials only. Those who lived in countries where midwifery was a recognized profession were able to pursue formal midwifery training, largely within post-graduate nursing programs. Others who lived in Canada where midwifery lacked official status chose to take up midwifery following their nursing careers without formal preparation or they sought formal
international training opportunities. Despite variation in their education and occupational backgrounds, these interviewees who were nurses first related a common desire to participate in the Ontario midwifery revival in order to offer childbirth alternatives to the nursing and medical models of mainstream maternity care that they were part of.

*Ontario Trained Nurses*

The interviewees who trained as nurses in Ontario linked the inspirational role of their backgrounds in nursing to their desire to support women to give birth without unnecessary technological interventions. Although these interviewees lacked ready access to midwifery training opportunities in Canada, they were able to specialize in the nursing care of childbearing women and newborn babies in hospital settings. They spoke of feeling drawn to nursing work that facilitated their ability to care for childbearing women, while at the same time developing a critical perspective on the care they both observed and provided. They attributed their interest in childbirth alternatives to their dissatisfaction with mainstream ideologies and practices that pathologized pregnancy and childbirth and normalized technological intervention.

Like many of the nurse interviewees, Elsie Cressman traced her interest in childbirth to her nursing training experiences. She attended a nursing program at St. Mary’s Hospital in Kitchener in the early 1940s. Her belief in the superiority of normal physiologic labour and birth was often at odds with contemporary obstetrical practice; however, it foreshadowed ideologies of international natural childbirth movements that had not yet gained popularity in Canada. She remembered the inspirational impact of witnessing a physician-assisted birth of a breech baby without the use of medical interventions routinely practiced at that time. Cressman characterized the physiologic process of the breech birth as calm and comfortable for both the labouring woman and the care provider, in contrast to her portrayal of the routine practices of forceps delivery and episiotomy as invasive and unnecessarily dramatic:

Well, in my nurses’ training I liked babies and I liked obstetrics so they would shunt me there quite often. I would get placed there. So I did a lot of work in obstetrics and I observed how people delivered babies. And I remember a woman doctor...One day she was delivering a breech baby. And I’d seen the doctors deliver them and they’d get all excited and tear them out and do big episiotomies. And she just stood there or I don’t know if she was sitting but she was so calm and let this woman push this baby out. And she was comfortable. The woman was comfortable and the baby came out so nicely. No tears, no nothing. And I thought, “That’s the way you should have a baby.” And that impressed me.
Cressman carried this vision of the normalcy of childbirth into her professional life as a nurse. She sought employment as a labour and delivery nurse following graduation from nursing school. She also explored other occupational opportunities that would provide her with greater professional responsibility for the care of childbearing women. She was aware of the profession of midwifery and its focus on normal childbearing from her sister who attended the Frontier Nursing Service, a midwifery program that trained nurses to provide primary midwifery care to women living in rural regions of Kentucky underserved by doctors.\textsuperscript{92} She recalled feeling this program was a good fit with her desire to have more professional autonomy to support women to give birth without unnecessary interventions. She contrasted her affinity with the Frontier Nursing Service program to a Canadian nursing graduate program that prepared nurses to work in remote northern communities under physician supervision.\textsuperscript{93}

…my sister went to Hyden, Kentucky, and took that course there where you rode horseback. And that was a good course. And so that inspired me. That was in the United States and the only thing Canada had was a course in western Canada where you could do births under the supervision of a doctor in outlying areas. And I thought of doing [the American program] but never got around to it.

Although Cressman never did attend the Frontier Nursing Service program, she maintained a longstanding interest in midwifery and normal birth. She pursued a baccalaureate degree in natural sciences for diploma-trained nurses at the Mennonite Goshen College in Indiana and subsequently took a missionary nursing position with the Eastern Mennonite Board. She worked in several African missions for over twenty years where her professional role encompassed the responsibility for delivering babies. The high birth rate in the Tanzanian leprosy mission where she lived and worked for much of her missionary career demanded that primary maternity care become a central component of her work:

I did lots of births. Two or three a day. I first set up a leprosarium and my patients had babies. If the patients didn’t, the husbands had leprosy and the mothers would deliver. So I delivered lots of babies there... we had a hundred bed hospital there too and once in a while I’d help out in the hospital.

As a mission nurse, Cressman developed expertise in assisting women to give birth in low resource settings with limited access to medical or surgical interventions. She was later able to translate these skills to the Ontario context where she worked as a midwife in the community, outside the health care institutions.
Cressman explained that her position at the Tanzanian leprosy mission ended in the early 1970s when the local community assumed responsibility for the administration of the leprosy mission. She wanted to continue to provide primary care to childbearing women. She received approval from the mission board to enroll in a twelve-month post-graduate nursing program in midwifery in London, England when she in her late forties. She noted the important role her formal midwifery training played in her future work as an Ontario midwife: “I was glad I did it. Then when I went home, I had something under my belt to do this alegal stuff.” Following her midwifery training, Cressman worked for several more years in Mennonite missions in Kenya and Somalia where she continued to have responsibility for delivering babies. On her return to Canada in the late 1970s, her midwifery credentials were not recognized and she took employment as a nurse in the Kitchener-Waterloo hospital. At this time, interest in home birth was surfacing in the Kitchener-Waterloo region where Cressman lived. Women wanting to give birth at home had difficulty finding a trained care giver willing to assist them. The number of family doctors who offered home birth services in Ontario was small and women faced giving birth without professional assistance. Those who learned of Cressman’s expertise and training through word of mouth requested her assistance. She described not knowing how women found her, but she recalled her willingness to provide midwifery care in response to women’s demands for home birth services. She learned of several other women in her community who were also beginning to offer care to women wanting home births. Cressman established an informal network of back up and support with several of these women, some of whom were experienced nurses. She also made connections with other women who were beginning to provide midwifery services elsewhere in Ontario.

It was evident from Cressman’s narrative that she felt compelled to respond to the needs of women in her community who were seeking alternatives to mainstream maternity care. When asked what motivated her to take the step to practice without legal recognition in Ontario, she replied matter of factly, “The women forced me to.” Cressman’s words suggest that she did not perceive personal agency in her decision to provide care outside her professional sphere as a registered nurse and in the absence of legal provisions for midwifery. However, she followed these words with a wry smile and a laugh that also suggested her role in providing midwifery services was more complicated than feeling coerced. She conveyed enthusiasm for the opportunity to provide a midwifery alternative that supported her vision of birth as a normal, healthy life event. Cressman related stories of her early Ontario midwifery career that conveyed
her palpable passion for childbirth and the high esteem that she placed on her identity as a midwife. She proudly shared newspaper clippings and photographs of her practice and the public recognition that she received from her local community, as well as from the Ontario government.\textsuperscript{95} It was also apparent from Cressman’s narrative that she found the unconventional life of a midwife exciting and personally satisfying. She wistfully remarked at the outset of her interview that, at the age of eighty-six, she was bored without midwifery in her life and that she would still be attending births were it not for health problems that limited her mobility.

Cressman’s passion to support women in childbirth, her experience “birthing babies” and her formal midwifery training gave her the confidence to provide care to women in Ontario, despite the tenuous legal status of midwifery. The potential professional and legal repercussions that Cressman faced did not deter her commitment to assist women wanting to give birth at home. She and her midwifery partner, who was also a registered nurse and a member of the Mennonite community, came under investigation by the College of Nurses of Ontario (CNO) because of reports from the College of Physicians and Surgeons of Ontario (CPSO) that they were practicing “medicine without a license.”\textsuperscript{96} They faced possible loss of their nursing registration for practicing midwifery. Cressman and her midwifery partner had a series of correspondences with the CNO over several months and they were required to meet in person with a CNO representative. She shared her correspondence from the CNO Executive Director and the Executive Office of Nursing Practice, in which she was repeatedly cautioned about providing services that were outside nursing standards and that required the presence of a supervising physician. Their case was referred to the Executive Committee of Nursing Practice. In correspondence of October 27, 1981, Cressman and her partner explained that they felt ethically obliged to provide care to women planning home births and that they had recommended physician involvement to women in their care, both verbally and in writing:

\begin{quote}
We have been drawn into doing Home Births during the past one and a half years. Our first experiences were with Doctors who attended births in the home and wanted assistance. We then found women coming to us who had decided to have Home Births regardless of the availability of help.

With our knowledge and training in Midwifery, we have been attending births. We feel consciously unable to refuse these requests.

In future, we will continue to encourage more medical participation in all births. Our policy has always been to have parents under the care of a medical practitioner who is aware of their Home Birth choice and our involvement with them.\textsuperscript{97}
\end{quote}
They reassured the CNO that they would refrain from using non-professional birth assistants who were not registered nurses. They also distanced themselves from providing what could be construed as private midwifery services by noting that they did not receive compensation for their “nursing services,” but rather “gifts” of varying amounts. In a letter dated January 11, 1982, they continued to emphasize their actions complied with nursing standards of practice:

It seems impossible to ignore the very strong feelings of these people for natural, unmedicated births. This is to them extremely important to their health and happiness...

If we ignore requests for help, we will be violating the standards of the College of Nurses in respecting the rights and worth of each human being.98

Cressman remembered that the investigation came to an abrupt end without any formal action, and that she and her partner were not further asked to curtail their home birth activities.

Cressman’s correspondence regarding the nursing college’s investigation suggests that her Mennonite heritage may have played a role in her commitment to practicing midwifery in the unregulated Ontario setting. Although unofficial practices of midwifery may have been at odds with Canadian nursing standards of the time, Cressman’s lived experience as a Mennonite “outsider” to mainstream society likely informed her willingness to work outside legal and social norms on matters of principle. The Mennonite values of duty and service that informed her commitment to missionary work may have similarly played out in her commitment to what she saw as right and just. Home birth also had a longstanding history in Mennonite communities where it was seen as compatible with traditional family values central to Mennonite society.99

The other interviewees with Ontario nursing training attended nursing school in the 1970s, several decades after Cressman. Medical routines and technologies continued to dominate Canadian obstetrics at this time, despite growing evidence of public and professional interest in natural childbirth reforms.100 Childbirth was almost exclusively a hospital-based practice and the hierarchical model of the primary care physician and assistant nurse team prevailed. This was also a time when social movements for home birth and midwifery were beginning to percolate in pockets of North American society under the influence of counterculture ideologies and second wave feminism. The interviewees who trained in this decade and entered practice in the early 1980s all encountered informal practices of home birth and midwifery that played a role in facilitating their interest and entry into Ontario midwifery practice.
Colleen Crosbie delivered her first baby at home in Toronto in 1974 when she was in her final year of nursing school. Her narrative illustrates the key role that her nursing preparation played in her entry into midwifery practice. Crosbie’s maternity nursing aspirations were deeply rooted in her childhood desire to be a maternity nurse. She also carried a vision of caring and compassionate support for childbearing women into her training from her experiences as a pregnant teen. She attended one year of nursing school at the University of Windsor in the late 1960s and subsequently completed a nursing diploma program at Centennial College in Toronto in 1974. She described the limitations of her obstetrical training with its primary focus on postpartum nursing:

I’d been to a few [births] in the hospital. I think I’d seen two in the delivery room, standing in the corner. But our role was postpartum. You know, we hadn’t done prenatal care. Our learning was on the postpartum floor but we weren’t any prenatal care clinics. At least, not that I can remember. And if we were, it was only for one day in a doctor’s office. I mean just a visit or something. I had really only done my postpartum.

Crosbie had not entered nursing with familiarity or an ideological commitment to childbirth alternatives. As a student, she discovered newly published literature on natural childbirth that inspired a passionate her commitment to natural childbirth reforms. Near the end of her training, Crosbie’s cousin requested her assistance at the home birth of a housemate that was underway. Crosbie readily agreed with the understanding that a physician would attend the birth as the responsible care provider. She speculated that her cousin saw her as skilled and sympathetic from her nursing training and her interest in natural childbirth alternatives:

I never even really thought of midwifery actually until I was in my final year of nursing school. My cousin was a Scientologist and she lived in a house in Toronto with some people and they were going to have a home birth. And I didn’t even know those people. I only knew my cousin. And one day she phoned and said that the young lady…was in labour and she was having a home birth and the doctor wasn’t there yet and could I maybe come and help, you know. I guess they were thinking I was a nursing student and must just know everything to do. So because I had just written my paper in nursing school on the disappearance of natural birth... it was my passion. It was what I centered on in nursing school, birth practices, even though I really didn’t even think politically about midwifery in other countries. My brain hadn’t developed to there yet. I was just trying to talk about how we were losing natural birth. Anyway, she knew all that.

In her narrative of this home birth, Crosbie emphasized her comfort and confidence in supporting the labouring woman to give birth without access to medical technologies or pain relieving
medications. She described her actions as “intuitive” and “instinctive” when she realized there were, in fact, no arrangements for a physician to be present for the birth:

...so they called me over to this birth. So my nursing school friend and I, we went over in her little Volkswagen beetle and we got there and Rosie was having her first baby. She was eighteen years old and as soon as I got there... she was totally freaking out. I’d never met her before. She was freaking out with her labour, screaming and scared. And the minute I walked in the door she put her arms around me and I said, “Look, it’s going to be okay. It’s going to be okay. Just breathe.” I’d read my little book on... what was it in those days? I can’t remember what it was called. Lamaze? Anyway, she immediately glommed onto me, calmed down and I felt like really in tune with her. And then she was labouring and contractions were coming and I kept saying, “Well when is the doctor coming? What have you guys got set up for the birth?” and all this. So then it became apparent to me that oh, maybe there wasn’t a doctor coming and maybe they had nothing set up for the birth. So then she started to push and so I thought, “Oh, oh okay, we’re going to have this baby right here so I better do something.” So I boiled a shoelace and a pair of scissors. We got out some clean towels and Rosie started pushing and I very intuitively checked in her vagina and I felt no cervix. Not that I’d ever done a vaginal exam in my whole life ever, but all I felt was head. I remember that. And so obviously she’d been pushing well and then I just instinctively put my hand on her perineum. Nobody had ever told me to do that and just supported the whole area while she gave birth. And soon after the baby was born, we tied the cord with our sterilized shoe string. We cut it with our sterilized scissors and soon the placenta was born and everything was fine. And about a half an hour later the doctor came who had truthfully only agreed to come postpartum. So I was sort of fooled, but willingly fooled or something, into the birth. I didn’t say, “Call an ambulance.” I said, “Oh, okay, well we’re going to have this birth here. This is going to be really exciting.” And that was the first time I ever caught a baby.

On graduation, Crosbie chose to work for a nursing employment agency in order to have flexibility and control over her work schedule and assignments. As an agency nurse, Crosbie sought opportunities to work in labour and delivery and in the emergency department. She liked the fast paced environment and unpredictability of emergency nursing that demanded confident assessment and care management skills, ones that were later transferable to the demanding conditions of a legal midwifery practice and out-of-hospital birth.

Shortly after completing nursing school, Crosbie moved to a rural community near Maynooth, Ontario to “build a cabin in the woods and grow organic food and live on a commune.” “Back to the lander hippie types” living in the area asked her to assist at their home births because of her nursing background and her previous experience attending a home birth. She felt obliged to
share her knowledge and skills with women in her community. With laughter, she reflected on the acceptance of her limited expertise that was characteristic in the home birth revival where women and their families looked to create alternatives to institutional practices and medical expertise:103

...they heard that I'd delivered a baby and that I was a nurse, so I should just be the one at their births. That would make them feel so much safer. And so I agreed to go to the first person’s birth. And of course once I attended that birth, which was very nice and went really well and was quite a magical experience for everybody including myself, then other people in the community asked me to attend their births and I started attending births in the Maynooth and Bancroft areas.

Crosbie explained that she felt motivated to seek out organized midwifery training after attending a small number of births as she became more aware of the potential risks inherent in the process of childbirth. She wanted to feel better prepared to provide safe and skilled home birth care when complications arose:

After I attended maybe ten or twelve births, I wanted to know more. You know, as the saying goes, the more you know, the more you don’t know. I wanted to have more experience because I was concerned. I wanted to be able to take care of people if they bled or I needed to do some sutures to repair a perineal tear. If any of those things happened, I wanted to be able to take care of them properly.

She learned of a midwifery clinic in El Paso, Texas from American midwifery manuals that offered intensive midwifery training, the same one Sharpe later attended.104 Crosbie arranged to travel to the Maternity Centre, an out-of-hospital childbirth clinic run by midwife Shari Daniels, for three months of practical training in 1978. When she returned to Ontario, she continued to attend births but now called herself a midwife.

Crosbie’s narrative of her early home birth experiences and her entry into midwifery practice reflects popular and scholarly understandings of North American home birth and midwifery revivals as grassroots counterculture movements. Home birth embodied conservative family values and gender constructs that held relevance for women from distinct cultural and religious communities, such as the Scientology community where Crosbie’s cousin lived and the Mennonite communities Cressman served. It also represented a progressive counterculture alternative that shifted the locus of reproductive control from institutionalized medicine to childbearing women in the community, an alternative that was appealing to Crosbie who was
living a countercultural lifestyle. Crosbie’s narrative also mirrored Cressman’s memories of feeling drawn into home birth care because of her nursing background and her interest in supporting women in normal births. Like Cressman, Crosbie recalled her willing enthusiasm to participate in childbirth experiences that fell outside the norms of her nursing training but that were compatible with her desire to provide supportive and personalized childbirth care. Her narrative embodies motivational factors commonly understood to have inspired women to take up practice in modern “lay” midwifery movements. She expressed an affinity with the caring work of childbirth support, confidence in the normal process of childbirth, and a commitment to childbirth alternatives outside official health care. Crosbie also spoke of the inspirational impact of women’s determination to give birth at home rather than in the medically and socially accepted setting of the hospital:

…it was a huge area of back to the land hippie types living in cabins and it was that group of people that insisted on having their babies out of the hospital. That’s what started me thinking. They were so adamant. They were ready, just like Rosie had been in Toronto, to have their births with just their friends around instead of going to the hospital. So it was really women and families who taught me how to stand up for home birth at first. They were just refusing.

MaryAnn Leslie and Patty McNiven shared a similar interest in the care of childbearing women when they attended nursing school in the latter half of the 1970s. Their narratives of their transitions from nursing to midwifery reflect the influence of natural childbirth reform ideologies and practices on critical perspectives on hospital-based maternity care. They were both aware of midwifery as a career option outside Canada when they were considering post-secondary education; however, they chose to study nursing without ready access to midwifery training or professional opportunities. They were also aware of home birth and midwifery revivals in the United States that were documented in a growing body of popular and scholarly literature and the emergence of similar practices in Canada. They entered nursing with critical perspectives on mainstream childbirth practices gleaned from literature on childbirth reform and midwifery alternatives, and they hoped to contribute to change within the mainstream maternity care system. When they entered the nursing work force in Toronto at the end of the decade, a small number of family doctors were providing home birth services and midwives were beginning to practice outside the system in Ontario. Leslie and McNiven grew increasingly uncomfortable with the routinized and interventionist approaches to childbirth practiced in the
hospitals where they worked. They both sought home birth and midwifery care for their own pregnancies early in their nursing careers and they were subsequently motivated to take up midwifery because of their dissatisfaction with hospital-based obstetrics and their desire to make alternatives available to other women. Their personal encounters with home birth and midwifery in Ontario also facilitated their opportunities to train in an apprenticeship model with their midwives care providers.

MaryAnn Leslie’s interest in midwifery that had originated in childhood from nursing and midwifery adventure stories and later deepened during her first experience of pregnancy as a teenage undergraduate student was reinvigorated in her nursing training and practice. She remembered feeling inspired by claims to midwifery’s potential to humanize medicalized childbirth practices that she read in newly published American critiques of modern obstetrics that promoted home birth and midwifery. Leslie understood midwives offered “the possibility of different care providers, more woman-centred, family friendly care…not just dictated.” Her teenage desire to give birth in a style that ran counter to normative obstetrical practice influenced her future professional commitment to women’s self-determination in childbearing, both as a nurse and a midwife.

When she became a mother, Leslie decided that she “didn’t really want the kind of academic science or science career and got interested in birth and midwifery.” Although she had investigated medical education, international midwifery training opportunities, and Canadian outpost nursing training programs that prepared nurses to provide primary maternity care, she enrolled in a nursing program at Seneca College as a first step in her path to becoming a midwife. She planned to specialize in obstetrical nursing and later apply to a midwifery program for nursing graduates in the United Kingdom. Despite her critical analysis of obstetrics and the hierarchical relationship of medicine and nursing, Leslie recalled her optimism about the potential for second wave feminism to enhance the autonomy of nurses and the nursing profession: “…nursing was at a point where it was starting to change, and starting to take on some power. And the feminist movement was having some impact on…nursing education and nursing theory and philosophy.” She remembered the formative influence of counterculture and feminist ideologies on her vision of childbirth as a normal process and her desire to support women to take control in the experiences of childbirth:
...most of the health events in our life are normal and healthy and we just have to support the body to get on with it most of the time...I was influenced by ideas of social movements coming out of the end of the sixties. Freedom from oppression, taking control of your bodily processes as a woman instead of being dictated to by male hierarchical medicine, having a say in what happened to you, having choices and having your wishes respected, especially when they were sensible.

Leslie entered the work force as a labour and delivery nurse at Toronto General Hospital in 1979, but quickly found she was disillusioned with the model of care provided to childbearing women:

I worked in labour and delivery for about nine months and was just so totally frustrated by the experience and …some of the practitioners that were there and the whole atmosphere of how women were treated. I couldn’t handle it and I went and moved to the postpartum floor. I worked there until sometime in 1981.

Leslie maintained her determination to become a midwife while working as a registered nurse; however, her plans to enroll in a British midwifery program were interrupted by her second pregnancy in 1982. She was determined to plan a home birth and this time she was able to arrange care from an experienced home birth physician in Toronto where there was an active home birth community. She also remembered stumbling upon practices of midwifery that had formerly “eluded” her: “I found out we had midwives in Toronto, actually at the very end of my second child’s pregnancy...I started to become aware that we actually had a bunch of lay midwives practicing in Toronto along with a variety of home birth doctors.” Leslie’s physician referred her to childbirth education classes that were offered by Heather Burton, a self-taught midwife who was beginning to offer midwifery services in west Toronto and Mississauga.

Leslie joined the Ontario Association of Midwives, a newly established support organization formed by a group of practicing midwives and became aware of the growing interest in home birth and midwifery around the province. She recalled attending a midwifery event late in her pregnancy and feeling inspired by a talk given by Toronto midwife Vicki Van Wagner about modern midwifery movements in North America. Leslie also trained as a Lamaze childbirth instructor and she began to attend births of her friends in a support role over the following year before becoming pregnant with her third child.

In 1984, Leslie gave birth to her third child at home with midwife Heather Burton in attendance. She continued her involvement in local midwifery activities and Lamaze prenatal class teaching. Burton learned of Leslie’s midwifery aspirations and her nursing background and
requested her assistance at home births. Leslie noted her arrangements to assist Burton were informal and did not represent a training commitment:

...probably sometime in ’83 every now and then I would go to births with this midwife if she needed an extra pair of hands or something because she worked a reasonable bit in this area...And so I went to a number of births as a helper or an extra pair of hands. Maybe somewhere between six and twelve over thirteen months...She approached me. She asked if I would help her...But it wasn’t a commitment for training. It was me thinking about it, trying it on a bit if you will...I didn’t have a very defined role. I wasn’t doing anything particularly clinical but support, help.

In November 1984, Leslie attended a three-day childbirth assistant and childbirth educator training program called “Informed Home Birth and Parenting” designed by American lay midwife and childbirth author Rahima Baldwin. In the fall of 1985, when she felt her “youngest got old enough to start thinking about an actual apprenticeship,” Leslie formalized arrangements with Burton to become her first apprentice trainee:

She had never had an apprentice before. She never had someone who was actually formally doing an apprenticeship. I think she’d had a couple of people doing bits and pieces of things with her but as far as I know I don’t think anyone else trained with her. She hadn’t been practicing all that long herself, like a few years...And so I started in the January, myself and another woman who didn’t keep it up for too long. We both started with her and so I was an apprentice then for the next couple of years...

Patty McNiven similarly gravitated toward midwifery as an alternative to mainstream maternity care in her early years of nursing practice, informed by both personal and professional experiences. She first learned about childbirth alternatives as a teen in the mid-1970s when she was asked by her neighbours to babysit their older child during their home birth. McNiven investigated midwifery programs when she was considering options for post-secondary education, but decided instead to pursue nursing training that was locally available. She saw it as a transportable credential that would facilitate her interest in travel. She aspired to work in labour and delivery and, in nursing school, she arranged to do her elective clinical placements in maternity care. She recalled the difficulty for nurses seeking employment in the late 1970s because of a surplus of nurses in the Canadian job market. She was hired at a downtown Toronto hospital to work in labour and delivery following her graduation from nursing school in 1978, which she attributed to her elective training experience in obstetrics. She moved to Vancouver a short time later where she was unable to secure an obstetrical nursing position. She
described her disappointment in accepting a position in neonatal intensive care rather than labour and delivery:

I applied to labour and delivery but I got hired in the neonatal intensive care unit, which was called the intensive care nursery way back then, and looked after newborns or neonates there which was I guess okay. I didn’t love it. I wanted to go to labour and delivery but they never got openings there.

McNiven returned to Toronto when she was pregnant with her first child in 1979. She applied to work on the labour and delivery floor at Women’s College Hospital, but was again offered an intensive care nursery position because of her skill and experience in the complex care of unwell newborns that she had acquired in Vancouver. She was able to arrange occasional opportunities at the hospital to work in labour and delivery and she gradually transitioned to an obstetrical nursing position. Two years later, she had a second child. When her children were young, she did part time “relief” shift work so that she could choose when to accept work assignments in relation to her family demands.

McNiven’s personal experiences of home birth played a key role in the evolution of her critique of mainstream maternity care and her motivation to take up midwifery outside the system. In her first pregnancy, she wanted to plan a home birth but did not have the support of her partner. She was able to arrange care with a family physician who attended home births and was supportive of McNiven’s plans for a natural birth in the hospital setting. She contrasted her birth experience to the daily practices she encountered in her work as a labour and delivery nurse:

…I was young. I was only twenty-one. I did find [a home birth doctor]…I found him. I did go to someone else first but I knew I wanted a certain type of birth. I would have liked a home birth but the man I was with forbade it. So I didn’t have a home birth but I did have a fast, straightforward birth. I laboured. I went for walk in labour and had no epidural and no episiotomy, no stitches. Breastfed…I was into natural. I was into alternatives.

McNiven interpreted her desire to have a natural birth at home as an alternative lifestyle choice that was typical of many women’s motivations in the early home birth revival. She noted that she had not yet appreciated the relationship between childbirth practices and women’s empowerment: “I don’t think I had a sense, and I think it came later to me, the sense of empowerment, the sense of confidence you have in mothering.” In her second pregnancy, less than a year later, she was determined to plan a home birth: “I really wanted to have a home birth...
and my partner said no but I said, ‘Well I think I’m going to anyway.’” She “connected with some midwives” through the family doctor who had cared for her in her first pregnancy, and she gave birth to her son at home. Several months later, a neighbour planning a home birth asked McNiven to assess her labour progress. The neighbour was uncertain if it was time to call her midwife and she knew that McNiven was an experienced labour and delivery nurse. The labour progressed quickly and the baby was born as the midwives arrived. McNiven recalled that she was “really involved” and that her “nursing training in labour and delivery just kicked in.”

McNiven became increasingly uncomfortable with what she saw as an incongruity between in-hospital and out-of-hospital childbirth management. She explained that her exposure to natural birth and home birth alternatives unsettled her acceptance of obstetrical practice norms:

…I started to feel like it was wrong what happened in the hospital…I didn’t notice it as much as a student. I just accepted the shaves, the enemas, the degrading talk to women. And I think when I got a little bit older and had two kids, the degrading talk towards women really started to upset me…the more I worked in labour and delivery I felt like I was in these two worlds of the home birth and the hospital birth and that there was real incongruence between them.

She recalled her growing uneasiness with the style of authoritarian care provided in the neonatal nursery and on the labour floor and her efforts to subvert what she saw as dehumanizing practices by nurses and doctors:

…it was so entrenched into every aspect. Even in the NICU I used to always try to protect the women who wanted to breastfeed their babies because the nurse would say, “Oh, you’re frustrating your baby.” Or they’d put a little fence around them and say, “You can try in there but don’t tire your baby out.” So I started doing things, like saying “You go on break and I’ll help her” to those nurses. In labour and delivery, I felt that somehow the woman was like an object. Only not even. It’s hard to explain how. I don’t think they really saw the woman as a human giving birth. That sounds so stereotyped but there’s just some of the derogatory statements, like “I like my women on the bed,” from doctors to women when we’d get them out the bed to stand for a contraction. I think that’s very rude. When a woman was writhing in pain during a vaginal examination, a bullying obstetrician once said, “Oh, come on. What are your trying to tell me that my one finger is bigger that your husband?”…It was inhuman, infantilizing, but more than infantilizing by treating women like they weren’t even there.

McNiven’s reflections on her nursing experiences are reminiscent of feminist critiques of patriarchal medicine that were emerging at that time and that influenced feminist interpretations of midwifery built on the concepts of female control and empowerment. She identified the
attitudes of the hospital staff, more that the use of medical technologies, fuelled her desire to provide a style of care that respected childbearing women’s autonomy and control:

It wasn’t the technology. It was the people. And I think that seventies natural childbirth was an attempt to humanize it. It was. We talked about routine episiotomies and enemas and shaves and those things were important but it was also about letting people be people while they’re in labour…

McNiven’s non-conformity with hospital norms extended beyond the boundaries of her professional nursing role. Her personal childbirth choices were both contested and marginalized in mainstream maternity care. She described her reluctance to disclose her personal childbearing experiences to her nursing and medical colleagues:

...confessing that I was a breast feeder at the beginning was even, “Oh, you’re one of those.” You know...people didn’t breast feed as much then...it must have been so negative to them that I couldn’t share it because I don’t think that I am a secretive person. But the fact that I wasn’t comfortable even sharing that I breast fed, that I had a natural childbirth, that I had a home birth, and that I was going to births let alone home births was so repugnant to the hospital staff that I couldn’t openly disclose that and work there... And the punitive attitude toward the home birth crowd and that we were idiots and doing something wrong. And I didn’t think they were right but I felt that they would treat us like that.

McNiven’s narrative offers insight into why women looked outside the walls of health care institutions to create childbirth alternatives. Although natural birth, home birth, and breast feeding promotion are integral to the current model of regulated midwifery in Ontario and their safety is well supported by current research evidence, they were viewed with suspicion in the early years of the home birth and midwifery revivals. Both the medical and popular press dismissed these practices as radical and regressive, ones that strayed from the scientific paradigm of modern obstetrics.

McNiven’s personal childbearing experiences brought her into contact with the nascent home birth and midwifery movements in Toronto and facilitated her pathway into midwifery practice. She recalled her realization following her son’s home birth in 1981 that she “really still wanted to become a midwife.” Rather that attend an international midwifery program for qualified nurses, she chose to pursue informal opportunities that were typical of aspiring midwives who lacked direct access to formal training. When her son was five weeks old, McNiven enrolled in childbirth educator course sponsored by one of the leading childbirth education organizations of the time, the International Childbirth Education Association, that was taught by a Toronto
Although she did not go on to teach prenatal classes, McNiven remembered it as “a good pre-midwifery course.” In 1982, when her son was ten months old, she accepted an offer of apprenticeship training from the midwife who had been her home birth care provider.

McNiven was inspired to learn and work in a model and philosophy of health care that was constructed in opposition to what she was seeing in the hospital system. She particularly valued the opportunity to learn a style of care that respected women’s role in directing their own health care decisions and provided continuity of care provider. She also reflected on the role that her nursing background played in her transition to becoming a midwife. She noted that some of her nursing knowledge and skills were transferable to midwifery practice and that she was able to share her expertise with her midwifery teachers and colleagues who did not have formal nursing or midwifery training. She also recognized that she had to relearn some of her nursing skills and attitudes in order to learn midwifery:

I learned a lot from the midwives I apprenticed with. I knew I had to unlearn certain things and I was open to it...I learned from observation, from reading, from discussion groups, from the family physicians and from my nursing experience. Nursing did help with skills and scientific background.

McNiven also spoke of her struggles to feel a part of the growing midwifery community in Toronto: “I felt like there was bias against my nursing background...I think they just thought I was the hospital crowd or some nursey thing and that I was going to pollute it...” Her dual identities of registered nurse and lay midwife complicated her position in relation to both the mainstream and the alternative childbirth communities. She explained that although she understood why the midwifery community was hesitant to embrace registered nurses, she nevertheless valued her nursing knowledge and skills in her midwifery work: “I don’t regret the nursing training...I don’t. I’m glad I did that.”

McNiven continued to work as a nurse on a part time basis for several years in order to financially support her family while she was building her midwifery practice. She kept her midwifery activities “secret” from her hospital colleagues out of concern for her professional reputation:

I kept it secret. I worked shifts in the hospital when I had no one due. Or I’d sign out to someone. Because [nursing] was the only way to make a living because we didn’t make a living doing [midwifery]...I didn’t tell them I was doing home births. I was never asked about that at the hospital. They weren’t very open minded about it.
Like Cressman, McNiven received a warning letter from the College of Nurses of Ontario about her involvement in home births. McNiven recalled the letter stated: “We understand you are attending home births.” She was unclear how the CNO learned of her home birth activities, but she remembered the warning did not deter her from practicing midwifery. Despite her reluctance to discuss her personal or professional involvement in home births and midwifery in the hospital setting, she felt confident to practice midwifery in Ontario where it was alegal, unlike its illegal status in other regions of Canada. She was aware that the College of Physicians and Surgeon’s of Ontario had issued a statement in 1983 cautioning physicians against attending home births and cooperating with unofficial practitioners, as well as the threats made by the Ontario Medical Association to discipline home birth physicians. She recalled the actions of some Toronto physicians to continue to provide home birth services buoyed her confidence that the College of Nurses would not take disciplinary action: “I just ignored [the letter]. I laughed at it, like [a home birth doctor] did from the OMA, because they really can’t stop you from doing it...I don’t really remember being afraid.” McNiven described the factors that motivated her to practice midwifery in an uncertain legal and professional context: “I loved going to births and I really felt strongly that birth should be different than it was in the hospital...I always felt like we were right and the system was wrong.” Her expression of passionate commitment to childbirth alternatives as right and just reflects a common narrative of motivational factors voiced by other midwives in midwifery revival literature and by other interviewees.

Evelyn Cressman’s interest in childbirth alternatives evolved more slowly than many of the other interviewees and from a different perspective. Her attraction to midwifery grew out of her desire to enhance her nursing role rather than from a critique of medical or nursing practice that motivated other nurse interviewees. Evelyn felt inspired to offer continuous care to childbearing women, a hallmark of modern Ontario midwifery. She saw her aunt, Elsie Cressman, as her professional role model and mentor who encouraged her involvement in midwifery. Although her entry into midwifery followed similar steps to her aunt, Evelyn’s narrative also suggests she was more reticent to take up midwifery. Unlike other nurse interviewees, she did not feel an immediate resonance with childbirth as a student nurse or early in her nursing career. She took up midwifery practice in Ontario in the early 1990s, a decade after she graduated from nursing school, as pre-legislation midwifery was beginning to undergo the transition to regulated practice.
Evelyn attended nursing school as a young Mennonite woman in Kitchener, Ontario. After graduating in 1976, she travelled to the Mennonite mission on Rusinga Island in Kenya where Elsie was preparing to leave her community health nursing position to return to Canada. Evelyn had the opportunity to attend several births while she was there, but recalled she did not feel particularly inspired to specialize in the care of childbearing women: “I saw the work [Elsie] was doing there and saw a couple of births. That still did not really trigger things for me.” On her return to the Kitchener area, she took a nursing position at a small hospital north of the city where the seeds of her interest in childbirth began to grow:

I went back home and over a few months I eventually got a full time job in a small hospital further north and worked for over five years there. I got put into obstetrics which hadn’t particularly been my choice because I felt like I didn’t know anything about it. But I got put there and I really enjoyed it.

Elsie also returned to Canada at this time and had begun to practice midwifery in Kitchener-Waterloo. She requested Evelyn’s assistance at home births. Over the next several years, Evelyn attended births with Elsie when she returned home for holidays. She was impressed with the continuity of care provided to the women in Elsie’s midwifery practice. Evelyn explained that she felt an emerging desire to provide comprehensive care to women across pregnancy, birth and the postpartum period rather than to be isolated to one facet of the nursing role. She contrasted her role as a nurse in the Ontario hospital system with the midwife’s role that encompassed the responsibility for delivering babies:

...my hospital was a small unit so we would be involved in the whole thing. If there were problems, we’d get the antenatals, the labour, delivery, the births, the postpartum. But we didn’t deliver them. We were with them as nurses are. It was a small unit so we had it all and I thought it would be really nice to have the women through the whole pregnancy, for the birth. I liked how much more continuity there is in midwifery.

Evelyn decided to attend a formal midwifery program before taking up practice in Ontario. She attended an eighteen-month post-graduate nursing program in midwifery at All Saints Hospital in Kent, England in the mid-1980s. On her return to Ontario, she still did not feel ready to practice midwifery. She continued to assist Elsie and some other midwives who were practicing in the Kitchener area at that time. After several years, she decided to take the step to begin her midwifery practice: “I came back and nursed for a couple of years again. And in that time I think I may have attended a couple more births with some of the midwives. Then I finally
decided, ‘Okay. I’m going to do some of this midwifery stuff.’” She first sought further midwifery experience to consolidate her skills and confidence. She accepted a two-month nursing position in a Paraguay Mennonite mission where she was responsible for delivering babies. On her return to Ontario in 1991, as policy planning was underway for the legal recognition of midwifery, Evelyn began to offer her midwifery services to women in the Kitchener-Waterloo area.

**Nurse Midwives**

The interviewees who trained as nurses in countries where midwifery was legally recognized studied midwifery as a post-graduate specialty of nursing to be eligible for professional advancement in nursing. These interviewees did not enter their training with aspirations to become midwives, but instead discovered their passion for midwifery during their student experiences. They chose to practice midwifery following their training, which was uncharacteristic of many nurses internationally who completed a midwifery certificate as a requirement for other nursing opportunities. The interviewees related two distinct forms of inspiration to practice midwifery. They spoke of their early interest in midwifery from their formal training and work experiences, in addition to their subsequent motivation to take up practice in Ontario prior to midwifery legislation. When they relocated to Ontario, these interviewees were unable to continue their careers in midwifery. They became registered nurses and took employment as labour and delivery nurses in Ontario hospitals. Their dissatisfaction with the Ontario maternity care system motivated their decisions to offer a midwifery services. Their decisions to enter unofficial practice was informed by their professional experiences working in formal systems of midwifery, as well as by their familiarity with midwifery’s potential to support normal childbearing.

Rena Porteous’ enduring love of midwifery inspired her decision to practice midwifery in Ontario, more than twenty years after she had last worked as a midwife in the United Kingdom. Porteous had attended nursing school in Scotland following high school in the late 1950s. She completed a post-nursing certificate in midwifery at a Scottish maternity hospital as “a natural follow on...to move forward in a career in nursing.” Although she had chosen to study midwifery in order to “go up the ladder” in nursing, she found she “really enjoyed” the work and
decided to make midwifery her career. She described the settings where she worked as a midwife in Scotland and England before moving to the Hamilton area in Ontario in 1966:

I trained in Dumfries in a maternity hospital there. I also worked in Glasgow in Govan, which is a poor area by the docks, and a number of small cottage hospitals in the southern part of Scotland. Then when I married, we went down to England where I worked as a staff midwife in a maternity hospital down there.

Porteous was accustomed to offering midwifery care in health care systems that relied on midwives’ expertise to assist women to give birth without ready or routine access to medical interventions. She had two children shortly after coming to Canada and re-entered the work force when her children were school age. Without midwifery opportunities in Ontario, she took a nursing position at a local hospital and worked on the labour and delivery floor. She recalled her transition to Ontario maternity care nursing in the late 1970s as “quite a difficult experience” that diminished her enthusiasm “to get back into the obstetrical area.” She reflected on her “huge culture shock” in moving from a midwifery-based system of maternity care to an obstetrical-based model:

You practically had to hide the fact that you had a midwifery background. The way they dealt with childbirth was in such opposition to anything I knew. Any knowledge that you had wasn’t respected or wanted. But at the same time, any of the doctors who were British or who had had some contact with midwives in some other place were very good. If they knew during the night if they had a woman in labour and they knew you were on, they would tend to take their time getting in. So you got to catch quite a few babies that way. But I didn’t like the attitude, the interventions. And the way they couldn’t just let childbirth happen as it was supposed to. There was no respect for the women. Even the nicer doctors, there still was not a very respectful attitude to childbirth. It was pretty awful…I did not like the hospital environment and its rules and the approaches to childbirth...the whole social attitude toward childbirth. There was a vast gap between where midwifery was coming from and how childbirth was happening. They were still giving people general anesthetics back then.

Porteous’ memories of the Ontario maternity care system varied significantly from the British system where she learned and practiced midwifery. Her narrative of her transition to Ontario nursing touches on ideological tensions between midwifery and medicine, as well as between and non-North American systems of maternity care. In the United Kingdom, midwifery was a legally recognized and socially respected health care profession. Midwives were integral to British maternity care as professional experts in normal birth and they were trained to assist women to give birth without unnecessary technologies. Despite concerns articulated by
midwifery scholars and practitioners about the erosion of midwives’ professional autonomy and normal birth in the United Kingdom, the highly technical approach to childbirth management practiced in North America had not yet pervaded British mainstream maternity care. In contrast, midwifery was seen an antiquated and regressive practice in North American settings where modern scientific obstetrics had come to dominate maternity care over the course of the twentieth century. In her reflections on Ontario obstetrical practice, Porteous noted the absence of respect for the labouring women and the normal process of childbirth that were foundational to her midwifery training and work experiences. She also noted professional respect for midwifery was lacking in the hospital where she worked, even though midwives were viewed as desirable employees due to their maternity care expertise. The subservient role of the obstetrical nurse who acted as a technical assistant to the expert physician was also unfamiliar to her. Porteous was accustomed to providing midwifery care as the most responsible care provider for women having uncomplicated births and accessing physician assistance at her discretion, based on her clinical assessment and judgment.

Porteous left maternity nursing after just over a year, frustrated and demoralized. She applied to the VON for a nursing position outside the hospital and maternity care, one that was based in the community. She secured a part time position with the VON as a home care nurse. She remembered finding particular satisfaction with the aspects of her work that that overlapped with her work as a midwifery practitioner. She liked providing one-to-one nursing care for people living with chronic and terminal health conditions in the community, and she enjoyed the independence and autonomy of caring for her own patients in the home setting. At the same time, she spoke of “culture shock” at the absence of a “holistic” approach in palliative care that she felt was similarly missing in Ontario maternity care:

With the VON, I worked part time so I didn’t have a permanent area that I looked after. I used to fill in for people who were sick or on holiday so it meant that I was all over the larger Hamilton area, in the city and out in the country covering for people. They were using me a lot to fill in spaces in their palliative care team, which is about as far away from childbirth as you can get. But I had done oncology nursing in Scotland in my training and afterwards, before I went into midwifery, so it was an area I was familiar with. And again there was culture shock because I was into a more holistic approach to health generally. It was a shock to see people who were terminally ill with cancer and to see the gaps in care they were getting with regard to detoxifying, nutrition, the values of those things to support people when they were going through those illnesses. But I loved the independence. I loved being out in my
own car and visiting people in their homes and making that one-on-one connection. So that was really good.

Despite her unhappiness with the Ontario obstetrical system and her transition to palliative nursing care, Porteous retained her passion for midwifery. In the late 1970s, she found out about an association of nurse midwives that had formed in Ontario that she understood was interested in addressing issues in maternity nursing and exploring the legal recognition of nurse midwifery in a Canadian context. She joined the Ontario Nurse Midwives Association (ONMA) and began attending their meetings, becoming involved in the lobby efforts for recognized midwifery.120

Helen McDonald focused her narrative of the factors that inspired her interest in midwifery during her student nursing and midwifery experiences in New South Wales, Australia in the late 1960 and early 1970s. She entered a four-year hospital-based nursing program in her late teens. During her nursing training, she had aspirations to become an emergency room (ER) nurse, based on her student experiences working in the intensive care unit and the emergency department. She was attracted to the clinically demanding environment of the emergency room and the high degree of skill and responsibility required of ER nurses. The organization of the Australian nursing profession was similar to the British system where a midwifery credential was required for specialty nursing opportunities, such as of ER nursing.121 McDonald spoke of her dismay when she realized she would be required to midwifery program as a prerequisite to work in the ER. She remembered feeling that midwifery was irrelevant to her career choice, linking her lack of interest in childbirth to the influence of early second wave feminist theory linking women’s oppression and motherhood. Following her graduation from nursing school, McDonald worked in pediatric emergency and intensive care nursing until she gained admission to midwifery school. She recalled her concern that she would find the care of healthy women and babies as a student midwife “boring.” She was surprised to experience a dramatic shift in her attitude over the course of her midwifery training:

I hated it for about... it was a year on top of a four-year program, entirely hospital-based. I hated it for the first six months. Absolutely loathed it. And I think the reason that I loathed it was that I was really interested in pathology…I found it actually really very strange because I had charge of all these babies who were completely healthy. Like how boring is that? I mean, really. And it took me a long time, when I say a long time it took me about six months to begin to understand that the whole process of being pregnant, having babies, becoming a mother was actually something that first might be interesting, from my perspective…I was
twenty-two. It took me also that length of time to understand that this really was something that was sort of pivotal in women’s lives.

With the shift in her perception of the significance of childbearing in the lives of women, McDonald saw parallels in the social impact of health care provided in the ER with that provided in labour and delivery settings:

Labour and delivery in lots of ways has similarities to the emergency room. People come, people go. There’s no long term, there’s no chronic care sort of element to it really. You see people at moments of huge, overwhelming stress. I think the thing that I really like about it apart from its potential for disaster, which I really like, the other thing is that you can actually make or break people. It’s an incredibly, incredibly powerful place to be. An incredibly powerful place to work. And I think that’s one of the reasons that I actually like it all round is that it’s just incredibly powerful. You know, somebody can come into the emergency room and you can destroy their entire hospital experience, their entire hospital stay, what they think of the institution, what they think of the profession that you represent, what they think of you personally for that matter. And the same thing happens when you meet people in labour and delivery for the first time and when you know that what happens in the first few minutes after you meet them really has the potential to... it sounds so bizarre. It sounds so self-promoting but it’s true. It has the potential to change their entire lives. It’s really, it’s pretty wild to think about it in those terms I think. You know, we all know, you go talk to somebody who is eighty years old, had her last baby fifty-five years ago, she can tell you about the nurse who was there. She can tell you about the people who were nice, tell you about the people who were horrible. She can tell you, “It was a terrible thing. They did this, this and this.” Or, “It was wonderful. That nurse did...,” right? I mean I think it’s astonishing the idea that what you do actually has that much longevity. Wild. It’s just wild. Doesn’t happen in a medical ward. Not in the same way.

McDonald’s passion for the potential of professional caring to transform the lives of childbearing women sustained her longstanding commitment to obstetrical nursing and midwifery. Following the completion of her midwifery training, McDonald worked as an ER nurse for two years and subsequently travelled for several years until settling back in Australia. She then worked as a midwife for one year before re-locating to Hamilton, Ontario in 1979 where her partner was completing his PhD studies at McMaster University. She applied for nursing positions in the emergency department and the labour floor at the local hospitals, however there were no positions available. She was hired at the McMaster University Medical Centre (MUMC) to work on the postpartum unit and later transferred to labour and delivery. In contrast to the “edginess” she associated with ER nursing, she was deeply disappointed to be assigned to the postpartum unit: “I applied to the emergency room at all the hospitals in
Hamilton. There were no spaces, so I ended up on labour and delivery. I hated postpartum. I just hated it. And it’s because it has no edge to it.” When a position became available, she transferred to the labour and delivery unit where she worked until becoming a registered midwife in 1994. Her nursing role was expanded in 1984 to incorporate responsibility for delivering babies within an innovative “midwifery demonstration project” at MUMC.122

Like McDonald, Linda Moscovitch spoke of the inspirational impact of her student experiences on her decision to follow a career in midwifery as a dramatic discovery. Moscovitch studied nursing in Cape Town, South Africa following high school in the 1970s with aspirations to become a pediatric nurse. At age twenty-one, she attended a twelve-month post-graduate nursing program in midwifery as a mandatory prerequisite for a pediatric nursing specialty.123 However, she recalled experiencing an immediate certainty that she wanted to be a midwife when she delivered a baby for the first time as a young student midwife:

I wasn’t going to be a midwife. I was going to be a pediatric nurse but I had to do midwifery first. I’ll tell you a little bit about that my first night on the labour floor. I was left alone while the head midwife went to dinner and two babies were born. And I’d never caught a baby in my life. It was my first day on the labour floor. And she said, “Just push this button if anything happens. But nothing is going to happen because I just checked the woman and she’s 2 centimeters dilated. I checked this baby. And I just checked the other baby and woman and they’re fine. I’m just going to get something to eat.” And both women started pushing within five minutes. And I said, “No, no, you’re fine. You’re fine.” And I said to the one woman I was with, “Look, there’s nothing there.” And I lifted the blanket and there it was... the midwife came back and I was standing there holding a newborn baby and she said, “What did you do?” And I just remember going home after that shift thinking, “This is it.”...It was...I can’t even describe it to you. It was something that I knew. I just knew that I could do nothing else again.

Despite this revelation, Moscovitch expressed ambivalence about her formal nurse midwifery training in a hierarchical nursing system. At the same time, she acknowledged the important role her training played in inspiring her vision of midwifery that resonated with the new midwifery she later encountered in Ontario. She identified the high degree of professional responsibility and the volume of hands on experience fostered her confidence in becoming a primary health care provider:

There wasn’t anybody other than a midwife in the [maternity and neonatal] units. It was actually normal because it was a maternity hospital....I think my [midwifery] training was great in what we learned there. We ran the units. On night duty you were the only nurse on
the ward. I was nineteen years old and I was running a children’s ward at night with a matron wandering around in the hospital if you needed her. Huge responsibility. Now I look back and think it was nuts but on so many levels it was a real sense of you got in the deep end and you either seized the moment and went with it or you didn’t. I love the fact that I had that base. I think it provided me with a lot of strength as the years went by.

Moscovitch also described her uneasiness with the authoritarian style of clinical care and teaching that she felt undermined midwives’ caring attitudes. She related a student experience of her resistance to perform an unnecessary clinical procedure directed by her supervisor. She remembered this experience as formative to her commitment to provide personalized and supportive care for childbearing women:

I never felt totally happy with the way women were treated. In one of the last births that I did in Cape Town’s Groote Schuur Hospital right before I graduated, we would have the senior midwife conducting the birth and then the student would do the catch kind of thing. And this midwife said to me, “How many episiotomies do you need still before you graduate?” And I said, “I think one.” And she said, “Well do it.” And I said, “No.” And she said, “Well when do you think you’re going to do it?” I said, “This woman doesn’t need one.” And she was really angry with me but I refused to do it. I said, “I will not do that.” And it’s interesting to reflect back on those days because I was so young and I had no references for birth but yet inherently I knew. And anyway, I talked this woman through the birth and she had a very, very beautiful lovely birth, which was in contrast to a lot of births women had. It was more just this factory kind of birth. And I looked up and this midwife who was supervising me was crying. And she left the room and when I went to do the charting afterwards she said to me, “That was one of the most beautiful births I’ve ever seen and I thank you for that. You’ve made me remember what it is that we’re supposed to be doing.” And that stuck with me. You know, if you think of what people tell you. And honestly she said, “You’ll go on and do well because you care. And I’ve realized that I’ve stopped caring.” And she was very honest because she was very angry with me because I didn’t want to do this thing.

Following her midwifery graduation, Moscovitch moved to Toronto where she took a nursing position in a downtown hospital in 1981. Like other nurse interviewees, she related feelings of frustration working as an Ontario obstetrical nurse:

I became licensed to practice as a registered nurse in Canada. I had to do an upgrading course for foreign nursing graduates at George Brown [College] when I first got here. And then I got a job at Toronto General Hospital…I worked in the special care nursery and did a lot more of that than actual labour and delivery. I was frustrated working in labour and delivery, not being able to actually do the births themselves…I felt like I was a handmaiden, basically just there to rub backs and call the doctor when the baby was coming. I wasn’t of the mind set of
using epidurals because we didn’t use epidurals in my training. Maybe a bit of Demerol, Pethidine or whatever. So I was really great at helping women through labours.

Moscovitch had been accustomed to working in a health care system where midwives were the most responsible care providers for normal birth and where childbirth management was less reliant on technologies and pain relieving medications. Like Porteous, she was unhappy with the circumscribed role of the Ontario maternity nurse and the medicalization of the childbirth process. Her decision to take up unofficial midwifery practice was rooted in her passion to support normal birth:

I always felt totally passionate about birth and felt that... it was so awful. I felt that what was going on in the hospital here was so awful and there were these women who really wanted it to be different. And I was really driven by that, of saying like we should give women so much better, we can do so much better than this.

Though she felt constrained by the role of the obstetrical nurse in the Ontario health care system, Moscovitch continued to work as an obstetrical nurse in several Toronto hospitals until the regulation of midwifery at the end of 1993. She found opportunities to participate in new hospital-based childbirth reform initiatives that facilitated her desire to support women in normal births. Childbirth preparation programs that lay at the foundation of social movements for natural childbirth reform proliferated throughout the 1980s, becoming an integral part of mainstream maternity care. Moscovitch trained as a childbirth educator with the American Society for Psychoprophylaxis in Obstetrics in 1984 and was hired to teach childbirth classes for expectant parents at Mount Sinai Hospital and Toronto East General Hospital. She learned about unofficial practices of midwifery and home birth from written “birth plans” that expectant parents submitted to the hospital labour floor in which they detailed their care preferences. Despite her participation in hospital-based childbirth reform initiatives, Moscovitch remained skeptical of the mainstream maternity care system’s ability to provide a style of care compatible with women’s rights for reproductive control and self-determination in childbirth:

I think it’s very similar now. It pretends to be different but real control is not there in terms of “We know what’s best for you,” and “This is the policy,” and “This is how we do it and this is how you will do it.” Women not even really realizing that they had the option of saying no and feeling bullied. And I don’t think it’s changed that much. I think the optics are slightly different but I think it’s the same.
Moscovitch’s growing awareness of community-based practices of home birth and midwifery inspired her decision to care for women wanting home births in Toronto. She encountered practicing midwives on the hospital labour floor who accompanied childbearing women into the hospital in a labour support role and met a practicing midwife in her community through a family friend. She also met an obstetrical nurse at Toronto General Hospital, a German trained midwife, who shared her interest in normal birth. She remembered they “would both talk a lot about how we missed doing midwifery.” Moscovitch was inspired by American lay midwifery literature that incorporated a vision of midwifery that challenged her to go beyond her knowledge and experience of midwifery to offer “a different type of birth”:

What compelled me to do this different type of birth? I think it was a whole accumulation of seeing so much in the way of what I didn’t want or I didn’t perceive. And then moving into a place of reading *Heart and Hands* and Ina May [Gaskin]’s books and getting more familiarized with how things could be outside of the nursing and medical systems that I’d been trained in...I loved the fact that I had that knowledge. That made me comfortable because if I needed to I had it. But then I also was able to now go beyond it.

Moscovitch and her nursing colleague decided to start a midwifery practice together in the mid-1980s. They were approached by a Toronto family doctor to take over his home birth practice when the College of Physicians and Surgeons of Ontario issued its 1983 statement dissuading physicians from attending home births. She explained that the doctor entrusted his home birth practice to them because of their formal nursing and midwifery credentials, even though they were not “part of the community” of Toronto practicing midwives. She remembered her formal credentials and her seamless entry into an established home birth practice set her apart from the growing community of midwives who were working to establish their credibility and a clientele:

He sent us all his home birth clients…this is sort of the history around my personal introduction to midwifery and the community. I wasn’t part of the community at that time. He liked the idea that we were formally trained midwives. We were nurses and we worked in the special care nursery. So he really felt comfortable with who we were. And I had no idea at that time. I was very naive about the political environment that midwifery had…I was just so naive because I hadn’t been part of the political grassroots stuff.

Moscovitch began attending home births in 1985. She was sympathetic to women’s desire for more control in childbearing:
Back in the ‘80s there was a real sense of women wanting to take control in a different way to the control now, of saying “This is going to be my experience. This is what I want to do and I’m going to do it my way.” And we were kind of edgy then because we weren’t legislated. We were outside the system. And think that appealed to a lot of people who were…less conservative…saying, “This is going to be my birth on my own terms.”

She declined to join the Association of Ontario Midwives (AOM) that had established voluntary practice standards by that time. Moscovitch valued autonomy in midwifery, both for women in care and for midwifery practitioners. She recalled how her decision to work outside AOM practice standards reinforced her outsider status in the midwifery community:

I was doing home births, VBACs [vaginal birth after cesarean]. At that time, the AOM decided not to do these. So I wasn’t part of the AOM because I didn’t want to be told whether I should do VBACs at home. So I was traveling to Oshawa and all over the place doing VBACs at home. And I got a few very snarky remarks and then comments about once you’re a nurse, you’re always a nurse...So it was around that time that actually I felt a bit personally alienated from the community of midwives...always felt I was on the outside because I had come from another country, I was a nurse midwife, I worked at Toronto General Hospital, I had got this doctor giving us all these clients, and who did I think I was. But in my naiveté, I had no idea of the impression that was created. I was doing what I wanted to do.

Moscovitch’s status as a formally trained nurse and midwife working both inside and outside the Ontario maternity care system before regulation complicated her relationships with official health care and unofficial midwifery. Her formal credentials and work within the hospital setting brought her the approval of the home birth physician whose practice she was entrusted with, while at the same time leaving her feeling alienated from the established midwifery community. Her willingness to work within the constraints of the Ontario hospital-based maternity system as a registered nurse stands in her contrast to her resistance to follow “voluntary” clinical practice standards of the AOM as an alegal midwife. Moscovitch’s narrative of some of the intra and inter-professional tensions surrounding midwives’ backgrounds and credentials reveals some of the complexities of insider/outsider positionality experienced by alegal midwives.

Extended Role Nurses

Helen McDonald and Kathy Penczak’s entry into Ontario pre-regulation midwifery practice was unique among the interviewees, as well as among the wider community of practicing midwives. They were part of a small team of labour and delivery nurses who worked in a hospital-based
midwifery initiative at MUMC in the decade preceding midwifery regulation. Key leaders in the departments of nursing and obstetrics who had interest in midwifery designed a research “demonstration” project to evaluate the effectiveness and viability of a hospital-based nurse midwifery service. McMaster University approved the “midwifery project” in the early 1980s, a time when community midwifery practices were increasingly visible and organized across the country. This project began in 1984, using a “randomized control trial” research methodology, to compare obstetrical outcomes of physician-managed care with care provided by select labour floor nurses whose role was officially “extended” to include the responsibility of delivering babies. The licensing body for Ontario physicians and the governing committee of the hospital granted approval for extending the nurses’ role to incorporate “controlled medical acts” recognized in health law to be within the exclusive domain of the medical profession. The “extended role nurse” (ERN) midwives assumed new responsibilities through an existing legal mechanism of “delegated medical acts,” ones that included infant delivery, episiotomy, perineal repair and immediate newborn assessment. Nurses working in the project, many of whom held international midwifery credentials, received continuing education preparation for upgrading and standardization of their enhanced role.127

The organization of the McMaster University midwifery service shared similarities, as well as differences, with unofficial midwifery practices. While the new “medical” responsibilities delegated to the midwifery project nurses fell outside Canadian nursing practice standards, they paralleled the practices of midwives who were working without legal status in the community and they complied with international midwifery practice norms. The revival of public interest in midwifery as a low intervention and humane childbirth alternative inspired the project’s creation and sustained its growth beyond its demonstration phase.128 In the initial pilot stage of the project in 1984 and 1985, pregnant women were randomly assigned for their labour and birth care to a staff physician or a member of midwife team. In 1985, the midwifery project expanded to incorporate prenatal care and a limited scope of postpartum care with the research goal to evaluate the clinical and cost effectiveness of a more comprehensive hospital-based midwifery service. Although the second research phase did not receive funding, the project persisted and demand for its midwifery services grew beyond the project’s capacity. The midwifery service evolved over the ensuing decade with the impending prospect of midwifery legislative reform to incorporate a model of “continuity of care” that more closely resembled the model of practice in the community.129
The absence of professional or legal infrastructures for midwifery complicated the professional role and autonomy of the nurses who worked in the midwifery project, as it did for alegal practitioners. For the ERN midwives, however, it was their official status as nurses and hospital employees that constrained their midwifery work, rather than their alegal midwifery status. The midwifery project nurses worked on the labour floor as both labour and delivery nurses and ERN midwives, juggling their work assignments between these positions. This duality in their roles blurred the lines between their midwifery and nursing work and contributed to confusion in their inter-professional relationships with their nursing and medical colleagues. Their legally sanctioned practice within the formal maternity care system and their compensation as hospital employees distinguished their care from that of community midwives who were working in a private model of practice and payment without liability coverage until 1991. However, despite the expansion of their conventional nursing role, the ERN midwives were unable to practice in the hospital setting with full professional autonomy. The legal mechanism that facilitated their ability to work as midwives also restricted their professional independence, as ultimate medical-legal responsibility and medical authority for the care they provided rested with the delegating physician. As the prospect of midwifery’s legalization as a self-regulating profession independent of nursing and medicine was becoming a reality by the end of the eighties, McDonald and Penczak extended their midwifery practice beyond the walls of hospital, into the community. Like other nurses working in the project who were interested in becoming registered midwives, McDonald and Penczak collaborated with community midwives to attend home births in order to meet the entry criteria for the Michener Institute’s Midwifery Pre-registration Program.

McMaster University Medical Centre’s position as progressive leader in Canadian health education, research and practice was conducive to the design and implementation of the midwifery project. The project was aligned with the medical centre’s founding core value of “family-centred care.” It also signaled a changing relationship between the medicine and nursing that was evolving in Canada at that time. In the 1970s, Canadian nursing was undergoing transformation with the development of distinct professional standards and accountability rather than being defined by and working under the supervision of medicine. MUMC was founded in 1972 as one of the first tertiary care hospitals in Canada to be integrated into a university as a health sciences centre. The organization of medicine and nursing as collaborative partners in the health sciences faculty symbolized this shift toward greater inter-
professional equality. MUMC was a national leader in the evolution of extended nursing roles into areas of practice traditionally restricted to medicine, as in the midwifery project.

The introduction of the midwifery project as a research initiative also complied with MUMC’s growing commitment to “evidence-based medicine.” Beginning in the early 1970s, key researchers at MUMC gained international prominence in defining “a new paradigm” in medical research that moved conventional health care practices under a critical lens using scientific research principles to determine the evidence basis for clinical practice. Obstetrics came under particular scrutiny for its lack of a solid foundation of evidence to support its practices. By the 1980s, a research specialty in “evidence-based obstetrics” emerged in Canada in the 1980s under the leadership of researchers and practitioners at McMaster University. The “randomized control trial” research methodology that compared outcomes of an intervention versus no intervention was embraced as the “gold standard” in evidence-based medical research. The use of the randomized control trial technique in the midwifery project to compare the effectiveness of midwifery care with normative medical care demonstrated the project’s viability. The project’s research findings also contributed to a growing body of evidence of unnecessarily high rates of technological interventions in childbirth that echoed the claims of childbirth reform advocates for natural childbirth, home birth and midwifery.

Although research and policy initiatives took on new directions in the promotion of normal birth and evidence-based health care delivery and the infusion of family-centred maternity care principles and practices transformed the landscape of mainstream maternity care, these childbirth reforms continued to be critiqued as superficial and ineffective at disrupting biomedical hegemony. MUMC’s midwifery service was one of three hospital-based midwifery “demonstration” projects established during the eighties in Canada. The development of these hospital-based midwifery programs in the absence of professional and legal frameworks for midwifery was innovative in the modern Canadian maternity care system. The impetus for the creation and design of these projects came from nursing and medical practitioners, researchers and administrators working inside tertiary care hospitals with university affiliations who shared popular concerns about the medicalization of childbirth. New evidence-based research findings that promoted normal birth and a reduction in medical interventions as healthy for mothers and babies lent support to these projects as a “low risk” childbirth alternative. The “family-centred” philosophy of the projects was also seen to respond to growing public demand for more
personalized childbirth care. Leaders in these projects were aware of provincial interest in midwifery legislative reform and envisioned these projects as a viable model for hospital-based nurse midwifery. In their reflections on these hospital-based projects, nursing leaders asserted they shared goals with community-based midwifery including: “to promote change in the care of childbearing families; to provide care that was responsive to the expressed needs of childbearing women; and to keep midwifery alive.” They argued these projects were equally compelling to childbearing women and policy makers who were interested in humanizing childbirth.

McDonald tied MUMC’s position as a modern and innovative health care institution to its progressive approaches to maternity care and its organization of health care delivery. She credited the infusion of international perspectives on midwifery among the hospital staff for fostering respect for the midwifery backgrounds of many of the nurses working on the labour floor. She recalled that the unique hospital environment of MUMC enabled her and the other labour and delivery nurses to play an active role in the maternity care team and in patient advocacy and contributed to her feelings of satisfaction with her nursing role:

I’ve actually never thought that the birth is the most important thing about labour and birth care, but it’s certainly like the icing on the cake. You do all that work, you should have a little treat. And the little treat will actually be having your hands on that baby. That will be great. But I could give that up. I really could. I could give that up to continue to work in the obstetric nurse role. I probably tolerated it pretty well because McMaster was quite weird in the late 1970s and early 1980s. First it was a brand new hospital. It was full of brand new people who had brand new ideas. All the physician staff was really young. Most of them came from other places, other countries. Most of them were English, Irish, Scottish. They had a long history of working in a midwifery-dominated maternity service. They say it all the time, “Oh the midwives taught me everything I know”…it was pretty wild. I think it’s interesting. I think they actually expected the nursing staff to behave like the midwives. And the midwives were mouthy. The midwives had opinions. The midwives told them what to do. I think they expected the nursing staff would be like that. McMaster had a very interesting nursing staff. They were people who were very willing to take on the physicians, very willing like to take on the OBs…there are limitations but really quite willing to challenge people. Highly protective of the clients…it was perfectly clear that the nursing staff ran the unit. There was no question about who ran the unit and you would hear that from people who came from other parts of the city because at that time there were three maternity units in the city.

It was evident from McDonald’s narrative that she took great pride in her work as a labour and delivery nurse. She felt empowered as a nurse when she joined the midwifery project in 1984, in
contrast to the disempowerment expressed by other nurse interviewees. Her satisfaction with her nursing role initially muted her interest in the midwifery project; however, she welcomed the opportunity to expand her responsibilities to provide more comprehensive care to childbearing women. She envisioned her participation in the midwifery project as formalizing her role as a primary care provider rather than enhancing her role as an assistant to the supervising physician:

I really had absolutely no interest in this extended role of the nurse as part of a physician extension. I figured that if we were going to do that, I thought it was absolutely fine for nurses to work in that role. But they should work in that role as primary care providers or as close to primary care providers as they could get, not as physician assistants.

Increasingly, McDonald felt disillusioned with the institutional demands on nurses that took them away from patient care. In her reflections on her motivations to take up Ontario midwifery, McDonald’s expressed ambivalence and regret about giving up her nursing role:

My reason for being a midwife is that I could no longer be a nurse, which was really awful. I couldn’t be a nurse because they wouldn’t let me be the sort of nurse I had to be. And that has to do with the increasing alienation of nursing from patients. The increasing insertion of technology and policies and procedures and bureaucracy between nursing and patients. When I first went to McMaster, you’d be assigned a patient and that’s what you’d do. You’d go spend all this time with this woman...it was great and I loved it. And then it became so that there was...the implication that if you were spending time in a room with someone it was because there was a problem. And it really was very, very hard to provide care in the way that I thought care should be provided...but there’s so many things I miss about it. One of the things I miss about nursing is the effortless acquisition of knowledge. It’s there, all the new stuff, all the new drugs, they just sort of float by and you just sort of soak ‘em up. You don’t have to think about changes. They just happen around you. I like working in teams. I like working with groups of people. Midwifery is very lonely sometimes...I liked being known as a good labour and delivery nurse. But I look around now and I think I just couldn’t ever work in that environment.

When McDonald learned of the provincial government’s intention to legalize midwifery in 1998, she knew she wanted to continue her work as a midwife. She remembered the hospital staff and administrators that she worked with remained optimistic that a hospital-based model of nurse midwifery would be legally sanctioned; however, McDonald understood a self-regulated model of practice that included home birth care was under consideration by policy makers. By the late 1980s, McDonald began attending home births as an “instrumental” step in pursuit of formal recognition as registered midwife. She explained that she had only ever attended one home birth in Australia when she “was still very young” that was complicated. She recalled
“just being scared to death.” She was aware of local home birth and midwifery practices from her encounters with alegal midwifery practitioners who accompanied labouring women to the hospital when complications arose and she knew of a few physicians who were attending home births in the Hamilton area. She contacted several community midwives in southern Ontario and was able to arrange opportunities to attend home births with them. She remembered encouraging other nurses working in the midwifery project to take the necessary steps to prepare for midwifery regulation, including gaining home birth experience, even though home birth was a contested practice in the hospital setting. McDonald described her experiences attending home births for several women who sought care in the MUMC midwifery project. She noted the presence of a quiet tolerance among the medical staff regarding the ERN midwives’ participation in out-of-hospital births, particularly as midwifery regulation drew near and a community-based framework for practice became inevitable. She successfully negotiated her multiple roles as labour and delivery nurse, ERN midwife and home birth practitioner and gained the necessary experience to qualify for the mandatory Midwifery Pre-Registration Program.146 McDonald noted the surprising appeal of home birth:

I knew there was going to be midwifery. I had long decided that this was the sort of health care that I wanted to do...I understood there was going to be midwifery and I knew that there was going to be home births. I knew if you don’t do home births, you were never going to be a midwife in this province. So I went and did home births. And it wasn’t, I have to say, any sort of philosophy or ideology. It was absolutely and completely instrumental. I was going to be a midwife and if that meant I had to do home births, then I had to do home births. Then I discovered I liked them. I continue to like them. They’re very cool. I like, like, like home births. I don’t think there is a midwife who doesn’t. Well, I think there are people who are more or less comfortable in different places. But how could you not like home births? And it was so much fun. And for me it was a whole brand new thing.

Kathy Penczak joined the McMaster ERN midwifery program in 1987, as one of several Ontario trained nurses who did not have previous midwifery training.147 Like McDonald, she took great pride working as a maternity care nurse at MUMC and she joined the midwifery project to expand her professional responsibilities in labour and delivery nursing. She valued the medical centre’s innovative maternity care policies and practices that had originally attracted her to nursing. Penczak first encountered the progressive character of MUMC in her fourth pregnancy in the late 1970s when she faced complex health concerns. The maternity staff’s sensitivity to her desire to minimize unnecessary interventions in her high risk pregnancy left a
lasting impression that she carried into her nursing training. She studied nursing at Mohawk College in the early 1980s with aspirations to become a neonatal nurse. She applied to do her senior clinical placement at MUMC to have a “university experience” in a tertiary care hospital setting, rather than in her local “small town community” hospital in Brantford. She was inspired to become a labour and delivery nurse because of a student experience in her surgical rotation when she unexpectedly delivered the first twin of a woman with a high risk pregnancy in the hospital bathroom. Following her nursing graduation in 1985, she applied to work at MUMC’s labour and delivery unit. Obstetrical nursing positions were not available at that time and she was hired to work on the high risk pregnancy unit; she later transferred to labour and delivery.

Penczak recalled that her nursing colleague, Helen McDonald, encouraged her involvement in the midwifery project even though she did not meet the requirement of two years of labour and delivery experience. She described her decision to take the opportunity:

You had to be a nurse in labour and delivery and had to have two years of experience. I started in ’85, so I had just under my two years of experience but clients had given me good feedback. I had good feedback so they said, “Let’s push her through a little earlier.” So I was able to get in and start...I just sort of landed in it and decided that I’m going to take this and run with this as fast as I can because I’m not going to get an opportunity like this again. And especially coming from the background that I came from, it was a whole new ball game for me.

Penczak was motivated to participate in the midwifery project to have more control over clinical decision making in order to minimize unnecessary interventions. She reflected on her desire to “preserve normal” birth that was rooted in her experiences of high risk pregnancy, both personally and professionally:

...after about two years of doing the high risk I started to feel I was losing touch with reality and normalcy. We always saw pregnancy as high risk...So it was really nice when you had straightforward normal births. It was like, “Now this is what I really prefer to do. This is much more pleasurable, much more exciting.” Although I know that people gave really good care, I felt like I wanted to do more the normal and preserve more the normal. And that’s what probably drove me into the ERN program, just getting control. Watching a few births with whoever, family docs or whoever, anybody who’s rushed, they cut episiotomies when they didn’t need to. Those things really made me think I’d like to get in there and actually be able to be in control myself. So I’d say I was interested in having more the control and trying to preserve normal.
Penczak received mentoring and some direct teaching from the more experienced ERN midwives and supervising physicians to expand her scope of practice. She remembered the work in the project provided a valuable learning opportunity for professional independence and multi-tasking that would later be key components her work as a community-based midwife. She also noted the organization of her work created multiple demands that prepared her for the complexities of being an autonomous midwifery practitioner. She described the personal and professional challenges she faced as an ERN juggling a double workload of being on call for ‘patients’ in the ERN program while working regular nursing shifts on the labour floor:

Women would come in in labour when you were doing your regular shift. When they came in in labour then you took care of them. It didn’t matter what you were doing, you had to also now take care of the midwifery client. So if you had the woman in room one who was toxemic and you were running MagSulf [Magnesium Sulfate] or whatever, you still had to admit and labour and deliver this other woman. So it was a bit crazy. Unless somebody else was able to relieve you, which quite often they weren’t able to. So you were managing on your own. You got to learn how to juggle things and prioritize so it was a good experience. Not the type of care you’d want to be providing but it gave us a good experience.

In her narrative, Penczak described her transition from a hospital-based ERN midwife to a registered community-based midwife. When she learned that midwifery was going to be structured as a community-based, self-regulating profession rather than as a hospital-based speciality of nursing, she was uncertain if she wanted to let go of nursing as her primary professional identity to become a midwife. She made a commitment to prepare for the qualifying program at the encouragement of her ERN colleagues, despite feelings frustrated by what she saw as changing eligibility standards:

So I thought, why not take the opportunity. I’m going to do this at least two years to make sure it’s what I want. There were so many hurdles put in front of us during the whole Michener program. The hurdles kept getting changed and I think that was the most frustrating part. You have to do this number of births. You have to do this many home births. And when you do that, then they moved that hurdle and said now, instead of five home births we’re making it ten. So it was getting very frustrating. But I thought, I’ll stick it out as long as I can and it was fine. I ended up sticking it out to the very end and I’m very glad I did.

Penczak was aware that other nurses in the midwifery project were attending home births with community midwives. She contacted Elsie Cressman and they agreed to assist one another to prepare for the Michener Pre-registration Program by exchanging official and unofficial learning
opportunities. She valued the support that the ERN midwives provided to one another to meet the Pre-registration Program’s entry requirement for home birth experience:

It was when the Michener came into play and we needed to get experience doing home births and the home birth midwives needed experience in the hospital. It was when I did that transition that Elsie Cressman came and worked with me. She did some shifts to get the experience of suturing and I got the experience of home birth by going with her. And it was really hard juggling those two careers, trying to do the midwifery outside of the hospital and doing the nursing on regular shifts… I can’t remember if it was seven or nine nurses who were doing the ERN program who would cover for each other. If I got called out to a home birth, somebody was able to come in and take over at three in the morning.

Although Penczak was initially concerned about the safety of home birth, her perceptions shifted with her exposure to home birth and continuity of care:

It was quite an experience. Quite an experience. I really enjoyed it. And it probably gave me a better outlook on what is normal. At first when I first started this, in all honesty I did not think I’d ever want to do home births. I really thought, you know, hospital birth. You need to be where everything is at your fingertips, because we always saw the shoulder dystocias and complications that came in. But what you’re not looking at is the whole picture of all the prenatal care that you’re screening women for up to the point of labour. We’re seeing them from a nurse’s point of view…being able to do that whole continuity of care, that whole scope where you’re watching them from beginning to end and you’re getting to know your women, and setting up the flags when you need to. Then doing the home births and seeing how beautiful they were and non-interventive and how you don’t need to be checking women’s progress every couple of hours to know where they’re at. I think that sometimes we get way too interventive and sometimes we need to back off as long as mom and baby are fine just give them a little time. And don’t call it labour when they’re not in labour so that you’re not having to start an IV, get oxytocin going, then getting an epidural going, and getting the vacuum out, and getting the forceps out and going down to do a crash section. It’s just, yeah, it’s just so much nicer.

Penczak’s narrative of her inspirations for midwifery stood out among the interviewees. Rather than entering midwifery practice in the MUMC project or following regulation with formed midwifery aspirations, she felt inspired after practicing as a registered midwife for “about two years.” Penczak’s motivation to become a lead care provider for low risk women was informed by her personal and professional commitment to normal birth and personalized care, yet she saw her work in the midwifery project as an extension of her nursing role more than an embracing of midwifery. Unlike some of the other ERN midwives, she did not have a formal background in midwifery to rely on in her changing role and relationship to the health care
system when she became a registered midwife. She noted a connection lingered between the midwives who had worked in the midwifery project and MUMC, even though the organization of midwifery as a self-regulating profession altered the midwives’ relationship to the hospital. They were no longer hospital employees. As registered midwives, they worked in community-based practice groups and entered designated hospitals where they had secured admitting and discharge privileges for labour and birth. Penczak described the evolution of her professional identity as a midwife that accompanied her growing confidence and experience working in a community-based model of care. She expressed gratitude for the opportunity the MUMC project gave her to “slide” into midwifery. Like other interviewees coming from different backgrounds, she described a sense of destiny in coming to midwifery:

Now I’m in the hospital and I’m seeing what it’s like for those who didn’t have it as comfy as I had it. And I have to admit that it was a luxury that I had being able to slide into it the way that I did and the support that I had both from my family and from the professional part of it. I consider myself very lucky. I was meant to do it. It’s just that I landed there. I can’t say I came full circle but there’s always that little bit of nursing in the back of me that says think this through as a nurse, now think it through as a midwife. And so I feel that I can give good advice and I feel that I support home birth way more than hospital any more. And I didn’t know that I would ever do that from the beginning.

The narratives of the interviewees with nursing backgrounds about their decisions to take up midwifery in Ontario challenge many of the assumptions in popular and scholarly literature about midwives who practiced in the modern practice revivals. These interviewees commonly identified their nursing experiences as playing a key role in their pathway into midwifery. Like other interviewees, those who were nurses first could be inspired by rewarding or difficult personal experiences of childbirth. Some described their frustration with the existing maternity care system that made it impossible for them to work with any satisfaction in the hospital setting. Their inspirations to practice midwifery flowed from wanting to improve the quality of maternity care. Others found their work as maternity nurses fulfilling, feeling they were able to achieve some success in making positive change within the system. For these interviewees, midwifery symbolized a furthering of professional autonomy and continuity with childbearing women that they found appealing. Like other non-nurse interviewees, some of the nurse interviewees were pressured by their communities to provide midwifery services when women sought them out as home birth attendants. They were seen by others to have expertise in home birth from their training in maternity care, however minimal, in contrast to the non-nurses whose “qualifications”
were seen to arise out of their personal experiences of home birth. Some came upon their love for midwifery by surprise as they pursued midwifery training as part of career advancement within the formal health care system. Some combined nursing work with alegal midwifery practice, often keeping their inspirations and activities secret for risk of disapproval from their professional colleagues or sanction from hospitals or regulatory bodies. Others, like their non-nurse counterparts, openly challenged the formal health care and the law. The narratives of the nurse interviewees are indistinguishable from the other interviewees in their expressions of passionate commitment to childbirth reforms that motivated and sustained their work as midwives in a tenuous legal environment. They expressed deep respect for and attraction to the normal process of birth, as well as a compelling desire to offer an alternative to mainstream maternity care, attitudes in keeping with assumptions about midwives working in North American midwifery revivals.

SOCIAL MOVEMENTS AND MIDWIFERY ACTIVISM

Many interviewees spoke of the formative influence of progressive social movements of the 1960s and 1970s on their visions of childbearing and their decisions to become midwives. They were attracted to counterculture and feminist constructions of childbirth that challenged hospital-based, medically-managed birth. Their experience is consistent with popular and scholarly understandings of the prominent role played by the counterculture and second wave feminist ideologies in the evolution of North American home birth and midwifery revivals. American home birth and midwifery movements that pre-dated similar movements in Canada both informed and inspired some interviewees. The growth and organization of midwifery in Ontario over the two decades prior to the enactment of midwifery legislation in 1994 similarly provided inspiration and a route of entry to practice for aspiring midwives who took up midwifery in the later years of the pre-legislation period. Midwifery also symbolized a site of political activism for some interviewees that played a key role in motivating their midwifery aspirations.

Sixties Counterculture

Progressive social movements of the sixties and seventies in North America that challenged mainstream authority and institutions provided a social context that was conducive to the reclamation of home birth and midwifery as childbirth alternatives to mainstream maternity care.
Countercultural questioning of institutional and medical authority contributed to the development of alternative interpretations of pregnancy and birth. Valorization of the “natural” that lay at the foundation of counterculture ideologies reconfigured childbirth as a normal daily life event and moved birth out of health care institutions and into family life and the surrounding social community. A holistic view of the body challenged medical constructs of the pregnant female body as mechanical and pathological, emphasizing the normal physiologic process of childbirth. Technological and routinized care was seen to undermine women’s spiritual, psychological, and physical integrity, all highly valued within the counterculture.\(^{150}\)

Judy Rogers’ inspirations to become a midwife grew out of her struggles as a “back to the land hippie” to give birth in her rural Nova Scotia farmhouse. Following her daughter’s home birth in 1972, Rogers took up practice as a self-taught midwife to make home birth available to other like-minded women. Her evolution from counterculture mother to community midwife reflects a quintessential narrative embodied in the literature on midwifery’s late twentieth century revival in North American settings. Rogers’ narrative of her midwifery inspirations also provides a portrait of how women living a counterculture lifestyle envisioned and constructed childbirth practices that integral to their ideological commitment to natural ways of living. In addition, Rogers’ memories illustrate how childbirth alternatives were marginalized in prevailing systems of maternity care and the personal determination that was required to remain committed to non-normative practices like home birth.

Rogers learned she was pregnant when she was living in a counterculture community on Saturna Island in British Columbia. She explained that her desire to plan a home birth was consistent with her counterculture beliefs that valued a “natural approach” to childbirth as a “family experience”.\(^{151}\)

What I was looking for and I guess what I valued was a natural approach and not being restricted in terms of who would be with me. I certainly wanted my partner with me for the entire experience. I believed very positively that I could give birth. My body was made to give birth. What I’d read about episiotomy just seemed ridiculous that there should routinely be a cut to such a sensitive area of my body. I knew that babies breast fed best on demand and that they digested the milk a lot quicker than the four hours recommended by pediatric experts. The thought of a newborn baby screaming when it had just been with its mother for nine months being separated or needing to wait if it wanted to feed for some time clock was just unacceptable to me. And that was almost more important because I felt like that was
going to do psychological damage to my baby. But it was really a sense that this was a family experience…

Rogers approached a family physician whose son attended the alternative school in the small community where she lived to see if she would be willing to provide home birth care. Although midwives were not yet visibly practicing in Canada at that time, this physician was one of a small number of Canadian medical practitioners willing to attend home births as either a traditional practice or a counterculture alternative. The physician agreed to provide home birth care to Rogers with the condition that the birth take place at her own residence in Victoria for ready access to a hospital in the event of complications. Looking forward to the birth of their first child, Rogers and her partner wanted to purchase a rural property by the ocean to “go back to the land and raise a family.” When they were unable to find affordable property in British Columbia, they looked to eastern Canada where land values were lower. They purchased a tract of farmland that was “a bit of a bargain at $6,000 for one hundred acres” in the Annapolis Valley of Nova Scotia when Rogers was seven months pregnant. Rogers characterized her and her partner as stereotypical hippies, travelling across the country in their Volkswagen van with a manual on emergency childbirth to rely on for guidance about pregnancy and childbirth. Although they did not move to an established “intentional counterculture community,” they had heard through word of mouth that other like-minded people were living nearby who had had home births. Rogers described the back to the land movement that was occurring in rural Nova Scotia at that time and its valuing of home birth:

We had only lived there a couple of months. I only kind of knew one other couple who had a home birth but I had heard rumours. You know, you hear about, “Oh there are people that have had their babies on their own.” So there was a general back to the land movement going on. There were a number of American and Canadian families living all over the place in the rural parts of Nova Scotia trying to go back to the land and grow their own vegetables and live in a more harmonious way.

Rogers recalled making her own assessment that her home birth plans were reasonable after consulting the manual on emergency childbirth and determining that she was “healthy and in a good situation to have a home birth.” She sought out a willing home birth attendant from the local medical community, surprised by the resistance she encountered given the ease with which she found a willing physician in British Columbia. She nevertheless remained persistent in her plans to secure professional support. She interviewed five physicians in the local area, all of
whom were unwilling to provide care outside of the hospital setting. She reflected on her naiveté in asking local physicians to attend a home birth at a time when the medical profession viewed home birth as dangerous and regressive:154

I was planning to have a doctor. There weren’t midwives that I knew of in Canada at that time. The first doctor we had met in BC had agreed to our plan for a home birth as long as we had it at her house because she didn’t live that far from the hospital. So I wasn’t really expecting to have quite as much resistance as I met…when we settled into the Annapolis Valley in Nova Scotia I went to a number of doctors, five in total. As a healthy person having my prenatal visit I’d say I’d like to have a home birth and would they agree to it? And I got a variety of reactions, most of which were extremely negative. One doctor said I was going to die, my baby was going to die and basically told me to get out of the office. Another doctor basically said…he was probably about the fifth I had seen…he recognized that my choice was coming from a sincere place but that he would lose his license if he agreed to do it and anything went wrong. So he couldn’t really support it. I felt that was the most honest response I’d had.

Rogers was increasingly adamant that mainstream maternity care practices were not compatible with her vision of childbirth, particularly after touring the local hospital where she would give birth. She recalled the reluctance of the hospital staff to provide care that strayed from routines and policies:

We went on a tour of the local hospital to see what the option was and we hadn’t been to a hospital even in BC so it was a bit of an eye opener. The nurse that took us around basically said that my partner would be able to stay with me in labour but not for the birth, the baby would be taken to the nursery right after birth and brought out once every four hours for breast feeding, that every woman had a routine episiotomy. And I questioned her on all of these factors because they had started having rooming in occasionally in BC. And she said that was the policy and she didn’t really agree with it but that was the policy. And so I remember kind of laughing and saying, “Well I don’t think you’ll be seeing us here for our birth.”

Rogers’ determination to find care that was congruent with her values of non-intervention and that respected her role in health care decision making led her to contemplate giving birth with only the assistance of her partner and their emergency childbirth manual. She remembered her partner’s concern about potential legal repercussions if anything went wrong dissuaded her:

I knew there were couples having babies without any attendants at all. I was not so enthusiastic about that because I felt like there were potential problems that could occur…When I was starting to think quite seriously about possibly having the baby alone
with my partner, he was not supportive of that. He was worried that he would get charged with manslaughter if anything went wrong and so it was difficult.

In desperation, Rogers contacted the family physician who had cared for her in British Columbia and offered to pay her travel costs and provide accommodation if she was willing to come to Nova Scotia. She was surprised when the physician agreed to take a holiday with her son in the Maritime provinces and attend Rogers’ birth:

We contacted the doctor that we had had in BC and asked her if she knew anyone on the east coast within one hundred miles and if she didn’t would she be willing to come for our birth if we paid her plane fare. And she wrote back and said she didn’t know anyone but she had never seen the Maritimes and she would love to come…And so we started selling what few possessions we had to raise money to buy her plane ticket. And she came a week before I was due with her twelve year old son.

The physician’s willingness to travel across the country to attend Rogers’ birth reflects the strength of conviction to childbirth alternatives among those committed to a style of care that was marginal within the health care system and within the wider social context. It also suggests the broad notion of community that existed in the “alternative birth movement” of the home birth and midwifery revivals. Her story also illustrates that although often portrayed as anti-medical, this movement included some physicians.

Rogers and her partner worked to repair the abandoned farmhouse on their property to make it suitable for their imminent home birth. She and her partner had “been sleeping in our van up to this point,” as they had given the tent they had been living in to the doctor and her son. Rogers’ narrative of their preparations for their home birth conveys qualities of self-sufficiency and perseverance characteristic of those living a back to the land lifestyle:

We had a house that had not been lived in for seventeen years when we bought it. It was extremely vandalized and so I basically spent the last month and half of my pregnancy ripping all the plaster out – ceilings, walls, the entire thing, gutting the entire house down to the foundation…We had an outhouse and no electricity. I bought a bed at a farm auction and some linens and we decided to sleep in the house one night and realized there were bats. As soon as it got dark, there were bats flying all around us because all the windows needed to be replaced.

When Rogers realized in late in pregnancy that their house would not be suitable for the impending birth, she refocused her efforts on making alternative arrangements to have a home birth. She arranged to give birth at a nearby friend’s house that had indoor plumbing and
electricity. Although Rogers felt secure in these plans, her doctor’s insistence on the symbolic importance of giving birth in their own home swayed her to find a way to create a useable space in their farmhouse. Rogers and her partner cordoned off one room that they managed to get prepared just prior to the onset of labour.

Rogers identified the experience of giving birth in her home with the support of her doctor and her partner as pivotal to her decision to become a midwife. Her feelings of personal transformation inspired her desire to make home birth available to other women:

We had quite a long labour, twenty-four hours. It really kind of pushed me to the limit in terms of what I felt was acceptable but I had a lot of support from [the doctor]. She was really unfailing in her presence and we had a home birth in our own bed. I had an intact perineum and the baby stayed with us. It was just what we wanted. So it was quite a revelation for me to have what I felt was personally a transformative experience. I had never thought about being a midwife. I had never been interested. I wouldn’t take biology in high school because I didn’t want to cut up a frog. I read a midwifery textbook and it never crossed my mind to be a midwife. But it was really the experience of what we went through trying to have a home birth with assistance, with some skill, a care giver, the amount of hurdles in our way, what we had to go through to actually have it, and then of course the joy and the power of having a baby at home and how we were supported by someone with skills and knowledge. I really felt other women deserved that option and it was really very shortly within that experience that I decided I was going to become a midwife so that I could give other women a better option than just being at home alone… But for me that need to support women birthing in their own homes and in their own way was really as much a political statement as it was a supporting of women’s choice… the actual experience of giving birth and having just given birth was so exhilarating that I remember saying to someone, “If I don’t become a midwife I’ll probably have twenty kids.”…so that was there but I’d say the other probably more strong piece was just this feeling of women deserve to have help to do this that makes it as safe as it can be.

Rogers’ doctor gave her the instruments she had used at the birth as a contribution to her midwifery aspirations. Rogers investigated options for midwifery training with the plan to pursue midwifery education in England when her daughter was school age:

I started investigating and it seemed like there was no way I could become a midwife in Canada. There was some kind of northern nursing training but you had to be a nurse first. That was for outpost nursing. In America, I could become a midwife but I also had to be a nurse first. Then I looked into England and Holland and England had a direct entry program as well as a post-nursing program. And Holland seemed to have a direct entry program but you had to speak Dutch and their admission was by lottery so I saw more barriers there. So
England started being the most logical goal for me but I was imagining that a good time would be when my daughter was about four for her emotionally to be able to be a bit more separate.

Rogers’ commitment to assisting other women to give birth at home was reinforced and further inspired she received one of the first books coming out of the modern North American midwifery movement, the Birth Book written by Californian lay midwife Raven Lang.\footnote{156} It offered practical advice that Rogers found informative as an aspiring midwife:

About three months about my daughter’s birth, someone sent me Raven Lang’s Birth Book in the mail which is a whole book of stories written by mothers, fathers, midwives about home births, one after the other accounts and tales of these home births from Santa Cruz, California. And one of them was a baby that died, was stillborn. It included all sorts of experiences plus some fabulous pictures, an actual drawing of crowning and quite a lot of information for wannabe midwives.

When Rogers’ daughter was a year old, a friend requested Rogers’ assistance because she was unable to find a doctor willing to provide home birth care. The friend saw her personal experience of home birth as conferring expertise. Rogers recalled feeling morally obligated to support her friend’s home birth plans, even though she did not yet feel prepared to be a midwife:

…when my daughter was about a year old a friend of mine got pregnant. She lived in Halifax. We lived about a hundred miles away out in the Annapolis Valley and she said, “Judy, I want to have a home birth and I want you to be my midwife.” And I’m like, “I can’t be a midwife. I’m not a midwife. I’ve only read a book about being a midwife. And that’s like driving a car after you’ve read a book about driving a car. It just doesn’t work like that.” And she said, “But I’m going through all the same things you did. I’ve been to all these doctors and they’re all saying no and they’re refusing.” I don’t think even in Halifax there was any kind of decent family-centered maternity care. So she was struggling and I was trying to say no repeatedly, but my resolve was crumbling because I knew every time I saw her she’d be playing her story. And I knew exactly what she was going through.

Eventually, Rogers agreed to attend the birth with the provision that her friend find an experienced labour and delivery nurse who could assist with recognizing “when things are going wrong with the labour.” She was surprised to receive a call two weeks later from her friend to say she had found a nurse who was willing to attend the birth. Rogers prepared for the birth by reading books on childbirth. She noted, with amusement, that her preparations focused on sterility of the birthing environment that was emphasized in lay childbirth manuals, mirroring contemporary hospital birth practices:\footnote{157}
So it was really by the book kind of thing. I was most concerned about sterility so I got her to sterilize about three sheets. We had this whole baking thing in the oven with water so it didn’t burn the wrapping. Oh my god, it was so complicated…I read about it in a book. And so I had her sterilize three big bed sheets, pillow cases, shirts for everybody who was going to be in the room which was of course a lot of people in those days. It was the back to the land era. And anyway, god knows what we put on the floor. I think we covered the floor with newspaper, which was also supposed to be sterile when it was first used. I think we probably could have done brain surgery in that bedroom.

The woman gave birth at home, with Rogers in attendance. The woman was happy with her home birth, however Rogers recalled that she was left feeling anxious and stressed. The baby did not breathe spontaneously at birth for a short period and the woman had a perineal laceration that required transfer to the hospital for repair. Rogers’ concern about the safety and well being of the mother and baby unsettled her confidence in home birth. She described her uneasiness with the responsibility she had undertaken and decided it was imperative that she seek out formal training in midwifery:

I was really having a major...I don’t know what to say...kind of really a rethink, feeling this had been a close call with death and what were we doing. This was crazy and maybe people shouldn’t have home births and what if that baby hadn’t breathed? And now she was having to go into hospital for stitching. What a mess up. And I was being very critical of myself. The woman was absolutely blissed out...she was so happy that she had the birth that she wanted. It didn’t faze her at all that she had to go in for stitching. I went back to my home eventually, really shaken. My confidence in home birth was shaken...and I had said to her beforehand, “Look, this is completely illegal. You have to promise you won’t tell anybody that we’re going to do this, blah, blah, blah.” And I was feeling that there was just no way I could do anything until I got some formal training and maybe home birth wasn’t the right way in the future.

Rogers lacked access to midwifery apprenticeships that were available in other regions of North America at that time. She continued with self-study of medical, nursing and midwifery texts, accessed newly published popular childbirth literature, and also became increasingly active in local childbirth education initiatives. Rogers played a lead role in organizing community public education events about childbirth alternatives, she started a study group on childbirth and parenting for mothers, and she created a library of childbirth books that were circulated by mail to women living in rural areas of Nova Scotia. She also taught prenatal classes and participated in the founding of an organization dedicated to childbirth education, The Nova Scotia Association of Prepared Childbirth.
Despite her uneasiness about the safety of home birth and the illegal status of midwifery in Nova Scotia, Rogers continued to feel obligated to assist other women who were determined to give birth at home, with or without her assistance.\textsuperscript{158} For several years, she continued to provide home birth services to women living in her surrounding community that heard about her through word of mouth. She described the people who accessed her care: “...hippies, alternative people at the time, back to the landers...Some of them lived in communes. Some lived in nuclear families. They all lived in rural areas or small towns in Nova Scotia, in the valley and surrounding areas.” As her midwifery practice expanded, she remained committed to accessing formal training, particularly as she encountered childbirth emergencies. She applied and received acceptance to a “direct entry” midwifery program in England.\textsuperscript{159} In 1975, she travelled by freighter to England with her toddler daughter to begin formal midwifery training in a hospital-based midwifery program.

Jane Kilthei’s aspirations to become a midwife evolved within the context of an organized counterculture community. Like Rogers, her difficulties accessing maternity care that was congruent with her counterculture values motivated her decision to pursue midwifery. Kilthei’s dissatisfaction with her life in Ottawa where she was working as a civil servant after her graduation from Carlton University led her to seek a more meaningful life in rural living. In the early 1970s, she moved to a log cabin in the Quebec Laurentian Mountains as a means of “stepping out and looking at [her] life.” After living there for one year, she became part of a group that started an “intentional cooperative community” near Kingston, Ontario where she lived for the next seven years. She developed an interest in women’s health that she considered ideologically linked to the community’s goals of self-sufficiency: “I think part of what we were trying to do in the community was just really take responsibility for our lives. Part of that was learning about growing our own food and some of it was learning about issues to do with health and health care.”

When Kilthei was pregnant with her first child in 1979, she faced similar struggles to Rogers finding care that supported her desire for autonomy and non-intervention:

When I decided it was time to have a child and got pregnant, that was where I encountered what the medical community was about. It was appalling. This was 1979. And just trying to find something that was congruent with my values that felt safe and sensible and human. It’s even hard to describe exactly what I was looking for, but I knew what I was finding was
wrong....I mean I think for me a lot of it had to do with choice and autonomy... and just trust in the body as being functional. You know, really basic stuff…..

Although she was comfortable with her family physician’s style of care, her doctor did not practice obstetrics and she referred Kilthei to an obstetrician in Kingston. Kilthei met with the obstetrician to discuss his care management of labour and birth. Her desire for self-determination in health care decision making was consistent with emerging trends of consumerism in health care that had not yet infused mainstream maternity care or altered the professional authority of medicine. Kilthei characterized the obstetrician’s response to her desire for information as patronizing and dismissive. She recalled her feelings of shock at the lack of respect for childbearing women’s autonomy that she encountered in Kingston:

I had a family doctor, actually a really wonderful woman family doctor out in the country…. We were an hour from Kingston. She didn’t have hospital privileges anywhere because she was too far away to make working out of a hospital possible. She was just doing a rural family practice. So she referred me to an obstetrician in Kingston and I went to see this doctor who was probably a nice man but he was living in a completely different world and I came...with a list of questions. I’d been doing a lot of reading. I’d been talking to friends who had had babies. I came into his office, pulled out my piece of paper with my questions and he said something like, “Oh, you’re one of those.” And so I just proceeded to ask my questions and every time I got to a point where I’d ask, “Well what would happen if this happened?” it was, “Well we would take you into the operating room and everyone who was with you would stay back there.” And I went, “This is just wrong”...I mean I had been working in women’s health around self-care, doing self-exam and all this and so I had that context. And the lack of interest in women having any autonomy around childbearing in the community was shocking.

Kilthei’s memories of her interactions with the obstetrician illustrate the type of resistance encountered by women who wanted a style of care that recognized childbirth as a normal, healthy process during the early years of the Canadian home birth and midwifery movements. Her tour of the Kingston hospital facilities strengthened her resolve to give birth outside the hospital setting. She remarked that her discomfort with the impersonal care provided to newborns routinely separated from their mothers solidified her decision to give birth at home:

I went to childbirth classes. I think what really clinched it for me was I went and did a tour of the hospital and saw all the little babies wrapped up like sausages in the nursery with nobody anywhere near them, some of the screaming their heads off. I just had this visceral body reaction. It was like nobody is going to put my child in that place.
Kilthei was aware that there were physicians attending home births in Canada. She continued her efforts to find a care giver who would support her to give birth in the way she wanted. She recalled how the actions of a medical receptionist assisted her to find a doctor who would better meet her needs: “Finally it was the receptionist of some doctor who was very unsupportive who told me, almost in a whisper, that she knew of this doctor in Kingston who occasionally did home births and that I should call him.” The covert nature of the receptionist’s communication with Kilthei highlights how alternative practices to mainstream maternity care were marginalized at that time.

Kilthei eventually secured care from the physician recommended to her by the medical receptionist. He agreed to attend her birth at her home outside of Kingston, even though she did not comply with his home birth standards. Kilthei explained his policy of attending home births was restricted to women who had previously given birth and who lived within a reasonable travel distance to the town hospital:

I called him. I’m an hour of out Kingston, living in the country. He would do home births not with people having their first baby and only if they lived within fifteen or twenty minutes of the hospital. So I said, “But can I just come and see you?” So I went and he did a visit and he said, “You seem healthy enough.” And I knew that was my opening.

Kilthei gave birth at home with the support of her partner, Larry Lenske, and other members of her community. She noted that she was the first member of her community to give birth at home on their communal land. The physician arrived shortly before Kilthei gave birth to her son. She noted his comfort with her straightforward labour:

I just had a rocket ship of a labour and by the time he got out to the farm I was seven centimetres dilated and I had my home birth...he thought he would have this nice drive out into the country. I would be in pain. It would make sense to come into town. But he was perfectly fine once it was straightforward to be out there in the country.

Following her son’s birth, Kilthei took steps to become involved in the care of childbearing women. Like other aspiring midwives in Ontario, she attended a teaching training program in childbirth education as a means to educate herself about pregnancy and birth that was offered by the Kingston Childbirth Education Association. This program had a standardized curriculum that included a series of training sessions before moving from observation and to supervised prenatal class teaching. Unlike other childbirth educator programs that involved attendance at several births, the program Kilthei attended did not integrate this as part of the curriculum due to
restrictive hospital policies on the number of support persons who could accompany women in labour. She characterized the philosophic orientation of the program as reinforcing the status quo of mainstream obstetrical practice. Her vision of childbirth education as a tool to assist women to make informed and personal decisions about their care strayed from the program’s teaching philosophy of educating women about what to expect from hospital procedures and technologies, assuming these would be followed. She found herself being “put on probation as a childbirth educator” for discussing the risks, as well as the benefits, of epidural anesthesia with expectant parents in her supervised class. Although her desire to inform women about medical technologies using a risk-benefit analysis is a guiding principle in contemporary inter-professional health care practice and was a founding principle in the “new” midwifery, it was interpreted as a radical challenge to medical authority and normative maternity care practices by the program organizers. Kilthei’s non-conformity to the program’s norms was further heightened by her personal home birth experience. She recalled the uncertainty of the program’s leaders about her suitability to be a childbirth educator because she had not given birth in hospital:

The Kingston Childbirth Education Association had a kind of apprenticeship process. You did some learning modules but mostly you went and observed a series of classes, then you assisted at a series of classes, and then you were observed teaching classes…The interesting thing is they had a meeting with me and said “We’re not sure that you should be a childbirth educator because you haven’t had a hospital birth.” And I’m sitting there in this room with three women who are childbirth educators and I went, “But she’s only had a cesarean. She hasn’t had a vaginal birth. And if she can be a childbirth educator, I can be a childbirth educator.”

Kilthei’s narrative of her teacher training program suggests that childbirth education was not a fixed concept; rather, it could embody a range of meanings and orientations to official maternity care. Childbirth preparation that had its roots in natural childbirth reform movements of the 1940s gained increasing popularity in North America in the 1970s and ‘80s as national and international childbirth education organizations were established. Childbirth education programs, such as the one Kilthei participated in, became integrated into hospital-based systems of maternity care. Kilthei grew increasing disillusioned with the program’s approach that promoted women’s passive acceptance of obstetrical norms rather than their active engagement in their own health care. She explained that she wanted to participate in childbirth reform initiatives that promoted women’s autonomy and shifted expertise from the care provider to the
childbearing woman. She remembered being called to assist a distressed labouring woman who had attended her prenatal classes and coming face-to-face with the restrictive hospital practices in Kingston at that time, in 1981:

They didn’t have any birthing rooms. They hadn’t reached the point where they were willing to just consider a labour room could be a birthing room just fine. So women were going into the delivery room. Fathers could be present for deliveries but there wasn’t even any policy that allowed a third person to be present. There was no possibility for additional labour support in the hospital.

Frustrated by the lack of accessible woman-centred and personalized care for childbearing women in her area, Kilthei felt a growing determination to become a midwife: “I realized more and more that [midwifery] was the only thing where I could really do what I wanted to do since the system was so uninterested in even looking at the possibility of change.” She noted that she decided to seek out training opportunities together with her partner Larry Lenske who shared her interest in midwifery: “…I was in a relationship with Larry and he was living in Virginia and I was living near Kingston and we were spending a lot of time traveling up and down Highway 81. He was very captured by childbirth as well and I think he was probably the one who said first that he wanted to be a midwife.”

Lenske, like Kilthei and Rogers, chose to live in a counterculture community where he too discovered his passion for childbirth. Living in an “egalitarian” community in rural Virginia in 1977, he felt inspired to attend a birth when he found himself “looking at a cow” and realizing he had “never seen anything be born, not even a cow.” Lenske was attracted to the primal nature of birth that was in keeping with the respect for nature inherent in counterculture ideologies and lifestyles. He asked a pregnant community member if he could attend her birth and she agreed. He offered to provide massage therapy in exchange for the opportunity to be present at her birth. Lenske remembered the experience as inspiring his desire to continue his involvement in childbirth:

My first connection with birth or pregnancy or anything like that was giving regular massages to a pregnant women and then during the labour and birth with her. She had her labour coach as her partner, the midwives and all those folks, and I was just there. Basically, it was her first labour and it was kind of intense. I think it was about a seven hour back labour and I spent pretty much seven hours during contractions giving her back pressure, counter pressure and rubbing her legs in between contractions. So in effect, I was like totally physically there
for that period of time. The experience just completely blew me away and I went “I want more of this.”

Lenske sought out books on natural childbirth and he was able to find “things like Spiritual Midwifery and Dick Grantly Reid. No not Dick Grantly Reid, whoever that guy was.” He continued to attend births over the next several years and discovered that his organizational skills were valued by members of his community in the planning of births. He described his growing expertise in organizing “environments around childbirth” that were tailored to the individual needs and desires of each pregnant woman:

I didn’t really know it but I tended to organize things a lot. Being an organizer I didn’t realize that about myself and so being in community, I quickly became known as one of the local experts. I would kind of organize environments around childbirth …I remember, I think about the second or third birth I went to that I was a person who basically organized all the supplies and the lists and this and that and choreographing everything in the community. It wasn’t that I was involved in the inner team. It was interesting because women there, it would range, and it was totally up to them, from wanting a public birth to having a private birth. Whatever they wanted would be provided to them, having a home or a hospital birth or whatever.

Lenske valued self-sufficient ways of living and his confidence in learning complex tasks as a lay person was typical in back to the land living. He continued to study books on childbirth and midwifery of the early American home birth and midwifery movements and he began to teach prenatal classes. He reflected, like others with skeptical amusement, about his teach prenatal classes with his limited preparation:

I was totally self-taught. That was in the days of you do it once and you become a resource...It’s ridiculous to think that I taught childbirth education. What did I know about it? The notions of expertise derived from personal experience, as well as the related notion of non-professional expertise, were concepts embodied within counterculture ideology.

Lenske’s memories of his participation in childbearing within his community illustrate how counterculture constructions of birth both paralleled and diverged from mainstream childbirth practices. Counterculture ideology expanded conventional notions of expertise beyond the professional to encompass lay participation and expertise. In Lenske’s community, two local certified nurse midwives and a physician provided care to childbearing women. They were part of a woman’s support team that also included family and community members who played equally important roles. Birth was organized at the community level in contrast to the
organization of normative care that took place at the level of an individual family in the private sphere of the delivery room. Women’s birth experiences played out according to their personal needs in contrast to normative care’s reliance on routines and procedures. Natural approaches to birth that strayed from the use of medical technologies were highly valued. Lenkse’s narrative also portrays the central role that ritual played in counterculture birth, one that parallels the role of ritual in other cultural traditions of childbirth, including the “elaborate” rituals of medicalized childbirth.164

By the early 1980s, Lenske involvement in the care of childbearing women culminated in his decision to become a midwife. He traced the evolution of his midwifery aspirations over his years living in alternative communities. Lenske had visited the The Farm commune on Tennessee in the early ‘70s, prior to settling in Virginia. He was aware that The Farm had established one of the first lay midwifery services in the United States under the leadership of Ina May Gaskin, a prominent figure in the American midwifery revival. He recalled feeling encouraged in his aspirations as a man interested in midwifery by seeing a passage about the importance of childbirth and midwifery written by The Farm’s spiritual leader Stephen Gaskin.165 Lenske “hung out with the midwives some” in the Virginia community where he lived in the late 1970s and “felt blown away by the energy.” He remembered feeling inspired by seeing the midwives at work: “This is neat stuff. I want to do more of this.” He had met Jane Kilthei and was travelling back and forth to visit her in Ontario. He attended the home birth of her son in 1980 that he remembered as “another incredible experience.” He reflected on the alignment of midwifery with his personal values and goals:

Politically, I was coming out of the ‘70s, trying to be the gentle feminist man and all of that stuff. Out of that it just seemed completely consistent with all the right ways to do things, very different than traditional obstetrics at that point in time. It was really humane and correct, a better way of doing things.

Lenske and Kilthei pursued midwifery apprenticeships. They encountered barriers due to Lenske’s gender. Midwifery’s reclamation in the late twentieth century North America was infused with gendered assumptions of midwives as wives and mothers. Midwifery was constructed as a female activity in opposition to a male dominated medical profession in North American midwifery discourse. In 1981, Kilthei was able to secure an apprenticeship with a midwife in the eastern Greater Toronto Area who was open to considering an apprenticeship for Lenske. Lenske described the gradual evolution of his midwifery training:
[Kilthei] became a childbirth educator and eventually we got together and decided we’re going to go somewhere in North America and become midwives. We had no idea where or how and ended up landing her an apprenticeship in Toronto which wasn’t too far from where she lived up in Kingston in her community. And she started apprenticing. And I was a pre-apprentice for a number of years...I was able to just go and attend a lot of births and just sort of be there and help out, be the go-fer and do whatever with that. I started teaching childbirth classes with her and [the midwife] who she practiced with. And so just kind of got started... between 1982 when I arrived in Toronto and 1986 I attended about thirty-five births...I wasn’t an apprentice. But I did a huge amount of observation and I learned how to do basic things like blood pressure and heart tones and what not and to monitor labour. I imagine that it was during that period of time I took courses...I think most of my education was just being at a lot of births and learning by osmosis. And I can remember I got to catch one baby for folks that we’d known because they’d been in Jane’s community up in Kingston and they had their baby at our place. That was a mind blowing experience. So that was the first phase of my training. And then the second phase would have been my apprenticeship which would have been between ’86 and ’88. I came into that having attended forty births when I started my apprenticeship.

Countercultural ideologies also resonated with other midwives who did not live in back to the land communities. Vicki Van Wagner recalled the profound influence of counterculture ideals on her inspiration to practice midwifery. Her confidence to learn outside of formal institutions was influenced by the countercultural ideologies that she absorbed in an alternative high school.

As a high school student I went to an alternative school and I very much adopted the idea that you could learn what you needed to learn if you wanted to learn it. So that gave me the courage to say okay, there is no midwifery school but I know I can learn to do this. It’s just a skill. It’s just a body of knowledge like anything else and I can transform my university studies as much as possible to learn what I need to know about midwifery. The idea of having to be self-taught and to find teachers wherever you might find them didn’t intimidate me. And I think it was very much encouraged by that social context of the late 1960s and throughout the 1970s, the idea of autonomy and freedom and being able to make the world, the idea of changing the world and remaking the world. In the sixties and seventies counterculture, my whole group of friends constantly debated what kind of world we wanted to live in and our responsibility to contribute to creating that world. I still live with that question and that feeling of responsibility. Those are ideas that I really grew up valuing. So when I think of it now, I realize that for all of us who worked illegally it took a lot of self-confidence and it took a lot of inspiration. That was the kind of context that inspired me.

Feminism and the Women’s Health Movement

Several interviewees located the roots of their desire to become midwives in what they saw as midwifery’s compatibility with their feminist identities and politics. Despite the early
dominance of theories that linked motherhood to women’s oppression, second wave feminism politicized childbirth and mothering as sites for female empowerment.\textsuperscript{166} Feminist perspectives on mothering and childbirth expanded and transformed traditionalist and counterculture revivals of home birth and midwifery that valorized essential femininity and nature. In the absence of formal status and standard definitions, midwifery was a mutable concept. The reclamation of midwifery as a nurturing female activity supporting the natural process of birth appealed to aspiring midwives across a spectrum of feminist ideologies.\textsuperscript{167} The evolution and diversification of midwifery paralleled shifts in feminist theory and practice, and shaped and was shaped by feminist discourse on reproduction. Tensions in modern North American midwifery movements regarding essentialism and reproductive rights are well documented, yet midwives of diverse feminist orientations shared a common commitment to women’s empowerment in childbirth.\textsuperscript{168} Midwifery was embraced by feminists who accentuated gender differences and valorized women’s nurturance, both as midwives and mothers. For feminists committed to women’s reproductive rights, including access to contraception and abortion, midwifery symbolized a woman’s right to control her body in childbirth.\textsuperscript{169}

In her narrative of midwifery inspirations, Mary Sharpe noted her involvement in the early women’s movement in New Haven, Connecticut at a time when motherhood was contested within feminism. As a new mother and breast feeding counselor with La Leche League, she envisioned the potential for women’s empowerment in breast feeding and the mother-infant relationship. Sharpe reflected on her internal struggles to reconcile the contradictions between La Leche League’s traditional notions of gender and motherhood with early second wave feminist discourse emphasizing women’s oppression as mothers:

...I began to be involved with women’s rights groups...there was a disconnect between the whole mothering role and the role of the woman who could be free from mothering tasks... it was a real interest of mine to bring these things together which could, or could not, be done successfully through La Leche League work. I think La Leche League was on one hand extremely feminist oriented, woman-centred, family-centred, but was also slightly oppressive…there were some requirements around becoming a La Leche League leader in those days that we would I think be a little bit surprised at right now. It was expected that you would be a stay-at-home mom, whatever that meant.

Sharpe recognized ambiguity in La Leche League’s concept of domestic motherhood, particularly because her volunteer activities encompassed skills that were valued in a professional context. She recalled her engagement in breast feeding support, education and
promotion called on and refined her abilities in teaching, counseling and advocacy. As her La Leche League work extended to the national and international levels, her work expanded to incorporate professional development, public speaking, writing, and organizational lobbying. Her volunteerism did not seemingly contradict her position as a stay-at-home mother because it was carried out in a non-professional context, centering on the mother-infant relationship within the private domestic sphere. Sharpe did not relate how she reconciled these competing ideologies in an era that pre-dated the second wave feminist reclamation of women’s maternal qualities; however, she carried her desire to empower women in their transition to motherhood through caring support and relationship into her work as a midwife. Her reflections give expression to some of the ideological complexities that have been associated with alterative childbirth and parenting movements regarding gender and women’s empowerment.¹⁷⁰

As a young nursing graduate contemplating her future, Helen McDonald also grappled with feminist discourses on motherhood. She wanted to pursue a post-graduate specialty in emergency room (ER) nursing that required a midwifery certificate as a necessary prerequisite. McDonald was initially reluctant to study midwifery as a result of her participation in a “women’s consciousness raising group” during the early woman’s movement in Australia where she learned about feminist theory linking motherhood and oppression. She enrolled in the midwifery certificate program only as a stepping stone to her ER nursing aspirations, but found herself “blown away” by the deep meaning women attached to their experiences of childbirth and becoming mothers. McDonald’s awakening consciousness of the transformative potential of childbirth for women altered her political and professional perspectives on midwifery and paralleled shifts in contemporary feminist analysis that recognized their potential for women’s empowerment in mothering and childbirth.¹⁷¹ She felt inspired to provide a style of care that respected childbearing women’s autonomy and integrity, as she embraced midwifery as consistent with her commitment to feminism and social justice.

Vicki Van Wagner discovered second wave feminism in her late teens as a student at a Toronto alternative high school in the early 1970s. She read feminist critiques of medical care as objectifying and pathologizing women’s bodies. When she was pregnant with her first child in her early twenties, Van Wagner investigated information and services to support her desire for a natural birth. She remembered feeling particularly inspired by early midwifery and feminist
I began to read about some of the counterculture and illegal midwives working at The Farm in Tennessee and in California. One of the books that influenced me the most in terms of my vision of midwifery because it fit in with my emerging feminism was The Birth Book by Raven Lang. I could still probably find the paragraph in that book that said “Midwifery is my political work.” That really appealed to me. That spoke to me very deeply, women having the ability to give birth at home and to be attended by women. As I began to read about the history of midwifery, one of my papers in university was on the history of midwifery and particularly of the rivalry between medicine and midwifery in the late 1800s and the takeover of birth by medicine. I was very fascinated by that and it really spoke to my feminist activism that was growing at that time. I also stumbled across the writings of Barbara Ehrenreich and Deirdre English and the vision that they portrayed of the history of midwifery as a history of feminism and activism. That also really appealed to me. I was searching for a focus for my interest in women’s status in our society and the kind of political oppression that women faced in issues of autonomy, reproductive rights, and women’s bodies. Another strong influence for me was the Boston Women’s Health Book Collective’s Our Bodies, Ourselves. Throughout my career, as a midwife and also as an educator and a researcher, I’ve been very, very interested in the way we think about women’s bodies.

Van Wagner envisioned midwifery as part of a broader movement for women’s reproductive rights that she saw reflected in feminist publications and practices linking midwifery and abortion. She recalled her attraction to midwifery was strengthened by seeing alternative constructs to essentialist norms that dominated early midwifery revival literature and practice:

I was aware as a growing feminist of practices like the Jane Collective in Chicago where women organized themselves to provide illegal abortion services and legal midwives in France providing abortion services. I was also aware of the growth of midwifery as counterculture and feminist movement. Pretty early on I read a PhD thesis by a woman named Sheryl Burt Ruzek called “The Women’s Health Movement.” She drew together all the ideas of the women’s self-help movement, the abortion rights movement and midwifery. She had a lot of foresight I think to be able to link those things because so much of the early midwifery movement was about mothering and breast feeding, what I’d call the more counter-cultural aspects rather than the feminist aspects. I really liked that those things were being drawn together in midwifery.

Van Wagner carried her activist vision of midwifery as a symbol of reproductive control into her work as a midwife, becoming a prominent spokesperson in the Canadian reproductive rights movement of the 1980s and 1990s.
In her narrative of her inspirations, Katrina Kilroy remembered feeling an immediate resonance with midwifery’s woman-centred philosophy of care. She envisioned its “perfect” fit with her “feminist analysis of health care and women’s control over their bodies” and her interest in social justice. She described her coincidental encounter with midwifery as an undergraduate student at Trent University in Peterborough, Ontario in the mid-1980s:

I went to university four years after I finished high school. I was an extreme keener. I went to every talk, event, club you could possibly imagine. I was like a sponge soaking up everything, all these amazing things that were being offered in this university environment. So it was almost by coincidence that I went to a talk that was being given by a woman named Eleanor Barrington who had written a book called *Midwifery is Catching*. It was about how midwifery was being essentially reborn in Canada. She spoke about midwifery, which I had never really heard of before, and showed a film of a home birth. It was really, I mean not to be too corny, but it was really an epiphany. I was in second year university, I was studying international development, and I was sitting in the audience and it was just like, “That is what I want to do. Yes, that is what I want to do.”

Kilroy’s memory of her “epiphany” for midwifery is expressed in the narratives of other North American midwives and is consistent with the dominant representation of midwifery as a calling. She investigated international training programs but concluded they were unaffordable for her. She looked into local opportunities for apprentice training but discovered they were limited in number and financially inaccessible as she needed to be self-supporting. Kilroy enrolled in a master’s program in international development following completion of her baccalaureate degree because of the availability of scholarship funding, yet she remained uncertain about her academic future. She remembered her partner’s encouragement helped to crystallize her motivation to pursue midwifery:

I had completed my course work and was struggling with the thesis topic for a variety of reasons. And I remember in the summertime after I had finished my course work, sitting on a beach with my now partner and saying, “You know, I don’t know what to do. Should I go back? Should I finish my thesis? What should I do?” And he just said “You know you want to be a midwife. You should just do something that will help you to do that.”

Kilroy read advice literature on how to become a midwife in midwifery texts and newsletters that included the suggestion to do volunteer work in a women’s health clinic. She contacted a community abortion clinic in Toronto to volunteer her services and was surprised to be offered a paid position as a counselor. Kilroy remembered this experience as teaching her about women’s health, both from a clinical and a political perspective:
One of the things that was listed in a publication I found called *Becoming a Midwife* in terms of steps you could take was to volunteer at a local women’s health centre. We didn’t really have any women’s health centres per se in Toronto then but there was a woman-centered, kind of feminist, free standing abortion clinic that had opened recently in Toronto that I knew about. So I went to their office to volunteer and thought okay, maybe I can just be involved in women’s health in some way. And when I went and spoke to the executive director there or administrator, I can’t remember what her title was, for a little while about my interests and my background and she said, “You know, we’re hiring people. We’re hiring counselors. Why don’t you apply for the job?” So I applied for a job as a counselor in a free standing abortion clinic and I actually got that job. I worked there for two and a half years. So that was pre-abortion counseling and bedside operating room counseling of women who were having the procedure done under a local anesthetic. So I really learned an immense amount in that work about a whole bunch of things, some of them very technical health care related things, some of them about health care, some of them about feminist politics. It was a real opportunity to learn a lot.

*Midwifery Movements and Activism*

American Midwifery

Modern revivals of home birth and midwifery were first evident in the United States in the early 1970s, pre-dating and influencing similar movements in Canada. The early American midwifery movement contributed leaders with a presence in Canada, accessible routes for clinical and theoretical preparation, and a growing body of literature that was informative and instructive to aspiring midwives. In 1982, a North American midwifery organization was founded by American midwives that incorporated midwives with formal and informal backgrounds and facilitated communication between American and Canadian midwives. The Midwives Alliance of North American (MANA) developed training and practice standards that were formally adopted by the Association of Ontario Midwives in 1985.

Several interviewees spoke of the key influence of American midwives who were present in Ontario during the formative years of the Ontario midwifery revival, women who shared their knowledge and skills as conference speakers or workshop leaders. In Toronto in the late 1970s, Mary Sharpe was attending home births with several family physicians who offered home birth services in Toronto, providing “support work” for women in labour. She recalled a “defining moment” in her decision to pursue midwifery training when, in 1978, she found herself at a home birth as the “sole care giver.” Sharpe recalled: “The doctor arrived after the baby was
born and I thought if I’m going to be putting myself into this position I really should get more training.” Sharpe remembered the inspirational impact of a talk given by American lay midwife Shari Daniels at a meeting organized by the Home Birth Task Force in May 1978 on her decision to pursue midwifery training. She explained that Daniels encouraged women who were attending births as labour coaches and as labour assistants to home birth physicians to think of themselves as midwives. Daniels ran a freestanding birthing centre in El Paso, Texas that was regulated by a local city ordinance, serving women who sought care outside the formal health care system. Daniels’ clinic, The Maternity Centre, was one of several midwifery run clinics in El Paso that served a large population of Mexican women who crossed the border to give birth in the United States and who did not have access to American health care. These clinics operated as training centres for aspiring midwives seeking structured opportunities for clinical training. These opportunities were relatively accessible and affordable at time when access to midwifery education in Canada was limited or absent.

For those interviewees who entered midwifery in the late 1980s and early 1990s, midwifery had become a more organized movement in Ontario. Although apprenticeship training opportunities were more readily available, first with home birth physicians and later with practicing midwives, these opportunities remained limited in the pre-legislation decades. International training programs were also not easily accessible for Canadians and often required a nursing credential. As a result, intensive American clinical training opportunities remained a popular route of midwifery preparation for aspiring Ontario midwives in the pre-legislation decades. They also provided clinical intensive practice opportunities for Ontario practicing midwives with limited clinical caseloads, especially those working in rural areas, who felt the need to supplement their clinical experience.

Katrina Kilroy met several practicing midwives working at the abortion clinic where she was working as a counselor in the late 1980s. These midwives were working at the clinic as nurses or counselors to supplement their midwifery incomes, including one who had recently returned from a training program in El Paso, Texas. Aware that midwifery legislation was forthcoming in Ontario, Kilroy contemplated whether she should pursue midwifery training prior to legislative change or wait for the establishment of a formal midwifery education program. She recalled that, at that time, Ontario midwives were reluctant to offer apprenticeships because they wanted to consolidate their own clinical experience to meet eligibility requirements for a government
sponsored pre-registration program for Ontario practitioners that was in the planning stages. Kilroy decided she could afford to attend an intensive training program to contemplate whether midwifery was a suitable career choice for her and she applied to a six-month program at an El Paso midwifery clinic. She remembered feeling motivated by the uncertainty of how midwifery’s legal reform would unfold in Ontario: “I just wanted to do it. I was sick of waiting and had some money saved from my job.” Kilroy hoped her experience would help to facilitate her acceptance to a formal midwifery education program that was being planned for Ontario, if she still felt committed to becoming a midwife after attending the intensive program. She remembered feeling “shocked and thrilled” when she was still in Texas to be contacted by Ontario midwife Michelle Kryzanuskas with an offer to join her midwifery practice.

American childbirth and midwifery literature also played an important role in informing and inspiring aspiring Ontario midwives. Critiques of medically-managed childbirth and the promotion of home birth and midwifery alternatives were voiced in a growing body of American childbirth literature by the early 1970s. These publications offered critical perspectives on the “medicalization” of childbirth and disseminated knowledge about American practices of home birth and midwifery that reached beyond the borders of the United States. In their narratives of their inspirations and motivations, many interviewees referred to common publications that have since become classic texts of modern North American midwifery, many of which remain in print today. Guides to midwifery authored by practicing midwives provided detailed instructions on how to practice midwifery and represented educational and practical texts for many interviewees, particularly those who practiced without access to clinical training opportunities.

Heather Burton remembered feeling “revolutionized” about alternatives to normative medically-managed childbirth by reading newly published popular childbirth literature in her first pregnancy in 1977. Following the birth of her son where she “had to really, really fight just to be allowed to have a baby without drugs,” she was inspired to become a midwife. Like other interviewees, Burton first became a childbirth educator and attended births in hospitals as a “labour coach” for several years before practicing as a midwife. She relied on American midwifery texts in her self-study and preparation for practice. Burton recalled that she “just started to practice” midwifery in the late 1970s in west Toronto and Mississauga, feeling confident that her theoretical knowledge and her clinical experience attending births were sufficiently “amalgamated.” While the number of family physicians providing home birth
services had declined by this time in response to official statements on the dangers of home birth by Ontario medical organizations, the midwifery community was becoming more visible and organized. Burton recalled that although she “never did a formal apprenticeship because there weren’t many midwives” in Ontario at that time, she was able to form supportive alliances for clinical back up with several other midwives who had begun to practice in the Toronto area. She also formed an arrangement for medical back up with a local family physician who had previously attended home births in her community. Trained in the Netherlands where home birth was commonplace, he was comfortable with home birth.

Like Burton, Michelle Kryzanauskas pursued her midwifery aspirations through a program of self-study, relying on American teaching resources. She developed an interest in home birth and midwifery in the late 1970s while contemplating her first pregnancy. Home birth and midwifery services were not available in the Grey, Bruce and Simcoe regions of central Ontario where she lived. Following her daughter’s birth in hospital with a family physician, Kryzanauskas was inspired to pursue midwifery to fill this gap in services, but she was also determined to not leave her family or community for training. She was able to access outdated British and American midwifery and medical texts before discovering the Apprentice Academics Midwifery Home Study Course, a popular American self-study correspondence program for theoretical midwifery preparation founded in 1981 that did not provide a formal credential. Kryzanauskas teamed up with another aspiring midwife in her community and found it easier to stay motivated in the correspondence program by studying with a partner. She reflected on their difficulty accessing educational and professional literature in their local community during the pre-internet era:

I read Williams Obstetrics cover to cover, Varney’s Midwifery cover to cover, did the Apprentice Academics modules…There wasn’t a lot of online learning you could do in those days. It was just text and sitting at a desk. There wasn’t the access to the kind of research we can get now. The local hospital wouldn’t even let us use their health sciences library. They didn’t want anything to do with midwives. We had just gotten kicked out of the Collingwood hospital where we sometimes attended births in a support role for women. The hospital board changed and they weren’t supportive of midwives.

Kryzanauskas and her midwifery partner began to attend births together, applying their theoretical knowledge and learning to clinical opportunities. They made connections with two
internationally trained midwives who were attending home births to request their mentorship, a Dutch trained midwife working in Barrie and a British trained midwife in Huntsville.

Ontario Midwifery

The emergence of home birth and midwifery movements in 1970s Ontario paralleled similar movements in other parts of Canada. Midwifery in Canada became increasingly visible and organized in the last two decades of the twentieth century. Throughout the 1980s, provincial professional and consumer midwifery organizations were founded and there was evidence of growing public and government interest in provincial regulation in a number of Canadian provinces and territories. In 1981, a midwifery conference was held in Elora, Ontario that drew midwives together from across Canada and the United States. Starting in 1984, the Association of Ontario Midwives held annual conferences and published a quarterly newsletter with the provincial consumer organization that facilitated communication and networking among members. With growth and organization over the 1980s and early 1990s, Ontario midwifery acquired a public profile in the news and popular media and garnered government interest in regulation.

The growing visibility and organization of Ontario midwifery helped to inform and spark interest from a wider public, outside the midwifery community. Carol Cameron had just become a new mother in the mid-1980s when she learned about Ontario midwifery from local media coverage. She remembered feeling an immediate attraction to midwifery. She traced the evolution of her interest in midwifery, from consumer advocate to aspiring midwife:

I started reading about lay midwifery and what midwives were trying to do… It just seemed like something I wanted to support and through that discovered that I actually thought I could actually be a practitioner. I joined the consumer organization, the Midwifery Task Force. I started a chapter group in my community. I was teaching childbirth classes, writing articles for local newspapers. It was a really busy year. I got really spurred on by it.

Cameron related her persistence and success in arranging apprenticeship training with a midwife practicing in her community:

...immediately after my first birth, almost immediately, and I was just really caught up in this whole birth thing… I contacted her and she said she thought, “Like what is with this person calling me?” And I kept calling her and bugging her and finally she said she thought I’d just do something on my own anyway so she may as well help me. That was her attitude. So we
Evelyn Cressman was familiar with the revival of midwifery in Ontario as an unofficial practice. She had the opportunity to see her aunt, Elsie Cressman, evolve from a registered nurse to an alegal midwifery practitioner. She observed the growth of Elsie’s midwifery practice over the 1980s in their home community of Kitchener-Waterloo and saw, first hand, the realities of practicing outside the health care system. Evelyn herself was a registered nurse and was content working in the local hospital and as a mission nurse in international settings. She recalled being asked by Elsie to assist at home births, which she did from time to time, but, despite her aunt’s encouragement, she remained reluctant to take up midwifery in an ambiguous legal context. Eventually, Evelyn grew frustrated with the fragmented maternity care system she was a part of and she felt inspired to provide the continuity of care that was a hallmark principle of Ontario midwifery practice. She first felt the need to attend a formal midwifery program, enrolling in a British program for credentialed nurses. As midwifery legislation was becoming imminent, she took the leap into Ontario midwifery practice in the early 1990s, working alongside Elsie and her midwifery practice partners.

For Judy Rogers, her decision to practice in Ontario was motivated by her family’s decision to move to Canada in 1990 and her desire to continue to practice a community-based model of midwifery that she had pursued in England following her formal training as a direct entry midwife. As a student midwife, Rogers co-founded the Association of Radical Midwives in 1976. This organization advocated for maternity care reforms that were similar to those that lay at the foundation of midwifery’s revival in North America, including respect for normal birth, women’s self determination in childbirth, continuity of care provider, choice of birth place and greater autonomy for the midwifery profession. Both Rogers and Tyson were active members of this organization as students and later, following graduation, while working as “state certified midwives.” Rogers considered settling in British Columbia or Ontario, two provinces with active practices and organizations for midwifery, but in the end decided to move to Ontario where the process for legal reform was more advanced. Rogers explained her desire to see the style of midwifery care that she valued made available to childbearing women in Ontario:

In 1989, I came over to [Canada to] try and scout out what the prospects were. I felt very positive about the Ontario setting. I met with a number of midwives…and it was clear that midwifery was on the way to being legally recognized. I was thrilled that midwives were
working in the model that I had tried to bring about in England, continuity of care, home birth and hospital birth. Then I went to BC because I still really had a desire to live on the west coast and it wasn’t as together there. They weren’t close to legislation. So we decided to move to Ontario and I started working with a local practice, not far from Richmond Hill.

Midwifery Activism

Midwifery emerged in Ontario just prior to a decision by the provincial government to undertake a review of health professions legislation. In 1982, the Ministry of Health formulated a Health Professions Legislation Review (HPLR) that was mandated to make recommendations regarding the regulation of “new” health professions in Ontario, in addition to review of existing legislation. The Ontario Nurse Midwives Association (ONMA) and the Ontario Association of Midwives (OAM) formed a coalition to submit a joint application on behalf of midwifery. Over the period 1981 to 1984, the Midwives Coalition submitted three briefs to the HPLR addressing models for self-regulation and midwifery care and education. The ONMA and the OAM amalgamated into a single organization in 1984, the Association of Ontario Midwives (AOM), to lobby for legislation in collaboration with the recently formed provincial midwifery consumer organization, the Midwifery Task Force of Ontario (MTF-O). In 1986, the Liberal government announced its intention to legalize midwifery and planning was undertaken to determine the structure of Ontario midwifery. The ruling government changed parties several times over the subsequent eight years, creating uncertainty about the legislative process for midwifery. By the time the Midwifery Act was proclaimed in 1993, midwives and midwifery supporters had been involved for over a decade in an intense lobby campaign for legislation and a community-based, woman-centred model of regulated midwifery, both locally and on a provincial level.

Scottish-trained midwife Rena Porteous identified her participation in Ontario midwifery organizing and lobbying as inspiring her re-entry into practice as an alegal practitioner. Because her formal midwifery credentials from Scotland were not recognized when she immigrated to Canada in the late 1960s, she worked as a nurse in the labour and delivery unit. Disillusioned with obstetrical nursing in the Ontario maternity care system, she became a home visiting nurse with the Victorian Order of Nurses caring for the chronically or terminally ill. Porteous joined the ONMA that had formed in the early 1970s. She described the group as “a very small group of mainly British trained midwives who were nurses, most of whom had worked in the mission
field in Africa and India and were retired” who met to discuss Canadian maternity care and the potential for the introduction of midwifery. She met Elsie Cressman who was a member of the group and shared her interest in creating a midwifery alternative in Ontario; however, she was unaware of Cressman’s Ontario midwifery practice. Porteous characterized the ONMA’s interest in midwifery as a “hobby” and “an article of faith” that midwifery was worthy for legal recognition in Ontario without the impetus to actualize this goal. She remembered “there wasn’t a lot of energy in that group” and their commitment to advocacy or activism at a policy level was limited, even though the members wanted to see the implementation of a nurse-midwifery system based on the British model of education and practice.192

The ONMA’s role in advocacy for midwifery legislation changed in the early 1980s. This was a politically active time for midwifery in Ontario. Public interest in humanizing childbirth was growing and policy makers contemplated the integration of midwifery into the health care system.193 In 1982, the Ontario government initiated a review of provincial legislation governing health professions and invited submissions from groups interested in health professional regulation. The ONMA was invited to make a submission addressing the regulation of midwifery to the Health Profession Legislation Review (HPLR) on behalf of the nursing profession. Porteous commented on the broad scope of inquiry in the HPLR process and the ONMA’s hesitation to participate with the group of unofficial midwifery practitioners:194

...everybody and their dog was invited to make an application submission for it. I mean it was just so open. There were church groups. There were just all sorts of, just vaguely linked people that were putting submissions in on every aspect of health care. And we sort of sat and looked at one another and said, “What are we going to do? We have a choice here. We hardly know one another but we have a choice. We can either just commit to working on a submission on midwifery because this opportunity doesn’t come along very often or not. And if we don’t, someone else will.”

According to Porteous, the Registered Nurses Association of Ontario (RNAO) recognized the ONMA as a special interest group in the early 1980s to increase its profile across its membership and build momentum for the legislative review process. Porteous was energized to participate in the ONMA’s lobbying activities because of her enduring passion for midwifery as centred on normal birth and her desire to reform the interventionist approach to birth that dominated the Ontario health care system. She recalled her first encounter with a representatives from the
OAM who were practicing midwives working without legal status, some of whom did not have formal training, who “just turned up” at an ONMA meeting:

The RNAO was having their annual conference. I think it was the late ‘70s or early ‘80s. The ONMA managed to get a meeting room which we didn’t have to pay for. We decided we would just put it out there that we were having this little meeting for anybody who was interested in midwifery. And actually most of the people who showed up were people who weren’t members. They were practicing midwives in the Toronto area. I’m not sure how they found out about it but they were the ones who appeared to talk with us and it was really interesting. You know, just that first conversation.

Porteous’ portrait of the midwives’ youthful enthusiasm and their activist commitment to a community-based, self-regulating model for midwifery stood in stark contrast to her portrait of the muted energy of the ONMA and its narrow vision of a British institutionally-based nursing model for midwifery. She reflected on the expansion of her understanding of midwifery as a specialty of nursing to an autonomous profession:

The ONMA members felt midwifery legislation was a great idea but they were thinking British midwifery. You know, we all are what we’ve come from and that was what we knew. I’ve often wondered about that because it took me quite a while to really grasp the type of midwifery that was being thought about and spoken about here as we started to meet with the women who were practicing as midwives in Ontario. And I’ve often wondered why did I, coming from my background which was terribly British, make that change. I realized a long time later that for quite a while I believed that you really did need to have a nursing background to get that fundamental stuff and then you went on to do midwifery... in Scotland midwives were still regulated separately from nurses. I think it was the fact that they were regulated separately that gave me the split in my own mind that made me able, on some level, to think of nurses and midwives as not exactly being the same. So it opened me a little bit to that concept. And I remember the shock when the penny finally dropped that we really were talking about people being midwives who had no nursing background…I suddenly thought, “Yes, okay, now I really get it.”

Porteous became deeply engaged in the political movement for Ontario midwifery legislation with the evolving collaboration between the ONMA and OAM in the face of the HPLR process. She reflected on how the two groups negotiated their different visions for midwifery:

We sort of sat and looked at one another and said, “What are we going to do? We have a choice here. We hardly know one another but we do have a choice. We can either just commit to working on a submission on midwifery because this opportunity doesn’t come along very often or not. And if we don’t, someone else will...let’s take a deep breath and say okay, let’s do this and see what happens.” We had agreement that we would work together on
a submission. If we were really in agreement, we would sign the one submission and put it in. If there was just some disagreement about some things we’d footnote it. And if we were really separate on a number of things, we’d separate it out and do two different submissions. And that’s how we went forward...In fact, I was president of the ONMA by that time. I had decided that if they didn’t start to be a bit more active that I would probably leave that and join the other group. But it so happened that as we got working, there were a couple of other people in the ONMA who were interested in working together with the OAM. But it all became just too different and too radical for some and one member decided, “This is not the way to go. I don’t agree with this” and so that was that. And another stayed on quite a bit longer but finally ended up not really being active. I managed to convince the ONMA to pass some kind of constitutional changes to merge with the OAM so that the two organizations would become one. And for me this was political. We knew the significance of having formally trained midwives in the same organization as informally trained midwives... everybody had their own route to midwifery in the other group. Some were formally trained elsewhere. Some were apprentice trained and so on. But to come together as one organization made an incredibly important statement, because others like doctors or nurses would say, “Oh well these people, they’re just coming out of the woodwork and saying they’re midwives and it’s just awful and it’s shocking and it’s not safe.” But here we were, as midwives who were qualified and formally recognized, saying “Actually no. It’s perfectly fine because we know the standards to which these people are functioning and all of that stuff.” That message was very, very important. It was I think one of the really important things that helped us to move forward. And so we worked on the submissions together.

Porteous assumed a symbolically important role in the amalgamation of the nurse midwives association and the community midwives association in 1984 as a formally trained nurse and midwife, becoming the first president of the AOM. After several years of active participation in midwifery organizing and lobbying, Porteous was challenged by her close colleagues on the AOM Board of Directors to “put her politics into action” by taking up midwifery practice. She remembered, feeling buoyed by her partner’s “sensible” support when he suggested they “put the house in his name” as they contemplated the risks of a legal practice. Porteous reflected on her decision to take up practice, capturing some of the contradictions inherent in practicing on the margins of official health care and the law:

My dear friends had a little midwife encounter with me and said, “You know, Rena. You’re the president of the association and we were just thinking that maybe it’s time you went back to practice midwifery because it doesn’t look so good when you don’t practice”...At the time it seemed like a good idea. So I thought, “Yeah. Why not? That’s great.” So it was the bravest thing I’ve ever done in my life because there was nobody else around. I’d been out of it for a good number of years but I did have my hospital experience in obstetrics to draw on...I
always felt a bit of a fraud when I was doing these other nursing things because I never saw
myself as a nurse. I almost felt I was in sort of some kind of a disguise, like a fifth column. It
wasn’t what I enjoyed doing. It wasn’t where I wanted to be. And I was so envious. It’s
really quite shocking, but I was so envious of these women in Toronto who were able to
group together and work together and support one another. That supportive environment that
they developed was something that I just envied so much. So that’s what made it hard
because I didn’t have anybody here to bolster my courage or to say, “Of course we can do it
Rena. Come on. Let’s go.” That was the hard bit. But the thing that made me want to do it
was I saw how it worked. I saw how the other midwives worked. I saw the joy that they got
out of it and that the women got… I really wanted that. I wanted it so badly I could taste it.

Holliday Tyson’s decision to take up a legal practice in Ontario in the early to mid-1980s
followed her formal midwifery training in England and a period of overseas practice in Africa
and in India. Her plans to continue in international midwifery work were interrupted by a family
crisis, resulting in her return to Canada. Her exposure to systems of health care that recognized
midwives as specialists in normal birth fuelled her critique of medical and technological
interventions in childbirth that dominated Canadian maternity care:

I found midwifery so compelling and the whole scene that was happening in Canada. It hit
me that it was completely absurd and obscene that, for no good reason, we had this high
cesarean section rate and we were doing episiotomies on everybody. We were taking away
anyone’s chance to just have a normal birth or normally breast feed or feel like birth was
normal. That for me seemed really compelling to fix. So from that point on, I didn’t really
look back. That would have been 1984. I knew I wanted to have this other stream opened to
me to work internationally but I also knew now that I was focused on working for midwifery
in Ontario.

Tyson felt politicized by the growing midwifery movement in Ontario and became committed to
working for midwifery’s legal recognition so that women in Ontario could have the option of
midwifery care. Tyson reflected on the debates about legal reform that were present in the
Ontario midwifery community in the early 1980s, emphasizing her commitment to a system
that valued normal birth:

It seemed to me that as imperfect as any legislated, publicly funded system for midwifery
might be, it would be far preferable to the monopoly and craziness of hospitals and doctors on
childbirth….I think it’s the right thing to do to promote normal…It seems clear that even
when you take away intervention for profit’s sake, you still get intervention just for control’s
sake. Even amongst really well meaning physicians you had this complete pathologizing of
birth…I wanted to at least be a drop in the other bucket of water. I wanted to be against
intervention and control.
Cameron also identified “midwifery politics” as central to her midwifery aspirations. At the time Cameron became interested and involved in midwifery, the provincial organizations representing midwives and midwifery consumers were well established. The AOM had assumed the dual roles of a professional organization and a voluntary regulatory body with educational and practice standards. Cameron described her ability to seamlessly enter into midwifery political activities:

I was attracted to the politics to be honest. I was interested in the legislative changes and the politics, being involved in helping that… I started going to meetings. They were all over the place. I was just really absorbing and listening at first. It was already a well-oiled machine in many ways by the time I came. I certainly wasn’t one of the people who created the impetus for legislation. But I quickly got involved and got on board and I think I contributed in a meaningful way. I got on various committees and I actually ended up being on a funding committee. I helped around the strategy moving forward with funding and negotiation. I remember all those meetings and Getting to Yes. We had to get to read that and all those meetings with lawyers. Anyway, it was just fascinating. Like a lot of people, I did a lot of work at that time and it was really important work. I’m glad I did it. It was a lot of work at the time and I just got more and more involved in the AOM in a more formal capacity as time went on.

The interviewees’ narratives show a profound influence of the progressive social movements of the mid-century. For many, their inspirations to practice alegal midwifery was rooted in belief systems connected with the counterculture movement, which led them to value a more “natural” approach to birth consistent with a “back to the land” life style and which valued self-sufficiency and questioned authority. Feminisms provided inspiration for interviewees who saw midwifery as connected with a valuing of essential female qualities and, simultaneously or alternately, as part of an activist reproductive rights movement that promoted self-care, choice and autonomy. For many of these interviewees, practicing without legal sanction was a political stance seen to be consistent with their ideals and identities as members of movements for social change. The growing political movement for midwifery that accompanied the growth of alegal practice began to act as an inspirational force for new alegal midwives who were inspired by midwifery itself as a social movement for change in the lives of women.

The midwife interviewees described complex and multi-layered experiences that inspired and motivated their decisions to become midwives and to practice in the modern Ontario revival
prior to midwifery legislation, ones that cross childhood, adolescence and adulthood. Many of the midwife interviewees spoke of inspirations that pre-dated or lay outside the Ontario midwifery revival. Several traced their interest in childbirth and midwifery to early life experiences. Others came to midwifery through their active engagement in childbirth reform movements of the late twentieth century that stressed natural childbirth, home birth and midwifery. While the women who became mothers prior to becoming midwives commonly located their inspirations within their own childbearing experiences, as is commonly understood in North American midwifery literature, they also spoke of motivations that were distinct from their embodied experiences of pregnancy, childbirth and motherhood. Midwives who were not mothers when they began midwifery work similarly found inspiration and intense meaning in the process of birth. Midwives who were nurses first described the influential role of their nursing backgrounds to their decisions to practice midwifery in the pre-legislation decades in Ontario. Most of the interviewees were influenced by the ideologies of contemporary social movements that reconfigured discourses on health and the body. Some midwives were inspired by the questioning of social norms of mainstream society and the valorization of “natural” ways of living inherent in counterculture and back to the land movements. Many of the interviewees spoke of the influence of emerging second wave feminism and women’s health movements on their vision of midwifery as integral to women’s reproductive control and empowerment. Several of the interviewees described the passion that they felt for participating in a political movement for midwifery’s legal recognition. Analysis of the midwives’ narratives also reveals their common desire to provide an alternative approach to the medical management of childbirth that dominated women’s experience in late twentieth century Canada. Most of the interviewees described a keen sense of agency in their active pursuit of midwifery work despite legal and practical barriers that were led by and responsive to the needs of the childbearing woman. They expressed a shared belief in the transformative power of childbirth practices that respected the physiologic childbirth process and their narratives were infused with a common passion for midwifery and for supporting women in their transition to becoming mothers.

1I was able to locate only one qualitative study that specifically focuses on midwifery inspirations or motivations in a modern North American context. This study examines factors
motivating applicants to seek a career in midwifery through analysis of their written application essays to an American nurse-midwifery program. Although some findings parallel themes from my analyses of the midwifery literature and the interviewees’ narratives, such as calling and personal birth experiences, this study does not allow for a direct comparison. Rather than retrospective reflections on becoming midwives in an uncertain legal environment, this study analyzes application essays to a formal nurse-midwifery program that would prepare applicants for legal practice in mainstream maternity care settings. See Suzan Ulrich, “Applicants to a Nurse-Midwifery Education Program Disclose Factors that Influence Their Career Choice,” *Journal of Midwifery & Women’s Health* 54, no. 2 (March/April 2009): 127-132.

2 Barrington’s *Midwifery is Catching*, one of the first publications describing Canada’s “new” midwifery, features portraits of twelve practicing midwives that mentions factors that motivated their interest in midwifery. Burtch’s examination of midwifery and the law in Canada, *Trials of Labour*, provides a description of pre-legislation practices of Canadian midwives that infers what motivated their commitment to work in ambiguous and tenuous legal settings. Alberta nurse and midwife Alice Ouwkerk’s examination of the emotional and psychological transitions experienced by pre-legislation Alberta midwives in “becoming” midwives touches on their reasons for taking up practice. See “Uniting Vocation and Avocation: Becoming a Midwife in Alberta Prior to Regulation” (master’s thesis, University of Alberta, 1995). Margaret MacDonald’s ethnographic study of Ontario midwifery a decade after regulation incorporates discussion and analysis of midwives’ narratives of their work lives and their pathways into practice. See MacDonald, “What is Midwifery?” chap. 3 in *At Work in the Field of Birth*, 52-92. Recent historical documentation of pre-legislation midwifery movements in other Canadian provinces also touches on how and why midwives entered practice. Quebec midwife Céline Lemay conducted interviews with fifteen midwives about their “lived experiences” working in Quebec prior to the 1999 legalization of midwifery that explores the personal meaning they found in midwifery. See Céline Lemay, “Être là.” The University of British Columbia has established a midwifery archive that houses transcripts and recordings of several oral history interviews with midwives and other inter-professional maternity care providers who were active in the home birth and midwifery revivals in British Columbia that include mention of their motivations to practice. See University of British Columbia Archives, “The B.C. Midwifery Collection/Megan Davies (Collector).” Ontario midwife and midwifery scholar Carol Cameron interviewed midwives who left regulated midwifery practice, most of whom entered the profession in the post-legislation period. Her findings include factors that motivated her interviewees to enter the profession of midwifery. See Carol Cameron, “Becoming and Being a Midwife: A Theoretical Analysis of Why Midwives Leave the Profession,” *Canadian Journal of Midwifery Research and Practice* 10, no. 2 (Summer 2011): 22-28.


4 The link between midwives’ personal birth experiences and their midwifery aspirations is widely infused in American midwifery literature published in the early years of midwifery’s modern re-emergence, as well as in the social science literature on modern North American midwifery.

5 MacDonald, *At Work in the Field of Birth*, 60-65.

6 Shroff, for example, refers to Ontario midwifery as “The Rebirth of an Ancient Calling” in the subtitle of the introduction to her anthology *The New Midwifery*, linking historical and modern traditions of calling in midwifery.


8 See, for example, Arms, *Immaculate Deception*, 155-160; and Burtch, *Trials of Labour*, 139-144.

9 Davis, *Heart and Hands*, 6-7.

10 This can be illustrated in titles of publications, such as The Interdisciplinary Midwifery Task Force Association and the B.C. Association of Midwives, *Midwifery is a Labour of Love: A Sourcebook of Factual and Moral Support for Introducing Quality Midwifery Services to Your Province or State* (Vancouver: Maternal Health Society, 1981); Davis, *Heart and Hands*; and Muhlhahn, *Labour of Love*. The phrase “midwifery is a labour of love” was a commonly used slogan of modern North American midwifery movements. I am aware, from my experience as a
midwife practicing in the decade before midwifery regulation in Ontario, that this phrase was printed on car bumper stickers, t-shirts, and pins. Presently, Ontario midwifery practice groups use maternal analogies in the names of their practice, such as “Caring Hands Midwifery Services” and “Womancare.” See “Find a Midwife,” Association of Ontario Midwives, accessed September 24, 2012, [http://www.ontariomidwives.ca/](http://www.ontariomidwives.ca/).

11 American midwife Penfield Chester notes in the introduction to her anthology of American midwives’ life stories, *Sisters on a Journey*, that the book’s title was inspired by the “theme song” of the Midwives Alliance of North America, a midwifery organization founded in the early 1980s as an alliance of independent and nurse midwives practicing in North America. She sees the title as symbolic of the links between historical and modern traditions of midwifery in America. Prominent midwifery author and American sociologist Barbara Katz Rothman uses the phrase “daughters of time” to refer to modern midwives and their connection to historical traditions of midwifery in “The Daughters of Time.”


15 Davis, *Heart and Hands*, 2.

16 The link between midwifery and women’s reproductive rights was made in the early years of the midwifery revival by social scientists and midwifery practitioners such as Lang, *Birth Book*; Ruzek, *The Women’s Health Movement*; and Rothman, *In Labour*.

17 Diverse practices of midwifery that emerged in late twentieth century North America as counter practices to medically-managed childbirth embodied principles of support for the normal process of birth, respect for women’s informed health care decision making, continuity of care provider, and choice of birth place in hospital and out-of-hospital settings. For a detailed discussion of the philosophic foundations of “community” midwifery in Canadian and international contexts, see Van Wagner, “With Women.”

18 Barrington, *Midwifery is Catching*, 41.

19 Ibid., 42.
20 Ibid., 13

21 See note 29 above in Chapter 1.


23 Ibid., 5.


25 MacDonald refers to Bourgeault’s theories described in *Push!* regarding the impact of midwifery regulation on the relationship between midwives and the women in their care in *At Work in the Field of Birth*, 82.


Mainstreaming Midwives edited by Davis-Floyd and Johnson provides a multifaceted social analysis of the debates and activities for the recognition of direct entry midwifery in various regions of North America.

For example, Canadian sociologists Pat Armstrong and Hugh Armstrong present midwifery’s integration into the Ontario health care system as an example of successful health care reform in Wasting Away: The Undermining of Canadian Health Care (Toronto: Oxford University Press, 1986); and Women, Privatization and Health Care Reform: The Ontario Case (Toronto: National Network on Environments and Women’s Health, 2006), 27-28.


Daviss also notes that Canadian midwives were more closely aligned to feminism than “spiritual enlightenment” as compared to their American counterparts who were more likely to embrace new age spirituality. In, “Reforming Birth and (Re)Making Midwifery in North America,” in De Vries, Benoit, Van Teijlingen, and Wrede, Birth by Design, 81.

MacDonald, “What is Midwifery?” chap. 3 in At Work in the Field of Birth, 52-92.

Mason presents a dichotomous portrait of midwives divided along lines of their relationship to childbearing women versus the state in her critical analysis of the regulation and integration of midwifery into the Ontario health care system in The Trouble with Licensing Midwives. Her binary of “counter-culture midwives” and “state-employed midwives” mirrors Bourgeault’s non-elite/elite binary of midwives that has become a common narrative in critical scholarship on the professionalization of Ontario midwifery. For a detailed discussion of a hierarchical structure of elite and non-elite in the Ontario midwifery community, see Bourgeault, Push!, 262-266.

Ibid., 82.

A popular childbirth and parenting magazine in the pre-legislation period published a critical commentary on the legalization of midwifery in Ontario that associated regulated midwifery with
male obstetrics and lesbian identity. Magazine editor and author Catherine Young described politically engaged midwives as “a small cliquish body of obstetric midwives who now has [the Emperor] wearing hob-nailed boots,” with reference to the Hans Christian Andersen fairy tale *The Emperor’s New Clothes*. She reflected on midwifery’s integration into the hospital system with the statement: “It will be a grim statistic when three Mamas go into a maternity hospital where the issue of control is wrestled from the hands of the female head nurse/male obstetrician into the iron hands of the lesbian midwife-in-charge. Catherine Young, no title, *The Compleat Mother* (Summer 1994): 4.


39 MacDonald and Bourgeault, “Birth Models that Work.”


41 Margaret MacDonald discusses scholarly interpretations and debates about the application of this concept of hybridity to midwifery in *At Work in the Field of Birth*, 86-87.

42 Helen Lenskyj argues for midwifery advocates to recognize the importance of allowing for difference and diversity among midwives and midwifery consumers, rather than “cling to exclusionary and essentialist notions of woman as mother or woman as midwife,” in “A ‘Natural’ Calling?”

43 Women’s work force participation in Canada was concentrated in the female helping professions of nursing and teaching well into the 1970s. Nursing continues to be the most dominate health profession for women as reported in Brandt et al., *Canadian Women*, 443-447, 501.

44 Margaret MacDonald describes the iconic symbol of the frontier midwife in *At Work in the Field of Birth*, 71-72.

For a discussion of the dominance of medical routines and interventions in the interwar and post-World War II periods in North America, see Wertz and Wertz, Lying-In, 165-173; and Mitchinson, conclusion in Giving Birth in Canada, 298-306.

The term “elderly multip” used by Teevan refers to a pregnant woman in her later childbearing years who has previously given birth. Multip is a contraction of the word multipara, with multi meaning more than one and para referring to births. Obstetrical literature often refers to the increased risk of complications for older pregnant women, often defined as over thirty-five years of age.


MacDonald explores the themes of “nature, tradition, and home” in her anthropological analysis of Ontario midwifery in At Work in the Field of Birth.


Tyson is referring to the Daniel McLaughlin-Harris inquest, one of the court proceedings involving pre-legislation midwives that Burtch refers to in his study of midwifery and the law in Canada prior to midwifery regulation, Trials of Labour. This inquest is recognized as having a significant impact on the Ontario government’s commitment to legalize midwifery in 1986, as noted by Bourgeault in Push!, 107-109.


Mona Gleason, Normalizing the Ideal.

Linda M. Blum, “From Sacred to Disembodied Motherhood: Breastfeeding with the Experts and the State,” chap. 2 in At the Breast: Ideologies of Breastfeeding and Motherhood in the Contemporary United States (Boston: Beacon Press, 1999), 19-62.


Leavitt, *Make Room for Daddy*.


Dr. Herbert Thoms, chair of the Department of Obstetrics and Gynecology at the Yale University School of Medicine in the second half of the 1940s, was a leading proponent of natural childbirth in the United States. Thoms introduced programs in natural childbirth at the Yale-New Haven Hospital where Sharpe gave birth. See Herbert Thoms and Robert H. Wyatt, “A Natural Childbirth Program,” *American Journal of Public Health* 40, no. 7 (July 1950): 787-791.

Yale University Pediatrician Edith B. Jackson was a prominent advocate of infant rooming-in. She worked with Thoms at the Yale-New Have Hospital to establish rooming-in policies and practices. See Sarah Lee Silberman, “Pioneering in Family-Centre Maternity and Infant Care: Edith B. Jackson and the Yale Rooming-In Research Project,” *Bulletin of the History of Medicine* 64, no. 2 (Summer 1990): 262-287; and Elizabeth Temkin, “Rooming-In: Redesigning Hospitals and Motherhood in Cold War America,” *Bulletin of the History of Medicine* 76, no. 2 (Summer 2002): 271-298.


69 Leslie noted the formative influence of Suzanne Arms’ *Immaculate Deception* to her critical perspective of medical childbirth practices and Gaskin’s *Spiritual Midwifery* to her understanding of lay childbirth alternatives. She was also influenced by feminist theories of female empowerment in childbirth and midwifery as a woman-centred alternative that she read in publications of the emerging American women’s health movement, such as the Boston Women’s Health Book Collective’s *Our Bodies, Ourselves: A Book By and For Women* (New York: Simon & Schuster, 1973).

70 Judy Rogers is one of the interviewees in this thesis research study.

71 Pre-regulation midwifery practice in Alberta is described by Susan James in “Regulation: Changing the Face of Midwifery?” in Shroff, *The New Midwifery*, 181-200.

72 Barrington lists midwifery organizations that existed in Canada in the mid-1980s, including CAPSAC, in an appendix in *Midwifery is Catching*. See, “How to Find a Midwife (or make contact with the midwifery community),” 68-174.


74 Barrington notes home birth and midwifery were first evident in British Columbia in the early to mid-1970s and in Ontario by the end of the decade in *Midwifery is Catching*, 12, 34-38.


76 Fynes describes the practices of home birth doctors in the early years of the Ontario home birth revival in ibid., 65-67.

77 *Spiritual Midwifery* was the first lay midwifery publication in the modern North American practice revival. It provides detailed instructions on how to practice midwifery without formal training. Half of the book relates stories of childbirth that took place in the rural Tennessee counterculture community of The Farm that Gaskin founded with her partner and the
community’s spiritual leader, Stephen Gaskin. The other half of the book provides detailed instructions on how to practice midwifery. See Gaskin, “Instructions to Midwives,” part III in *Spiritual Midwifery*.

78 Barrington, *Midwifery is Catching*, 171.

79 See note 100 above in Chapter 2.

80 Daviss comments on the role of childbirth education organizations in the evolution of North American “alternative birth movement[s]” in “Reforming Birth and (Re)-making Midwifery,” 75-76.

81 At the time of the midwifery’s modern emergence in Ontario, a professional childbirth support person was referred to as a “labour coach.” Many of the interviewees spoke of providing labour coaching services to women giving birth in hospital under the care of a physician before the regulation and integration of midwifery into the hospital setting. The term “doula” is now widely used in North America to refer to a person hired to provide support to childbearing women.


84 Blum, “‘Mother to Mother’ in La Leche League,” chap. 3 in *At the Breast*, 63-107.

85 Blum explores contemporary American breast feeding and mothering ideologies in relation to feminism in *At the Breast*. Hausman describes the ambivalent relationship between feminist and breast feeding activists, that Sharpe expressed, in “Breastfeeding, Feminism, Activism,” chap. 6 in *Mother’s Milk*, 189-228. Canadian historian Deborah Gorham and sociologist Florence Kellner Andrews examine La Leche League from a feminist perspective, highlighting the complexity of the reclamation and valorization of breast feeding in relation to feminist ideologies in "The La Leche League: A Feminist Perspective."

86 See, for example, Barrington, *Midwifery is Catching*, 42; and Bourgeault, “Delivering Midwifery,” 36-37, 130.

87 Fynes, “The Legitimation of Midwifery,” 68.

88 Ibid., 68-71; and Bourgeault, *Push!*, 69.


For an historical overview of the Frontier Nursing Service, see Nancy Schrom Dye, “Mary Breckinridge.”

In her historical overview of Canadian midwifery, M. Joyce Relyea describes three post-diploma nursing programs with specialized training in primary maternity care that were developed in postwar Canada for the care of childbearing women in remote and isolated regions. See “The Rebirth of Midwifery in Canada: An Historical Perspective,” *Midwifery* 8, no. 4 (December 1992): 164.

Barrington documents demand for midwifery services in the Kitchener-Waterloo region of Ontario by the late 1970s in *Midwifery is Catching*, 94.

See note 83 above in Chapter 2.

Joan C. Macdonald, Executive Director, College of Nurses of Ontario, letter to Elsie Cressman, September 9, 1981.

Elsie Cressman, letter to Joan C. Macdonald, October 27, 1981.

Canadian historian Marlene Epp has documented the extensive histories of midwifery and mission work in Canadian Mennonite communities and their relationship to traditional values of family, duty and service. See the Bibliography for a listing of Epp’s work.

Analysis of intervention rates for “low risk” women by obstetricians and family physicians in 1980s Canada is provided, for example, by Anthony J. Reid, June C. Carroll, James Ruderman, and Michael A. Murray in “Differences in Intrapartum Obstetric Care Provided to Women at Low Risk by Family Physicians and Obstetricians,” *Canadian Medical Association Journal* 140, no. 6 (March 15, 1989): 625-633.

This birth predates the emergence of visible home birth and midwifery movements in the Toronto area. Organized and active practices of home birth and midwifery were evident in the Toronto area by the late 1970s and early 1980s, as described by Fynes in “The Legitimation of Midwifery,” 65-71. Barrington similarly notes that home birth and midwifery practices were evident in Ontario by the end of seventies in *Midwifery is Catching*, 34-38.

Crosbie referred to books and articles that popularized the theories and practices of prominent natural childbirth advocates Grantly Dick-Read and Fernand Lamaze, such as Dick-Read’s *Childbirth without Fear* and Karmel’s *Thank You, Dr. Lamaze*.


See, for example, “Midwifery Training Programs,” appendix A in Davis’ *Heart and Hands*, 181-182. Ontario midwives’ efforts to access “eclectic” learning opportunities in the context of restricted access to formal educational have also been described by scholars, such as MacDonald in *At Work at the Field of Birth*, 31-32. The influence of American midwives on burgeoning midwifery movements in Canada will be explored further below in this chapter in the section titled Social Movements and Midwifery Activism.

For a discussion of the influence of second wave feminism on nursing philosophy and practice, see Janet Ross Kerr and Jannetta MacPhail, “Feminism and Nursing,” chap. 6 in Canadian Nursing: Issues and Perspectives, 2nd edition (Toronto: Mosby Year Book, 1991), 62-67; and Adams and Bourgeault, “Feminism and Women’s Health Professions in Ontario.”

The Ontario Association of Midwives was founded in 1981, as reported in the program of the organization’s first conference shared with me by interviewee Elsie Cressman, who attended and was a speaker at the conference. See Ontario Association of Midwives, “Loving Hands,” conference program for conference held at Elora, Ontario, August 16-20, 1981.


In his review of health human resource management, Orvill Adams notes growth in the number of nursing graduates in the 1970s and 1980s contributed to a shortage of nursing positions in urban centres in “Management of Human Resources in Health Care: The Canadian Experience,” Health Economics 1, no. 2 (July 1992): 131-143.

For early feminist analyses of modern midwifery as a symbol for women’s control and empowerment in childbirth, see Ann Oakley, “Wisewoman and Medicine Man; Ruzek, The Women’s Health Movement; and Rothman, In Labour.


For an historical overview of the development of childbirth education programs sponsored by International Childbirth Education Association, see the history webpage available on the ICEA’s official website, accessed August 22, 2012, http://www.icea.org/content/history.

See Van Wagner, “With Women,” for a discussion of the foundational principles of care in the midwifery’s re-emergence in Ontario. For an overview of the Ontario midwifery philosophy
established by the Interim Council of the College of Midwives of Ontario in the early 1990s, see Tyson, Nixon, Vandersloot, and Hughes, “The Re-emergence and Professionalization of Midwifery in Ontario.”

114 See note 91 above in this chapter.

115 Betty-Anne Daviss ties midwives’ willingness to practice in tenuous legal settings to their desire to engage in midwifery as a social activist project to humanize childbirth. See Daviss, “From Social Movement to Professional Project: Are We Throwing the Baby Out with the Bathwater” (master’s thesis, Carlton University, 1999). In their study of fifty American “lay” midwives, Deborah A. Sullivan and Rose Weitz note the reluctance of childbirth attendants to assume the title and role of midwife but were compelled by women’s desire for midwifery and home birth services, in Labor Pains, 64. See also, Beckett and Hoffman, “Challenging Medicine.”

116 In this section where I discuss Evelyn Cressman and Elsie Cressman in close proximity, I refer to them using their first names.


119 Rothman, “Awake and Aware, or False Consciousness,” 160.

120 For an overview of the emergence and evolution of the Ontario Nurse Midwives Association, see Bourgeault and Fynes, “Integrating Lay and Nurse-Midwifery into the U.S. and Canadian Health Care Systems,” 1057-1058. Porteous’ narrative of the inspirational role that midwifery activism played in her decision to take up legal midwifery practice are explored further below in this chapter in the section titled midwifery activism.

121 Barclay, “Australian Midwifery Training and Practice.”

122 The nature of this program, the McMaster University Medical Centre “midwifery project,” and its role in McDonald’s inspiration to practice in the Ontario midwifery revival will be discussed below in the following section of this chapter titled Extended Role Nurses.

123 The structure of midwifery training and practice in South Africa was modelled on the British system with colonization.
For a discussion of the role of childbirth education associations in the consumer movement for childbirth reform, such as the American Society for Psychoprophylaxis in Obstetrics, see Mathews and Zadak, “The Alternative Birth Movement,” 42-44.


The McMaster midwifery project is described by Harvey, Kaufman, and Rice in “Hospital-Based Midwifery Projects”; and by Karyn Kaufman and Helen McDonald in “A Retrospective Evaluation of a Model of Midwifery Care,” *Birth* 15, no. 2 (June 1988): 95-99.

Harvey, Kaufman, and Rice note the McMaster midwifery project was “stable,” with a staff of eight nurses by 1987 in “Hospital-Based Midwifery Projects,” 198.

Ibid., 198-199.


Harvey, Kaufman, and Rice, “Hospital-Based Midwifery Projects,” 198-200.


138 For a detailed overview of the evolution of a “new paradigm” of evidence-based medicine at McMaster University, see Evidence-Based Medicine Working Group, McMaster University, “Evidence-Based Medicine: A New Approach to Teaching the Practice of Medicine,” *Journal of the American Medical Association* 268, no. 17 (November 1992): 2420-2425.


142 Harvey, Kaufman, and Rice, “Hospital-Based Midwifery Projects.”

143 Ibid., 193.

McDonald was aware that the Task Force on the Implementation of Midwifery in Ontario had recommended a model of self-regulation for midwifery rather than regulation by the nursing profession and that midwives would be expected to have competence in providing care in home and hospital settings.

The Michener Institute Midwifery Pre-Registration Program was established to assess and upgrade currently practicing Ontario midwives for entry to practice while ensuring continuing care for women receiving midwifery services during the transition to legal recognition, as stated by Karyn Kaufman in “The Introduction of Midwifery.” Eligibility for the Michener program was based on minimum standards of clinical experience, including evidence of current Ontario midwifery practice and attendance at least sixty births with forty as a primary care giver, thirty in a model of continuity of care, thirty in Ontario, and twenty home births. See Bourgeault, “The Michener Institute Midwifery Pre-Registration Program Admission Criteria,” appendix 23 in “Delivering Midwifery.”


Kaufman, “The Introduction of Midwifery.”

The formative influence of sixties counterculture and second wave feminist ideologies on the emergence of social movements for childbirth reform based on the revival of home birth and midwifery are widely acknowledged by popular and scholarly researchers and writers of North American midwifery, as has been previously described. Bourgeault links Ontario midwifery’s modern re-emergence to counterculture and feminist ideologies in “Delivering Midwifery,” 5-6.

For examples of the reconfiguring of childbirth and the body using countercultural discourse, such as emphasis on nature, holism and deinstitutionalization, see Gaskin, Spiritual Midwifery; and Mason, The Trouble with Licensing Midwives.

Lemke-Santangelo, Daughters of Aquarius, 82-83.

See note 76 above in this chapter.

Rogers could not remember the name of the publication. A popular emergency childbirth manual available at that time was Emergency Childbirth: A Manual by physician Gregory J. White. It was first published in 1958 by the Police Training Foundation in Franklin Park, Illinois and a 15th edition was published in 2002 by The National Association of Parents and Professionals for Safe Alternatives in Childbirth International.

See note 91 above in this chapter.

Bennett M. Berger discusses the ideal of self-sufficiency and the spirit of perseverance among “communards” in “American Pastoralism and The Commune Movement,” chap. 4 in The

Lang, Birth Book.

A description of sterilizing linens and other supplies for out-of-hospital births in that era can be found in Gaskin, “Equipment and Supplies,” appendix C in Spiritual Midwifery, 458. North American hospital birth practices similarly emphasized sterility, with elaborate draping of the woman, mask and gowning of the care providers, and the use of operative delivery rooms. There was growing recognition that a non-operative vaginal birth was not a sterile procedure, as emphasis on sterility was replaced by practices that resembled more home-like settings. See Fannin, “Domesticating Birth in the Hospital.”

The legal status of midwifery in Nova Scotia at this time was similar to the alegal status of Ontario midwifery. According to Barrington’s summary of the legal status of midwifery by province and territory in Canada, the Nova Scotia Medical Act did not include midwifery as part of the practice of medicine as was the case in other provincial jurisdictions such as Quebec, Saskatchewan, and British Columbia. See Midwifery is Catching, 140-141.

Graduates of formal midwifery programs that did not require a nursing credential as a prerequisite are referred to as “direct entry” midwives.


Craven, Pushing for Midwives, 41-46.

Wendy Kline describes the inspiration experienced by some aspiring midwives, like Lenske, in their encounters with the “anthropomorphic qualities” of primates to their understanding and belief in the normal physiologic process of childbirth. See Bodies of Knowledge: Sexuality, Reproduction, and Women’s Health in the Second Wave (Chicago: The University of Chicago Press, 2010), 133.

Lenske is referring to British natural childbirth advocate and physician Grantly Dick-Reid, widely recognized as one of the founders of twentieth century social movements for natural childbirth reform.

Stephen [Gaskin] and The Farm, *Hey Beatnik! This is the Farm Book* (Summertown, TN: Book Publishing Company, 1974).

Adrienne Rich’s 1976 *Of Woman Born* is considered a foundational text in second wave feminist theorizing of the complex dimensions of empowerment and oppression in the experience and institution of motherhood. Umansky analyzes early second wave feminist discourse on mothering in *Motherhood Reconceived*.

Adams and Bourgeault summarize a range of contemporary feminist perspectives on midwifery in “Feminism and Health Professions in Ontario,” 85.

Beth Rushing notes the philosophies and practices of midwifery in modern North American revivals frequently embodied a feminist philosophy of care, even where midwives did not identify as feminist. Rushing uses the term “subtle feminism” to refer the work of midwives who situate midwifery’s woman-centred philosophy at the level of the individual rather than at a structural level for political change. See “Ideology in the Reemergence of North American Midwifery,” 57-60. In her anthology of portraits of American midwives, Penfield Chester notes her participants’ common commitment to woman-centred childbirth despite their philosophic diversity in *Sisters on a Journey*, 249. A study of midwives practicing outside the law in Michigan in the late twentieth century reports similar findings of diverse political perspectives and shared values about women’s health. See Kay, Butter, Chang, and Houlihan, “Women’s Health and Social Change,” 229-230. Sullivan and Weitz make this same observation of the striking congruence of beliefs about childbirth and health care among ideologically diverse American lay midwives in *Labour Pains*, 60.


The ambivalent relationship between feminism and alternative parenting movements such as La Leche League are explored by Rothman, *In Labour*, 103-109; and Gorham and Andrews, “The La Leche League: A Feminist Perspective.”

McDonald is referring to contested debates on mothering in the early second wave women’s movement. She spoke of the influence of prominent theories on mothering as a site of oppression, such as Simone de Beauvoir’s *The Second Sex* and Betty Friedan’s *The Feminine Mystique*, and a shift toward recognition of the potential for empowerment in the experience of mothering by feminist writers such as Adrienne Rich in *Of Woman Born*. 
In her narrative, Van Wagner refers to early feminist historical and contemporary analyses on
the medicalization of reproduction, including Ehrenreich and English, *Witches, Midwives, and
Nurses*; Boston Women’s Health Book Collective, *Our Bodies, Ourselves*; Ruzek, *The Women’s
Health Movement*.

Vicki Van Wagner and Bob Lee, “Principles into Practice: An Activist Vision of Feminist
Reproductive Health Care,” in *The Future of Human Reproduction*, ed. Christine Overall
(Toronto: The Women’s Press, 1989), 238-258; and “Legal Assault: A Feminist Analysis of the
Law Reform Commission’s Report on Abortion Legislation,” *Healthsharing* 10, no. 4 (Fall

Geraldine Simkins uses the terms “calling” and “epiphany” to refer to a common pathway
into midwifery in her anthology of narratives of twenty-five American midwives, *Into these
Hands*, xxiv-xxv. Suzan Ulrich uses the phrase “epiphany moment” in describing the motivation
of some applicants to an American nurse-midwifery program in “Applicants to a Nurse-
Midwifery Education Program,” 130.

Ontario midwife Jane Kilthei estimated her apprenticeship involved “an intense year
involving 30,000 hours of clinical experience and some 70 home and hospital births” at the cost
of $10,000 in Barrington, *Midwifery is Catching*, 44 and 68.

Bourgeault, *Push!*, 56.

For a discussion of the founding of the Midwives Alliance of North America, see Fran Ventre
and Carol Leonard, “The Future of Midwifery - An Alliance,” *Journal of Nurse-Midwifery* 27,
no. 5 (September/October 1982): 23-24; and Rooks, *Midwifery & Childbirth in America*, 241-
242. Mary Teresa Fynes and Ivy Lynn Bourgeault discuss the influential role of the 1984
MANA conference, Creating Unity, held in Toronto on the momentum of the political movement
for midwifery legal reform in their social histories of the recognition and regulation of midwifery
in Ontario. See Fynes, “The Legitimation of Midwifery,” 96-105; and Bourgeault, “Delivering
Midwifery,” 52-56.

The MANA standards for clinical practice were adopted by the Association of Ontario
Midwives at their 1985 annual general meeting, as stated in the preamble to the AOM’s
standards for practice. See Association of Ontario Midwives, “AOM Standards,” appendices 5
and 6 in Bourgeault, “Delivering Midwifery.”

Barrington contrasts the formative role played by Californian midwife Raven Lang to the
development of midwifery in British Columbia with the influence of Texan midwife Shari
Daniels in Ontario in *Midwifery is Catching*, 34-36.

This event is documented by Sharpe in “Ontario Midwifery in Transition, 203. Bourgeault
states Daniels’ workshop was “an important turning point in [the participants’] view of
themselves as midwives,” in Push!, 69. Fynes reports that there were about fifteen workshop participants with a range of backgrounds, including childbirth educators and home birth assistants, and that “It was from this group that some of Ontario’s first lay midwives emerged,” in “The Legitimation of Midwifery,” 70.


For a critical discussion of Ontario midwives’ participation as learners in the care of racialized women of developing nations,” see Sheryl Nestel, “Delivering Subjects”; and “Midwifery Tourism,” chap. 3 in Obstructed Labour, 69-83. Nestel problematizes midwives’ participation in training programs in “Third World maternity clinics,” such as the one run by Daniels, through the lens of race. She refers to midwifery training opportunities in American clinics on the U.S-Mexico border as “midwifery tourism” that she compares to the sex tourism industry in Asia.

A list of North American midwifery training opportunities, including apprenticeships, was included in the program of the Ontario Association of Midwives’ inaugural conference held in Elora, Ontario in 1981. See, Ontario Association of Midwives, “Loving Hands.”

For a discussion of the multifaceted routes for midwifery training and clinical experience in the pre-legislation period, see Barrington, Midwifery is Catching, 43-45.

MacDonald describes the influential role of American midwifery literature on Ontario midwives in At Work in the Field of Birth, 54-60.

Books commonly mentioned by interviewees included Suzanne Arms’ Immaculate Deception; Doris Haire’s “The Cultural Warping of Childbirth”; Raven Lang’s The Birth Book; Ina May Gaskin’s Spiritual Midwifery; Rahima Baldwin’s Special Delivery; and Elizabeth Davis’ Heart and Hands.

Information about the Apprentice Academics Midwifery Home Study Course can be found at the Ancient Art of Midwifery Institute official website, accessed November 15, 2012, http://www.ancientartmidwifery.com/node/64.


For more information about the Association of Radical Midwives (ARM), see their official website, accessed November 15, 2012, http://www.midwifery.org.uk/. ARM published a vision


191 Van Wagner, “Women Organizing for Midwifery in Ontario”; and “Why Legislation?”

192 Post-nursing vocational training was the dominant model of midwifery education in the United Kingdom at this time, although there was also a tradition of “direct entry” training that did not require nursing preparation. Kate Isherwood reports that a single “direct entry” program remained in England by the 1980s in “Independent Midwifery in the United Kingdom, in Murphy-Black, *Issues in Midwifery*, 24. Midwifery education in the United Kingdom underwent transformation in the 1990s, with a movement toward higher education and renewed interest and development of direct entry programs. See Benoit, Davis-Floyd, van Teijlingen, Sandall, and Miller, “Designing Midwives.”


195 Polarization of the midwifery community in 1980s Ontario regarding legal reform dominates the social science literature on Ontario midwifery. For a wide ranging discussion regarding legal recognition and integration of midwifery into the Ontario health care system by social scientists and midwifery practitioners, see Bourgeault, Benoit, and Davis-Floyd, *Reconceiving Midwifery.*
Conclusion

HISTORY OF DECLINE AND RENEWAL

Midwifery has a unique and diverse history in Canada. Midwives were the dominant care providers for childbearing women throughout much of Canadian history prior to the rise of modern medicine and the professionalization of maternity care. Midwifery was not a singular practice, as was theorized by early historians writing in the 1980s. Over the last two decades, historians have uncovered rich and diverse histories of midwifery in Canada. Midwives in Canada’s past were predominately, but not exclusively, women and their work was centred in the domestic sphere. Midwifery training and clinical practices crossed a wide spectrum, from informal to highly organized. Midwifery was an empirical or traditional practice in some settings and a professional practice in others, sometimes regulated by the church or the state. Family health care was considered a female activity well into the nineteenth century. Midwifery work often extended well beyond the role of childbirth attendant to encompass comprehensive health care delivery to all members of the community. The relationship between midwives and other “irregular” health practitioners, including physicians, was more complex than the overly dichotomized stance suggested by early histories of childbirth and ranged from mutually collaborative to overtly hostile.

Unlike the situation in other western countries, midwifery in Canada failed to professionalize with the modernization of health care at the turn of the twentieth century. Childbirth was gradually displaced from the home into a newly expanding hospital system that accompanied the urbanization and modernization of Canadian society. Maternity care specialties evolved with the professionalization of medicine and nursing, as scientific approaches to health care brought new technologies to the care of childbearing women. Mortality rates for mothers and babies fell sharply with improved social conditions and the introduction of antibiotics in the interwar years, seemingly justifying medicine’s dominance in the care of childbearing women. Mechanistic and scientific views of the female body contributed to a pathologizing of pregnancy and rising rates of technological and surgical interventions in childbirth. Despite several prominent social reform campaigns to secure the formalization of midwifery in early twentieth century Canada, midwifery declined rapidly and virtually disappeared by mid-century except in geographically isolated regions and in distinct religious or cultural communities. Even these remnants were
diminished with the routine evacuation of pregnant women from geographically remote communities to large hospital centres and the erosion of distinct cultural childbirth practices by the late 1970s, a time when grassroots movements reclaiming the traditional practices of home birth and midwifery were visible in Canada.

International movements for “natural childbirth” reforms to “medicalized childbirth” that advocated women’s conscious awareness at the moment of birth attracted the interest of middle class women in North America during the postwar era, signaling an emerging social discontent with medical and scientific authority and practices. Concern for social stability and the well being of citizens following World War II influenced new psychological imperatives in parenting that promoted healthy maternal-infant bonding, supporting the ideologies and practices of natural childbirth alternatives. Under the influence of progressive counterculture social movements of the sixties and second wave feminism, consumerist movements in health care lent support to critiques of technological routines and interventions in childbirth. Childbirth preparation programs and the transformation of operating rooms into home-like birthing suites gained popularity in the ‘70s and ‘80s; however, these reforms largely represented superficial changes as medical authority and technological interventions in childbirth largely remained intact. Social movements for the reclamation and revival of home birth and midwifery as alternatives to mainstream maternity care were visible by the early seventies in the United States where maternity care was similarly dominated by medical routines and technology, and later surfaced in Canada by the middle of the decade. A small number of midwives began practicing in Canada without legal recognition, providing home birth services or midwifery alternatives within a few select hospital-based midwifery pilot projects, working on the margins of official health care providing care to less than one percent of childbearing women. Some practicing midwives held international midwifery credentials or were registered nurses, whereas others learned and practiced midwifery without formal preparation. At the time of midwifery’s modern re-emergence in the 1970s, Canada was the world’s only industrialized nation and one of nine of the 250 member states of the World Health Organization without legal provisions for midwifery.
TRENDS IN HISTORIOGRAPHY

A growing body of historiography on Canadian midwifery has been generated in the last several decades that focuses on the period prior to midwifery’s twentieth century demise and re-emergence. Understandings of modern practices of midwifery are primarily informed by social science scholarship on midwifery’s late twentieth century emergence and subsequent legal recognition. Narratives of marginality, domesticity, and gender underscore theories about historical and contemporary midwifery and its practitioners.

In my review of the literature on Canadian midwifery, I identified three distinct periods of scholarship: recovery, reflection and reinterpretation. These shifts in midwifery scholarship mirror the rediscovery and growth of midwifery as a practice in late twentieth century Canada, as well as theoretical developments in the practices of social history and feminist critical inquiry. Research of the 1970s and ‘80s focused on the recovery and documentation of historical and emerging practices of midwifery that were unfamiliar to mainstream society accustomed to medicine’s dominance in maternity care. This early scholarship was celebratory and generated grand narratives of past and modern midwives as caring neighbor female figures, often mothers, in contrast to critical portrayals of professionalized male medicine as impersonal and scientific. The 1990s was a time of reflection in midwifery scholarship. Scholars critiqued the lack of complexity in theoretical understandings of historical and modern midwifery and uncovered more nuanced and varied portraits that undermined previous claims to midwifery’s universality. A large body of social science literature analyzing Ontario midwifery’s changing legal status and its transition from outside to inside official health care emerged in the mid-1990s, dominating midwifery scholarship of this period. Critical scholarship on midwifery regulation commonly portrayed pre-legislation midwifery as the neighbourly female community practice of past times in contrast to portraits of regulated midwifery as aligned with institutionalized medicine and the state. The image of the Ontario midwifery community divided along lines of elite and non-elite dominants this literature, echoing gendered binaries of midwifery and medicine that permeate midwifery discourse. In the early decades of the twenty-first century, over a decade following midwifery’s landmark legal recognition in Ontario, social science scholars have begun to revisit and reinterpret their critical perspectives on regulated midwifery. Integration of alegal midwifery into a funded and regulated system, which had previously been portrayed as a loss, is now presented as a model for other jurisdictions struggling to strengthen woman-centred care.
and the autonomy of midwives. At the same time, historians of Canadian midwifery have
reinterpreted grand narrative histories with insights from developments in feminist
historiography that recognize diverse histories of midwifery in Canada.

THE CONTRIBUTION OF ORAL HISTORY

The modern revival of midwifery in Canada is now becoming a field suitable for historical
investigation with the passage of over thirty years since practices were first visible in Canada.
Current scholarship on modern Canada midwifery is preoccupied with midwifery’s transition
from a grassroots social movement to a self-regulating profession, with a particular focus on
Ontario as the first province to legalize midwifery in late twentieth century Canada. Within the
existing literature, there are a small number of research studies investigating midwifery’s modern
renewal in Ontario from an historical perspective; these studies examine events leading to the
legal recognition of midwifery. Studies documenting the experiences of midwives who practiced
in modern Canadian midwifery revivals are beginning to emerge and midwifery archives are
under development in several provinces. Historical documentation of pre-legislation Ontario
midwifery is relevant and significant to the historiography of modern movements for midwifery
as a symbol for the reclamation of woman-centred childbirth, both within and outside of Canada.
Despite being a transitory period from the mid-1970s to the proclamation of midwifery
legislation in late 1993, the structures and philosophies of alegal practice influenced public
policy and the framework for regulated practice in Ontario and elsewhere in Canada.

Given the current limitations in the availability of robust and accessible evidence of this pre-
legislation period of midwifery practice from an historical perspective, oral history provides a
useful methodology. I interviewed twenty-one midwives who practiced in Ontario in the pre-
legislation period according to ethical guidelines and feminist principles for the conduct of oral
history. Their oral history narratives constitute a body of original primary research evidence that
makes an important contribution to the historical record and the understandings of this formative
time in Ontario midwifery history. The narratives are treated as legitimate sources of evidence
that provide insights into the daily lives of midwives whose experiences are often overlooked in
the existing body of scholarship that focuses on their changing legal status. At the same time, I
recognize the mediated nature of oral history and the need for caution in interpretation and
generalizability, much like conventional sources of historical evidence. Given the subjectivities
inherent in oral history interviewing and interpretation, the words and silences embodied in the midwives’ narratives are seen to represent one source for understanding the nature of alegal Ontario midwifery practice. The midwives’ words are seen as remembrances requiring analysis and contextualization rather than embodied truths of the past. To contextualize the oral history narratives, I looked to historical and contemporary writings on Ontario midwifery, as well as to literature on the lives of women in twentieth century mainstream English Canada to reflect the social profile of the research subject group. I also looked beyond the Ontario literature to relevant American and Canadian scholarship on midwifery, both in the distant and the recent pasts. Ontario midwifery shares a similar history to midwifery in other parts of Canada and the United States and, as a result, theoretical understandings of midwifery and its practitioners are deeply entwined with historical and contemporary writings on midwifery in other North American settings.

In my analysis of the midwives’ oral histories, I focused on the following two central research questions: Who were Ontario’s pre-legislation midwives? What inspired and motivated them to become midwives and to practice in the unregulated Ontario setting. In Chapter 2, I examined themes that emerged from the interviewees’ narratives about their lives before they became midwives, including their personal histories in terms of family, education, and work, and the social forces that shaped their growing up years and entry into adulthood. In Chapter 3, I examined factors that interviewees spoke about that inspired and motivated them to learn and practice midwifery. These factors included childhood aspirations, personal birth experiences, breast feeding and childbirth support work, nursing training and practice, progressive social movements of the sixties and seventies, and midwifery movements and activism. The findings of this research reveal new understandings and complexities when compared with current theories about Ontario midwives and midwives practicing in parallel midwifery movements elsewhere in Canada and the United States.

NARRATIVES OF HOMOGENEITY AND DIFFERENCE

Listening to the oral histories of these Ontario pre-regulation midwives provides insight into who they were and why they chose to practice outside of the formal health care system at a time when midwifery had virtually disappeared from Canadian society. Their narratives both confirm to and complicate current theories about alegal midwifery practitioners and their inspirations that
can be gleaned from popular and scholarly writings on Ontario and North American midwifery revivals and that centre around the concepts of motherhood and womanhood.

The findings in response to the question of who were alegal Ontario midwives are consistent with the portrayals of pre-legislation practitioners as the “white, middle class and well educated” mothers found in the popular and social science literature. While this research confirms the observation made by both midwives and scholars that most who could choose to take on practice outside the protection of legal regulation did so from a relative position of privilege, this characterization also obscures important nuances and contradictions. The midwives’ narratives reveal working class backgrounds, single parent families, high school drop-outs and those who faced challenges to fit into the counterculture midwifery movement because they were too young, too old, had no children, were male, or did not identify as heterosexual. Although midwifery discourse valorizes the “outsider” midwife figure, one third of the interviewees were formally trained midwives or nurses first, a proportion consistent with the pre-regulation population of Ontario midwives. My findings also reveal many similarities, as well as profound differences, that stem from variation in the social era in which the midwives grew up and their cultural backgrounds and personal ideologies.

The question of what inspired the midwives to work in an alegal context is an important one, given the significant risks alegal practice posed to midwives and their families. The oral histories reveal a high degree of passion and motivation for midwifery among most, though not all, of the interviewees. Despite the varied and multi-layered inspirations embodied in their narratives, many remembered their discovery of midwifery as an “epiphany,” one that was often articulated as an inner awareness that they were meant to be midwives, by fate or destiny. This was often portrayed by the interviewees as an instantaneous recognition from their first exposure to childbirth, either as a concept in stories or films or as a reality by attending a birth. Sometimes a passion for supporting women in labour came first, and the label “midwife” and the idea that this was formal work came later. Some of the nurses who were pushed into midwifery training as a prerequisite for another career path were surprised to find this was the work they wanted to do.

Finding profound meaning and beauty in the normal physiologic process of birth and the caring work of midwifery was another persistent theme in the oral histories, uniting interviewees who were mothers and non-mothers, nurses and non-nurses, women and men. The strength of
the midwives’ attraction to the physiologic process of birth and their sense of the social meaning and importance of birth work, summarized by the comment “you can change lives,”\textsuperscript{1} infused the midwives’ narratives of their inspirations. A strong sense of obligation to provide access to midwifery care for other women was expressed by many of the interviewees. Some recalled wanting to share their experiences of midwifery or home birth with other women, whereas others were motivated by difficult, often medicalized, childbirth experiences. Those who were unable to access the care they wanted for themselves from midwives remembered feeling galvanized to make home birth and midwifery services available to other women. Interviewees also related feelings of moral or ethical responsibility to respond to requests from childbearing women in their communities planning home births, with or without the presence of a reluctant “midwife.” The concept of “the women made me do it”\textsuperscript{2} conveys this sense of compulsion. For those who worked in formal maternity care systems, the sense that “we can do better”\textsuperscript{3} was a strong motivator, sometimes flowing from their experiences working as midwives internationally and at other times from their exposure to Canadian obstetrical practice in their work as nurses.

The interviewees’ narratives strongly, although not uniformly, reinforce the assumption pervasive in midwifery discourse of midwifery as a “calling.” This concept manifests itself in many of the interviewees’ expressions of midwifery as a good “fit” or being drawn into practice, sometimes reluctantly but inevitably, by the needs of others or by destiny. The lack of personal agency inherent in the concept of a calling was evident in the narratives of some of the interviewees that is somewhat at odds with the unconventional choice to practice outside official health care and the law, a decision requiring determination and conscious intent. It may be possible that these alegal midwives constructed this sense of having no choice but to be midwives to help justify the medical and legal risks they were taking on to themselves and to their families.

An unexpected finding, which resonates with the concept of the “calling,” was the formative influence that childhood experiences held for some interviewees in their midwifery aspirations. Several described their deep attraction to pregnancy, birth, babies, or breast feeding from a young age. The role of children’s literature featuring midwives, the neighbour who had a home birth, the birth story told by their own mother, or the revelation that their grandmother was a midwife pre-dated and loomed larger for many interviewees than their own birth experiences. Inspiration to be a midwife, it seems, reaches far beyond personal experiences of motherhood.
Personal childbirth experiences, for those who had children, were presented as more of a confirmation than as a primary inspiration.

The midwives’ oral histories nuance recent rethinkings of historical and social science understandings of midwifery. Their narratives both reinforce and challenge one of dominant theories in the social science literature about the resurgence of midwifery in North America: the polarity between medical and midwifery models of care. The midwives spoke passionately about the harms of unnecessary interventions and the need to change childbirth to allow both a more physiologic and social approach to childbirth to flourish. The decision to practice outside the system often flowed from personal experiences looking for change from within the system and finding closed doors. Seeking care from physicians and hospitals which would not accommodate their desires for a “natural birth,” wanting to avoid routine procedures such as shaving and episiotomies, or to not be separated from their newborn babies were strong motivators to provide a style of care they could not find inside the system to other women. For those who were nurses, frustration with trying to make changes from within the system pushed them to take on the tenuous role of working as an outsider or to join a hospital-based midwifery pilot project while maintaining their full time nursing positions.

Although midwives’ narratives of their inspirations to practice encompassed a passionate critique of medicalized childbirth consistent with many childbirth reform initiatives of the last half century, the midwives’ narratives simultaneously reveal a real sense of collaboration with sympathetic physicians. Many of the midwives, despite challenges, found physicians to attend their own home births when and where there were no midwives. Their narratives also reveal stories of physicians supporting aspiring midwives to learn and practice. This blended critique and collaboration with medicine is consistent with new understandings in the historical literature that medicine’s opposition to midwifery cannot simply be portrayed as monolithic.

The midwives’ narratives also challenge stereotypical portrayals of pre-regulation midwives and why they did what they did. Rather than simply the rebel outsiders portrayed in popular and scholarly literature, the self-identified “hippie lay midwife” interviewees sought to improve the safety of birth by increasing their knowledge and skills through formal training. Some crossed continents and oceans to do so. The hesitation in midwifery revival literature about the suitability of formally trained midwives and nurses for the woman-centred care that defined counterculture midwifery is challenged by the interviewees’ experiences as passionate advocates.
for women’s autonomy and choice in childbearing, both inside and outside health care institutions. The majority of interviewees also blurred the lines of caring work and political work in the pre-legislation Ontario context. Some were inspired through midwifery to become involved in political change projects, whereas others were inspired by politics to get involved in midwifery. But for most, caring and politics were both inherently part of the work of midwifery. These narratives complicate previous portraits of pre-regulation midwives as either grassroots nurturers or “elite” professionalizing activists.

FUTURE DIRECTIONS IN ONTARIO MIDWIFERY HISTORIOGRAPHY

The study of the modern midwifery revival in Ontario is a new and burgeoning field of historical investigation. Social science scholars Mary Teresa Fynes and Ivy Lynn Bourgeault have contributed “macro” social histories of Ontario midwifery that document events leading to the government’s commitment to legalize midwifery in 1986\(^4\) and the enactment of legislation in 1993 and the integration of midwifery into the publicly funded health care system.\(^5\) The recent imitative to develop a midwifery archive in Ontario that is underway by the Association of Ontario Midwives will not only assist in the preservation of this significant period in the history, it will also help to make inaccessible documents available to future historians of Ontario midwifery. The oral histories of this representative group of alegal midwifery practitioners contribute a body of original, primary research evidence to the historical record on late twentieth century midwifery revivals with a focus on the lives of everyday practitioners. The findings of this research add new understandings and nuances to existing scholarship about unofficial midwives and why they practiced without legal status in Ontario. Future areas for oral history research that will continue to add new dimensions to the historical record about this significant period of Ontario midwifery and its practitioners includes how midwives learned and practiced as alegal practitioners on the margins of official health care and the law.

\(^{1}\) Interview with Ontario midwife Helen McDonald, March 21, 2009.

\(^{2}\) Interview with Elsie Cressman, April 6, 2009.
3 Interview with Linda Moscovitch, April 8, 2009.

4 Fynes, “The Legitimation of Midwifery.”

5 Bourgeault, *Push!*. 
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Appendix A

University of Toronto
Office of the Vice-President, Research
Office of Research Ethics

PROTOCOL REFERENCE #23756

February 18, 2009

Dr. Cecilia Morgan
Department of Theory and Policy Studies
OISE/University of Toronto
252 Bloor St. West, 6th Floor
Toronto, ON M5S 1J6

Ms. Elizabeth Allemang
Department of Theory and Policy Studies
OISE/University of Toronto
252 Bloor St. West, 6th Floor
Toronto, ON M5S 1J6

Dear Dr. Morgan and Ms. Allemang:

Re: Your research protocol entitled “A legal midwife: An oral history of practising midwives in Ontario, 1974-1994”

ETHICS APPROVAL

Original Approval Date: February 18, 2009
Expiry Date: February 17, 2010
Continuing Review Level: 1

We are writing to advise you that a member of the Social Sciences, Humanities & Education Research Ethics Board has granted approval to the above-named research study, for a period of one year, under the REB’s expedited review process. Please ensure that you submit an Annual Renewal Form or a Study Completion Report at least 30 days prior to the expiry date of your study.

The following consent documents (received February 17, 2009) have been approved for use in this study: Recruitment flyer and Consent letter.

Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events should be reported to the Office of Research Ethics as soon as possible.

If your research has funding attached, please contact the relevant Research Funding Officer in Research Services to ensure that your funds are released.

Best wishes for the successful completion of your project.

Yours sincerely,

Dean Sharpe, Ph.D.
Research Ethics Officer–Social Sciences and Humanities
ORAL HISTORY PROJECT ON

MIDWIVES PRACTICING PRE-REGULATION IN ONTARIO

Did you:

or

Do you know someone who:

practice(d) midwifery in Ontario prior to regulation in 1994?

Midwife researcher seeking participants for an oral history project on Ontario midwives practicing prior to legislation. One to two hour long semi-structured interviews will be conducted with a focus on the midwife’s background, motivations to practice, midwifery training, and clinical practice in an alegal environment. This oral history research is the focus of a Master of Arts thesis at the Ontario Institute for Studies in Education/University of Toronto. Confidentiality ensured and anonymity will be offered and ensured to participants.

Contact: Elizabeth Allemang
elizabeth.allemang@utoronto.ca
(416) 979-5000 ext. 7625
Appendix C

TO BE PRINTED ON OISE/UT LETTER HEAD

Informed Consent to Participate in Research

Elizabeth Allemang
Theory and Policy Studies in Education
Ontario Studies in Education/University of Toronto (OISE/UT)

Thank you for your interest in my research project, *Alegal Midwives: Oral History Narratives of Ontario Pre-legislation Midwives*. I am conducting this research for my thesis in a Master of Arts program under the supervision of Professor Cecilia Morgan in History in the Department of Theory and Policy Studies in Education at the OISE/UT. The research findings of this study may also be used in future publications and presentations.

The goal of this study is to contribute a body of original research to the history of pre-regulation midwifery in Ontario by conducting oral history interviews with midwives who practiced in Ontario in the period of 1974-1994. The history on this period of midwifery practice is limited and is only beginning to attract the attention of historical researchers.

I plan to conduct semi-structured interviews with midwives who practiced in Ontario in the period of 1974-1994. The participants for this study will be selected to create a representative group of the pre-legislation practitioners with a range in age, practice location, years in practice and educational background. A voluntary pre-interview questionnaire will be provided initially to gather background information. This will be followed by a face to face interview of approximately one to two hours in length. During the interviews you will be asked about your motivations to pursue midwifery, your education and training, details about your clinical practice, your relationship to the health care system, and your role in midwifery activism. As the interview proceeds I may ask you further questions for clarification or understanding; however, my role is mainly to listen to you speak about your experiences. At no time will value judgments be made about your responses.

Interviews will be tape recorded and later transcribed to paper. You have the choice of declining to have the interview tape recorded. For those who decline anonymity, I will take your photograph where your consent is provided. After the interview I may write brief notes that will assist me in remembering details about your interview. In order to ensure that I am accurately conveying your ideas and opinions, I will send you the transcript of your interview by email within one month for you to clarify or correct any information. I would ask that you provide me with any changes to the interview within a 4 week period.

You have the right to withdraw from this research at any time or to decline to answer particular questions, without prejudice. You have the right to confidentiality and anonymity, unless agreeing to be identified by name as stated below. A pseudonym will be used for participants who wish to remain anonymous and any identifying information, such as geographical location of practice, will be made generic and materials will be assigned and filed under a number. You will at no time be judged or evaluated, and no value judgments will be placed on your responses.

I anticipate that the risks of this research are minimal and that the benefits outweigh potential risks. Midwife participants may appreciate telling their stories of pre-legislation alegal practice. You may value the recording of your experiences as a way to document and write history and as a means to pass on knowledge and tradition to future generations of midwives. Other benefits may go beyond individual
benefits to those to the profession as whole. Midwives may recognize the importance of documenting this period of midwifery practice as a significant contribution to Canadian midwifery historiography.

There is a potential risk that you may feel vulnerable in the interview process. Although midwifery has been regulated since 1994 in Ontario, I recognize that midwives can still experience marginalization in a health care system that assumes physician care for childbirth. Exposing personal histories of ilegal practice may have the potential to affect individual midwife’s reputations with current inter-professional colleagues in the health care system. As mentioned above, in order to modify this risk I will offer you anonymity and the use of a pseudonym, and I will make generic certain facts such as location of practice.

The information gathered from both questionnaires and interviews will be kept in strict confidence and stored in a secure location. Raw data (i.e. oral history interview audio tapes, transcripts, photographic film and photographs) will be held in a locked cabinet for the duration of this project that only my supervisor and I will have access to. Materials will be filed using a non-identifying coding system for those participants who have chosen to remain anonymous. Materials from the project will be destroyed five years following completion of this project, unless you agree to the donation of these materials to the Association of Ontario Midwives. All data collected will be used for the purposes of a MA thesis, and possibly for subsequent publications and public presentations. All information will be reported in accord with your wishes for anonymity.

If you have any questions about your rights as a participant, you may contact the University of Toronto’s Office of Research Ethics at (416) 946-3273, or at ethics.reviews@utoronto.ca. If you agree to participate, please sign the letter below and return to me in the envelope provided. Thank you in advance for your participation.

Elizabeth Allemang    Dr. Cecilia Morgan
Master of Arts Candidate    Professor
OISE/University of Toronto   OISE/University of Toronto
252 Bloor Street W. 6th floor   252 Bloor Street W. 6th floor
Toronto, Ontario M5S 1V6   Toronto, Ontario M5S 1V6
Telephone: (416) 979-5000 ext. 7625  Telephone: (416) 978-1209
Email: elizabeth.allemang@utoronto.ca Email: cecila.morgan@utoronto.ca

By signing below, you are indicating your willingness to participate in this study, you have received a copy of this letter and you are fully aware of the conditions above:

Name: ____________________________    Date: ____________________________
Signed: ________________________________

Please initial if:
i) you would like an email summary of the study upon completion: ________
ii) you agree to have the interview audio taped: ________
iii) you agree to be identified by name: ________
iv) for participants who agree to be identified, you agree to be photographed: ________
v) you agree to the donation of the interview audio tapes and transcripts, and photographs to the Association of Ontario Midwives: ________

Please keep a copy of this letter for your records.
Appendix D

TO BE PRINTED ON OISE/UT LETTER HEAD

OPTIONAL Demographic Questionnaire

The completion of this questionnaire is entirely OPTIONAL. If you agree, you may complete this questionnaire in advance of my interview with you, and return it to me in the enclosed self addressed stamped envelope. This information will assist me to familiarize myself with basic information about you prior to our meeting. It may also assist me in the selection of candidates to have a diverse participant group in terms of age, practice location, educational background, years of experience, if the number of participants exceeds the targeted sample size.

Name: _____________________________________________

Age or Age Range: ____________________________________

Years in Practice: ______________________________________

Dates in Practice: ______________________________________

Location(s) of Practice: __________________________________

Dates of Midwifery Education: ___________________________

Formal Midwifery Education: Yes / No Location(s): __________ - ______

Informal Midwifery Education: Yes / No Location(s): ____________

Nursing Education: Yes / No Location(s): ____________________

Nursing Practice: Yes / No Location(s): _____________________

Midwifery Registration in Ontario: Yes / No Dates: ________________

Route of Entry to Practice:

Michener  IMPP  Other: ________________________________

PLEA    MEP
Appendix E

Interview Guide

1. Personal Background

Question: What is your family/work/educational background?

Potential areas to be explored:
   • family, education and occupational backgrounds prior to becoming midwives

2. Inspirations/Motivations

Question: What were your inspirations and motivations to practice midwifery in Ontario in an alegal context?

Potential areas to be explored:
   • inspirations and motivation to learn/practice midwifery
   • inspirations and motivations to work in Ontario without legal recognition as a midwife

3. Midwifery Education/Training

Question: How did you learn to be a midwife? What role did you play in midwifery education?

Potential areas to be explored:
   • midwifery education/training
   • what valued/found challenging
   • role in the education of other midwives

4. Midwifery Practice

Question: Describe your midwifery practice.

Potential areas to be explored:
   • practices, e.g. dates, location(s), practice structure, number of births attended per year, birth settings, access to equipment, clientele, compensation
   • philosophies and beliefs about birth
   • forces that informed their clinical practice, e.g. women’s choices, clinical practice guidelines, community standards, peers, professional organizations

5. Relationship to Health Care System

What was your relationship to the health care system?

Potential areas to be explored:
   • relationship to health care system
   • how received in formal health care settings, e.g. hospitals
   • how accessed consultations, referrals, medical assistance and hospital care.
6. Working in an Alegal Context

Question: Describe your experience in working in an alegal environment.

Potential areas to be explored:
- what they valued/found challenging working in an alegal environment
- perceptions of legal implications of working in an unregulated environment
- involvement in any legal investigations or proceedings, if willing to disclose
- birth story from this period of their practice that they feel captures the spirit of pre-regulated alegal midwifery

7. Activism and Regulation

Question: Describe your involvement in midwifery activism? What was your experience of the regulation of midwifery?

Potential areas to be explored:
- involvement in midwifery activism
- goals in their activism
- transition to regulated practice, losses/gains
- perceptions of transformation of pre-regulated midwifery to regulated midwifery

ADDED AT THE SUGGESTION OF ONE INTERVIEWEE:

8. Looking Forward

Question: What would you like to say to current and future midwives and student midwives in Ontario from your experiences practicing midwifery in the pre-legislation period.
Appendix F

ASSOCIATION OF ONTARIO MIDWIVES

Represents Registered Midwives and Promotes the Profession of Midwifery in Ontario

December 15, 2008

To Whom It May Concern,

Re: Donation of Archival Material

I am writing on behalf of the Association of Ontario Midwives to express our support for the Master of Arts research study being conducted by Elizabeth Allemang at the Ontario Institute for Studies in Education/University of Toronto in the Department of Theory and Policy Studies in Education. The mandate of our organization includes the responsibility to promote the profession of midwifery in Ontario. A key component of this mandate is to protect and preserve the history of midwifery in Ontario.

We are willing to receive the materials generated in Elizabeth Allemang’s project, Alegal Midwives: Oral History Narratives of Ontario Pre-legislation Midwives. We have the facilities to responsibly store audio tapes, written tape transcriptions, photographs and any other written materials that midwife participants in this project have indicated they would like donated to our archival files.

Please contact me if you require further information at executivedirector@aom.on.ca, or 416-425-9974, ext 2230.

Sincerely,

Kelly Stadelbauer, RN BScN MBA
Executive Director
Association of Ontario Midwives

365 Bloor Street East, Suite 301, Toronto, Ontario M4W 3L4
t: (416) 425-9974 or 1-866-418-3773//f: (416) 425-6905/e:admin@aom.on.ca/www.aom.on.ca