Gender Expectations: Natural Bodies and Natural Births in the New Midwifery in Canada

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# Gender Expectations:

## Natural Bodies and Natural Births in the New Midwifery in Canada

*In this article, I examine the meaning of natural bodies and natural births in contemporary midwifery in Canada and explore the impact of these central concepts on the embodied experiences of pregnant and birthing women. The ideal of a natural birth has been used as a successful rhetorical strategy in scholarly and popular feminist works on childbirth to counter and critique the predominant biomedical or "technocratic" model of the pregnant and birthing body as inherently problematic and potentially dangerous to the fetus. Contemporary Canadian midwifery—which only as recently as 1994 made a historic transition from a grassroots social movement to a full profession within the public health care system—continues to work discursively through the idiom of nature to affect women's knowledge and experience of their bodies and selves in pregnancy and birth. However, my key finding in this ethnographic study, which focused primarily on midwifery in the province of Ontario in the years following professionalization, is that natural birth is being redefined by the personal, political, and pragmatic choices of midwives and their clients. I argue that the construction, negotiation, and experience of natural birth in contemporary midwifery both reflects and promotes a fundamental shift away from essentialized understandings as it makes room for biomedical technology and hospital spaces, underpinned by the midwifery logics of caring and choice. Natural birth in this context also carries important cultural messages—gender expectations—that posit women as persons and bodies as naturally competent and knowing.*

Keywords: [midwifery, natural birth, maternity care in Canada, gender performativity]

> How can our "natural" bodies be reimagined—and relived—in ways that transform the relations of same and different, self and other, inner and outer, recognition and misrecognition into guiding maps for inappropriate/d others?
>
> —Haraway, 1991

Reproduction has emerged in recent years as an important site of anthropological inquiry with a rich and growing body of work that takes seriously the notion of reproductive bodies as sites of cultural production, performance, and consumption. Choices to reproduce or not and how to manage pregnancy and birth ritually,

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clinically, socially, and economically are all matters of cultural negotiation and production. The recent reemergence of midwifery in Canada, after more than a century of official absence, presents a timely and compelling opportunity to explore the cultural production and performance of childbirth within Canadian society. In this article, I explore the meaning and experience of "natural" pregnancy and birth and the practices organized around them in contemporary midwifery in Canada at the turn of the 21st century, with particular attention to their implications for gender. Specifically, I show how midwifery works discursively through the idiom of nature to affect women's knowledge and experience of their bodies and selves in pregnancy and birth.

The ideal of a natural birth has long been used successfully as a rhetorical strategy in scholarly and popular feminist works on childbirth to counter and critique the predominant biomedical or "technocratic" (Davis-Floyd 1994) model of the pregnant and birthing body as inherently problematic and potentially dangerous to the fetus. Midwives and their supporters too have often appealed to the authority of nature as the basis for their work. In the new midwifery in Canada, natural birth is an idiom for what midwives clinically refer to as normal birth, and, as such, carries a kind of cultural weight that goes beyond this latter term. Specifically, the promotion and celebration of natural birth within contemporary midwifery posits women as naturally capable and strong, their bodies perfectly designed to carry a fetus and to give birth successfully without the high-tech surveillance and interventions of physicians in a hospital setting. Further, natural birth is said to be empowering to women, for through it they experience a sense of control and accomplishment that positively informs their sense of self not only as women and mothers, but also as persons.[1]

Natural birth, at the turn of the 21st century, however, is not what it used to be. Drawing on ethnographic data from my work with midwives and their clients in the province of Ontario in the late 1990s, I describe here how the construction, negotiation, and experience of natural birth in midwifery in Canada both reflects and promotes a fundamental shift away from fixed or essentialized understandings of the natural female body and childbirth. I argue that natural birth is being redefined by the personal, political, and pragmatic choices of midwives and their clients; it is a version of nature that makes room for biomedical technology and hospital spaces, underpinned by the logics of caring and choice within midwifery. Natural bodies and births are thus "reimagined—and relived" (Haraway 1991:4) in concert with what I call the gender expectations of pregnancy and birth inherent in the new midwifery in Canada.[2]

## A Brief History of Midwifery in Canada

The history of midwifery in Canada is unique in several respects that have strongly influenced its contemporary form—notably, the near total absence of a recognized midwifery profession in the country for more than a century. Indeed, this history has most often been read as a tale of loss and renaissance, unfolding more or less as follows: Traditional, women-centered, home-based midwifery birth culture of the 19th century was stamped out at the hands of the rising medical profession and the march of progress. A new kind of midwifery later emerged in the 1970s

as a grassroots social movement, eventually achieving full legal and professional recognition in the 1990s. Although I will continue with a more nuanced history below, to read the history of midwifery in Canada this way is to see how this version might serve as a key point of reference for contemporary midwifery—an origin story of sorts—informing its social meaning, its points of opposition to mainstream maternity care, its clinical approach, and its social and political goals.

Starting in the mid–19th century, physicians throughout North America struggling to promote their profession and secure their clientele engaged in a successful campaign to discredit traditional midwives as incompetent, unclean, and outdated (Ehrenreich and English 1973; Mitchenson 1991). Until then, the majority of pioneer women had been assisted in childbirth by other women, recognized and respected in their communities, who were called on for their expertise, whether they were empirical midwives or had received formal training in Europe. Most women who acted as midwives to their neighbors and kin were also busy with children and farm work and thus did not engage in midwifery as a profession full time. However, in parts of Nova Scotia, Quebec, Newfoundland, certain ethnic and aboriginal communities, as well as in remote parts of the country, midwives did work as established professionals appointed by either the church or the crown (Benoit 1991; Biggs 1983; Kaufert and O'Neil 1993; Laforce 1990; Mason 1988; Mitchenson 2002).

Integral to the displacement of midwives was the redefinition of childbirth as a medical event, fraught with danger and in need of intervention by obstetricians. Gender ideals of women as frail and dependent—and thus incapable of either giving or attending birth unaided by male experts—flourished during this time as well, especially among the middle and upper classes (James-Chetalet 1989:421; Mitchenson 1991). Hospital-based, physician-attended childbirth grew steadily throughout the 19th century and by the 1940s, midwifery was no longer a maternity care option for the vast majority of Canadian women. Traditional midwifery was retained only in some Mennonite, Hutterite, and First Nations communities as well as in remote and rural areas of Canada (Benoit 1991; Biggs 1983; Campanella et al. 1993).

Whereas regulated forms of nurse–midwifery were introduced to fill the maternity care gap opened up by the elimination of traditional forms of midwifery in the United Kingdom and the United States, no such provisions were made in Canada.[3] Consequently, the country was without a formally recognized midwifery profession for more than a century. In the 1970s, midwifery reemerged in Canada in the form of a grassroots social movement devoted to promoting low-tech, woman-centered alternatives to standard obstetrical care. This new midwifery drew on feminist, maternalist, and scientific ideologies as it sought to restore the definition of birth as a natural event; to reinvent women as competent birthers and attendants; and to restore the location of birth to the home.[4]

The orchestrated and prolonged absence of midwifery in Canada clearly influenced the social movement starting in the 1970s. Central to this part of the story is the renaissance of the traditional midwife—variously known as the neighbor midwife, the granny midwife, or the lay midwife. Historian Lesley Biggs rightly points out that the universalizing trope of the traditional midwife "homogenises a range of birth attendants under one rubric" (2004:22), whereas midwifery in Canada in the 19th and early 20th centuries was more varied and its demise more uneven.

Nevertheless, the traditional midwife became a part of official midwifery history, a political symbol (MacDonald 2004) in the "recovery project" of professional midwifery (Biggs 2004:17). She is a key figure in popular and scholarly feminist analyses of midwifery in Canada (Barrington 1985; James-Chetalet 1989; Mason 1988; Shroff 1997) and also shows up in Canadian midwives' own narratives about their historical antecedents—although sometimes in critical ways (MacDonald 2004). Most recently, this iconic traditional midwife was the subject of brief celebratory vignette entitled "Midwife: A Heritage Minute," which aired on television across the country.[5]

Closely linked to the iconic traditional midwife is the ideal of the natural birth that she attends. It is both the absence of biomedicine and the presence of the knowledge and skills of the midwife as well as the capable body of the birthing woman in a home setting that is crystallized in the notion of the natural birth attended by a traditional, predemise Canadian midwife. Many contemporary midwives themselves are critical of such a romanticized version of midwifery history—citing the harsh reality of maternal and infant suffering and death on the Canadian frontier during that time. Yet they simultaneously express a sense of kinship with traditional midwifery's pioneering spirit. In the end, critical rereadings of Canadian midwifery history caution us against overgeneralizing while acknowledging the important strategic and symbolic purposes that the story of tradition and rebirth has served.

By the late 1980s, midwives in Ontario had come to define their work, which took place outside the formal health care system, as community midwifery, a term that emphasized the decentralized nature of childbirth attendance and the relationship of the midwife to her constituents (Burtch 1988:354).[6] To the discourses of nature and tradition were added liberal feminist rhetoric of choice, rights, and health—reflecting diverse political alliances.[7] The essence of this new midwifery was not to create another childbirth authority but to put control of the process back in the hands of the women giving birth. Thus, midwifery during this time was consumer driven and -regulated, and women's experience ideally determined midwifery knowledge and practice (Barrington 1985; Bourgeault 2006). The intensification of this social movement throughout the 1970s and 1980s led to the legal and professional recognition of midwifery, in the province of Ontario in January 1994.[8]

Midwifery is now legally accessible to women experiencing clinically normal, uncomplicated pregnancy and birth (as defined by the College of Midwives of Ontario [CMO] and other professional medical bodies). Public funding for health care in the province means that women are free to choose their maternity care provider without direct costs to themselves. This provision facilitates access to a wider clientele than before, when one paid out of pocket for community midwifery services. In Ontario, as across the country, midwifery is built on the philosophical basis that considers birth a profound event in a woman's life, not just a physiological process. In the Ontario model of care, three clinical principles are emphasized: continuity of care, informed choice, and choice of birth place—including home birth. Through this model, midwives work to support women to "give birth safely with power and with dignity" (CMO 1994:1). Despite its new professional status, however, midwifery, even after ten years, still exists at the interstices of mainstream and alternative health care in many ways.

## A Natural History of Natural Birth?

Midwifery as a social movement shares with feminist scholarship on reproduction critical readings of mainstream maternity care as a process that alienates women from their bodies, fragments the potential wholeness of the birth experience, and commodifies both women and babies (Davis-Floyd 1992; Martin 1987; Rothman 1982). This medicalization thesis holds that obstetric medicine developed its tools and technologies for the control and manipulation of what was purported to be the inherently defective, and therefore dangerous, process of birth. Robbie Davis-Floyd's term "technocratic birth" (1994) describes the constellation of ideas and institutional and clinical practices that characterize modern obstetrical medicine and what is viewed to be its generally negative effect on women as individuals and a group. Although strategically useful, both feminist scholarship and ethnographic material on childbirth reveal a problematic tendency to search for authentic origins as if to chart the natural history of natural birth for the reeducation of modern women.[9] The foundations for such a project lie in the interdisciplinary effort to move beyond strictly Western scientific understandings of the universal, objectified body by demonstrating the social and cultural constructedness of all bodies. To this end, feminist scholarship sought to expose the layers of signification built up on the female body by the regulatory and self-regulatory practices of culture and modern power. Meanwhile, critical anthropologists focused on describing and theorizing the ways in which all cultural systems—including biomedicine—naturalized power in the body in particular ways.[10] Thus, as science continued to discover the so-called natural facts of the female body, feminist scholars continued to expose them as cultural constructions. Reproduction, of course, emerged as a key site of inquiry.

Alongside critiques of the cultural construction of the female body and medicalized birth arose a certain romantic bias toward non-Western birthing systems. Anthropological accounts often portrayed midwifery as a universal, woman-centered tradition, relying on simple or "appropriate" technology to aid the "natural" process of birth. Birthing women in other times and places appeared as knowledgeable, self-sufficient, physically strong, and close to nature. There was significant interplay between social science scholarship and popular writing on childbirth throughout the 1970s and 1980s. Popular writers drew explicitly on anthropological materials, and anthropological analyses frequently argued that mainstream obstetrics had much to learn from traditional non-Western birthing system (Davis-Floyd and Sargent 1997; Jordan 1993; Laderman 1983). This tendency is epitomized by the extremely popular and influential work of anthropologist–natural childbirth educator Sheila Kitzinger, who used anthropological data on diverse birthing practices in a series of popular books to lament the cultural impoverishment of Western-style birth (1980, 1982, 1988).[11] Part of Kitzinger's message was set to rest on the claim that natural female bodies and natural births had been rediscovered, as it were, dwelling in traditional societies throughout the globe, proving the existence of a prediscursive nature uncorrupted by scientific culture.

Yet the nostalgic desire for birth as a natural event that takes place in the home, however compelling and strategic, is problematic. Although in other realms of anthropological inquiry—kinship, medicine, gender, and nationalism—nature has been exposed as a cultural construction, it has not always been problematized in

scholarly analyses of midwifery and childbirth.[12] Given the development of feminist theory and practice beyond such essentialisms—even strategic essentialisms (Spivak 1993)—it is perhaps time to rethink our attachments to such a notion. Such a rethinking is aided greatly by feminist theory engaged in destabilizing the female body as a universal basis for feminism. Judith Butler's theory of gender performativity, in particular, is an important tool for understanding the construction of natural pregnancy and birth in midwifery discourse as an "effect," rather than some prediscursive reality. Gender, writes Butler, is "the repeated stylization of the body, a set of repeated acts within a highly rigid, regulatory frame that congeal over time to produce the appearance of substance, of a natural sort of being" (1990:33). In other words, gender is an "act" that is both intentional and performative, requiring the actor to reexperience a set of already established social meanings (Butler 1990:140). Moreover, Butler notes that when the repetitive, regulatory practices that construct normative bodies are interrupted, opportunities and possibilities for rematerialization of those bodies emerge (1993:55). Likewise, critical–interpretive theory in medical anthropology sees bodily processes as communicative and as opportunities for subversion (Lock and Scheper-Hughes 1991).

Thus, the task of peeling away the "fictions" of science and biomedicine as if to reveal the true female body and the natural process of pregnancy and birth—or as one midwifery client said, "pregnancy and birth as it was meant to be"—is impossible. In its place, however, a new task emerges: if pregnancy and birth are gendered performances that are repeated within the "regulatory frames" of biomedical culture and institutions, then midwifery seeks to interrupt them by reconceiving, rather than retrieving, the natural facts of pregnancy and birth. Dutch scholars Bernike Pasveer and Madeleine Akrich, studying midwifery in the Netherlands, argue that women "learn to be affected" by and come to embody the assumptions inherent in their maternity care (2001:236), be it midwifery or biomedical obstetrics. What has come to be known as natural birth, they conclude, "is not something that occurs all by itself" but is one possible "obstetrical trajectory" (Pasveer and Akrich 2001:236).

## Notes on Methodology

The data for this article are drawn from an ethnographic study of midwifery in Ontario I conducted in 1996 and 1997. My methods involved participant-observation at midwifery clinics, prenatal classes, professional meetings, and home births.[13]The other major source of data for this study are 51 formal, in-depth interviews—26 with registered midwives and 25 with women (and sometimes their partners) who had midwifery care in Ontario the 1990s.[14] Most community midwives in Ontario at this time were white, middle-class, and well-educated women. My study participants reflect this profile, although diversity in the profession is increasing.[15] The interviews were semistructured and open ended, designed to elicit what I call midwifery narratives—stories of becoming and being a midwife. Most of the midwifery clients I interviewed were drawn from the midwifery clinics I worked in, although several contacted me independently. All interviews took place at women's homes, which were the most convenient and comfortable locations for women with infants and small children. I often spent much more time with women after the interviews—touring gardens and upstairs rooms, sharing food, meeting

partners and children, holding babies, and viewing photo albums and birth videos. Like midwives, women who sought midwifery care in Ontario at the time of my study tended to be white, middle class, and relatively well educated, most having had some postsecondary education. They, too, are slowly diversifying in terms of cultural, linguistic, and socioeconomic background, as the outreach programs at many clinics draw in new immigrants and ethnic communities. My interviews with midwifery clients were designed to elicit another kind of midwifery narrative—stories about the meaning and experience of pregnancy and birth with midwifery care.

I conducted this research in the wake of the 1994 legislation that professionalized midwifery in Ontario. Although generally hailed as a victory this process was not without controversy. Not only did professional medical bodies oppose it but the midwifery community was divided as well: Some community midwives had no desire to join the mainstream system, whereas others found themselves fighting against the exclusionary practices of the new profession. It was an exciting, if sometimes awkward, time to be studying midwifery. Although greatly alike my study participants in many ways—and tacitly supportive of the professionalization of midwifery—I was not a complete insider, as I was reminded on several occasions. Rather, I situated myself then (as I do now) as an "interested researcher" of midwifery—someone with a long history of research and activism in women's reproductive health who is also an anthropologist committed to critical reflection and analysis.[16]

## Gender Expectations

Does midwifery in Ontario claim to have rediscovered the true nature of women's bodies and the natural facts of pregnancy and birth? Superficially, this might appear to be the case. When asked directly about natural birth, midwives and the birthing women they attend respond in predictable ways: "It means drug free"; "It means no interventions"; "It means nonmedicalized, the opposite of a hospital birth." When probed, however, the question of what constitutes natural birth begins to reveal some interesting and unexpected dimensions. Indeed, such notions of natural birth are clearly and creatively problematized in the stories and reflections of both midwives and birthing women. In the rest of this article, I explore several key themes that highlight the reconceptualization of nature in midwifery and its implications for gender, including: the reconceptualization of labor pain, the view of pregnancy and birth as individual accomplishments and routes to empowerment, and the importance of choice in midwifery care, especially with regard to use of medical interventions.

I begin, however, with the most basic assumption of the midwifery model of the body—its holistic, non-Cartesian nature—clearly revealed when midwives say that a woman must be able to "listen to her body" and "let go" to give birth naturally. The physical space she labors in and the people who surround her can have a profound affect; a crowded room, for example, or the "negative energy" of someone present can inhibit the progress of labor. Some midwives observe that it is often better when a woman is left in a quiet, dimly lit room with her partner. "Do midwives consider that more natural?" I asked Laura,[17] an urban midwife in her mid-fifties who has been a midwife for 25 years.

> Well, birth can be *more* natural. If we have a birth that is assisted with drugs or procedures or medication then that is not a natural birth. That I think we

> can agree on. But when we get beyond that to: Who is with the woman? What does she do? How does she behave in labor? That's very much influenced by culture. I have been to births in Canada with women from different cultures and I have been to births in two other countries in Latin America—Mexico and Brazil—and they weren't all that different at the moment of birth in terms of how women behaved: they all made noise, they all pushed and the baby came out, you know? Different things happened afterwards: the cord was cut right away, or the baby was taken away, or the baby was left to lie until the mother had interest in it. . . . I think we [as midwives] used to like to think that our way of doing births was more natural—well, yes, if it doesn't include all those medical things—but sometimes it does include some of those medical things; sometimes you rupture the membranes. But even if there are no medical procedures—the membranes aren't ruptured, nothing—then is that a natural birth? There is still the culture.
>
> Would that be more natural? The dim light by yourself? This is like Michel Odent who put them all by themselves and they all had their babies with no trouble. It's just these interfering—So is that more natural than somebody [giving birth] with supportive people in her community? So then is a woman without culture because she is by herself? No she's not. . . . You can even talk about prenatal culture. In Mexico, for example, they have *sobada* massage, babies being massaged through the whole pregnancy. And our babies don't have that. So even prenatally we have a culture for our babies: we have expectations.[18]

Laura's answer seems to confirm the position of natural birth in opposition to hospitals and obstetrical care (no drugs, no interventions). Her answer would also seem to place natural birth in close association with common imaginings about "primitive" birth (quiet, dark, animalistic). Yet the picture is more complex, as midwives are well aware. Laura's response goes beyond the natural birth versus medical birth dichotomy and addresses the false dichotomy between nature and culture. Indeed, she has come to a rather anthropological conclusion: that childbirth is a culturally constructed phenomenon. The important thing for her is that she works consciously to influence the way in which her midwifery culture shapes this universal phenomenon.

Can the search for authentic or natural pregnancy and birth lead us to replace predominant cultural versions with improved ones? Ada is a midwife who comes from rural Ontario. Her training to become a midwife was characterized by a mixture of formal education and apprenticeship. She worked for many years as a childbirth educator and a *doula* before entering the university Midwifery Education Program in Ontario,[19] and, at the time we spoke, had been practicing as a registered midwife for three years. After offering me an initial—and predictable—definition of natural birth as the opposite of medical birth, Ada began to hedge.

> Well, I guess the obvious thing that comes to mind is nonintervention in the sense of augmentation, drugs, episiotomies, procedures, vacuum extractions—those kinds of things. It's a hard one in terms of the medication issue because I would hate to say to a woman that she didn't have a natural birth because

> she required some pain medication. That's a hard one. On the one hand she did have spontaneous vaginal delivery and pain medication can be, in some cases, very positive for women. I guess I shy away from identifying what clearly is natural; maybe that's what got us into this trouble in the first place is that feeling we have to have some model of what natural is and we have to have techniques to obtain that natural birth.

"So having a specific ideal of natural birth necessarily means that some women will fail to accomplish it?" I pondered aloud. "Yes" she replied. Indeed, a young woman in the prenatal classes that I attended (herself a midwifery student at the time) said that she would feel "ashamed" in front of her classmates and her instructors if she ended up giving birth in hospital, and especially, if she ended up with a C-section. Another woman I met several times at a midwifery clinic and interviewed at her home after the birth of her baby was apologetic that she had "cried for an epidural" during labor and had "begged" to go to the hospital. "Next time it will be different" she told me. "Next time I will do it naturally."

The inevitability that some women will fail in the goal to birth naturally—at home, without drugs, without interventions, and without screaming in pain—is one reason that Ada, like many midwives, prefers to avoid defining natural birth. "The idiom of nature sets limits" not only in terms of defining acceptable ways to give birth but also in terms of motherhood and gendered identity (Michie and Cahn 2000:55). Thus, the pursuit of natural birth veils a troubling moral system underlying its visual and conceptual imagery. Another midwife in my study, Isobel, describes natural birth as a myth that says, "If you are a together person you can squat in the corner and have your baby by candlelight" and also that "You have to have a vaginal birth to achieve some sort of womanhood." Yet the myth of natural birth is important because it has served to counter another myth that says, "Childbirth is so horrible that you need to be knocked out in the hospital." Isobel, who first trained as an RN and lactation consultant before becoming a midwife, explains how her thinking about natural birth in the context of her work as a midwife developed:

> I think that's really dangerous when you are making people try to fit into little boxes. But I started out [as a midwife] thinking like that. My goal was to prevent cesareans. But I have seen so many women feel a sense of strength and dignity and satisfaction after a cesarean birth. And I think it's because they have given birth and they've worked really, really hard. Even like [when a woman has] an *abruptio placenta* and you have to have an immediate cesarean, it doesn't take way from it if you have that feeling that you are in control. I hear this all the time. Women consistently say on our evaluation sheets or I hear directly, "I felt I was the one making the decisions. Even though I would have preferred not to have to make that decision, I made it and I was ready for it and it was great that you guys were there because I felt that I had a friend there, someone on my side to help me through that difficult time."[20]

Making sure that a woman has choices in labor usually includes a variety of things including where to labor, who to have with her, what to eat and drink, what position to labor in, what kinds of pain management to use (including pharmaceuticals),

and whether or not to have augmentation of the labor. Very occasionally, ensuring women have choices in childbirth means planning for an epidural early in labor—not exactly the kind of planning usually associated with a natural childbirth. This is perhaps an extremely open interpretation of natural birth, and even the midwives who agree that natural birth might include epidurals are quick to elaborate how such choices are negotiated in prenatal visits and during labor.[21] Midwives do not want women making decisions based on fear of childbirth pain, peer pressure, or popular conventions, but they do want to ensure that women feel safe and supported in their particular needs. Midwives explain to clients that if they do not have any pain medication, they are likely to have fewer interventions overall, feel better, and recover more quickly. Nevertheless, most midwives agree that when they have tried all the tricks in the book to relieve a woman's pain and exhaustion through physical and emotional support, an epidural can be "a blessed, wonderful thing." Other interventions, too, have their place in the realm of the "natural." Isobel concludes that, "natural childbirth [is about] making sure the woman makes her own choices. That's my goal, not natural childbirth per se."

Gwen is a self-trained, urban-based midwife with nearly 30 years of experience. She told me a story over lunch one day about a client she cared for named Abby who, after 20 hours of labor at home, was transferred to physician care and was delivered by cesarean section. Months later, Gwen bumped into this former client on the street. Abby introduced Gwen to the friend she was with at the time as "the midwife who delivered my baby." Gwen was taken aback at this introduction because she did not, in her estimation, or in any literal sense, deliver the woman's baby at all. (Midwives, in any case, say that they catch babies, not deliver them.) Gwen described the labor and birth to me in more detail. They were laboring at home and things were unfolding very slowly. At each stage, Gwen explained to the woman and her partner about what was happening and what their options were. They tried different positions. They tried getting in the bath. Eventually Gwen, the laboring woman, and her partner arrived at the decision together to go to the hospital, and eventually to follow the advice of the attending physician to have a C-section. It was not an emergency situation, so there was time to talk about it beforehand. Gwen stayed with Abby in the hospital until she was brought into the operating room. Gwen and I wondered aloud together if it was not a profound sense of control in decision making throughout the labor—including the decision to have a cesarean—that allowed Abby to come to the remarkable understanding that Gwen had "delivered" her baby. Perhaps what Gwen had delivered was information and the space for the laboring woman to choose what was best for her and her baby. Midwives talk a lot about informed choice. Could it be this powerful?

The importance of informed choice in midwifery philosophy and practice cannot be overstated. It is one of the three guiding principles of the Ontario model of clinical care. Midwives explain informed choice as the act of conveying clinical knowledge to women and their partners in such a way that they can understand it and then make informed decisions about their own care. This may be something as simple as describing the importance of maternal nutrition on the developing fetus. Or it may involve citing the findings of a clinical study on the effect of artificial rupture of membranes on fetal outcomes. Midwives also encourage—indeed expect—clients to read on their own and generate their own questions. They make this possible

through their large lending libraries. They also stress that informed choice is about confirming and supporting women's own knowledge or gut feelings about their bodies and previous pregnancies in determining what is right for them. Anthropologists have observed that in many birthing systems the locus of decision making is shared between the birthing woman and the midwife, be it among the Maya of Mexico or in the high-tech hospitals of contemporary Sweden (Jordan 1993:87–88). In this next midwifery story, the aspect of choice emerges again as a powerful component of natural birth that can elide otherwise unnatural interventions.

## Labor Pains and Women's Power

> I think that natural is a stupid word. What does it mean in this society? I just wanted to have my birth. You know what I mean? I wanted to be the one who was making the decisions, or we were making the decisions. I didn't want to have a "natural" birth. I'm sure all of [my midwife's] clients would gladly use the hospital if they thought that their baby would die otherwise. I mean, we don't live in the hills. I just wanted to be able to trust myself in the experience of being pregnant and the experience of giving birth and I want to now be able to do that with raising my children. [Leigh, 36, midwifery client]

The vast majority of midwives recognize pain medication as having its place—if a woman has a preexisting health condition that makes it advisable, or if she experiences severe back labor, for example. But in the case of normal labor and delivery, midwives generally take the view that pain can and should be managed in nonpharmaceutical ways. The pain of labor is one of the main fears that women express in prenatal classes and appointments. Midwives do not pretend that labor is not painful and shy away from offering magic solutions, but they do offer clients another way to think about it, and, in turn, to experience it. How midwives reconceive the pain of labor is key to their view of pregnant and birthing bodies as naturally capable and competent. One woman in my study described the way her midwives helped her prepare for labor and birth was by teaching "almost another world view... more of an attitude than anything else." In the midwifery model of pain, a number of things are emphasized. One, the pain of labor is not continuous like most other pain: contractions are intermittent and build slowly in intensity so one can learn to cope. Two, the pain of labor is "pain with a purpose": You are pushing out your baby. Three, midwives invoke the image of the universality of birth: "Women have been doing this for centuries. Our bodies are designed, or have evolved, to do it well." Midwives insist that medicated birth is not usually necessary and that most women are capable of giving birth simply with proper emotional and physical support.

Midwives work hard to naturalize the pain of birth even from the first minutes that a woman goes into labor. They advise women not to fuss too much about labor in the early stages; they should do what they normally do—eat breakfast, do the dishes, go for a walk. Likewise, they advise women's partners not to fuss too much about each contraction in early labor, so as to not give her the impression that she

cannot cope. This kind of advice reflects an understanding that pregnancy is not an illness and labor and birth are not crises but rather normal physiological events. Midwives sometimes talk about contractions as intense, not painful. Ultimately, women are seen as capable of managing the pain of labor.

Leigh's story of pregnancy and birth with midwifery care is a good example of how midwifery works discursively to affect women's knowledge and experience of labor pain and how this becomes central (and indeed desirable) to having a natural birth. When I met Leigh, a lawyer in her mid-thirties, she had just had her second baby with midwifery care. The first one occurred before midwifery was a recognized part of the formal health care system. It was a planned hospital delivery, with the shared care of a midwife and a physician. The second was a planned home birth several years later with the same midwife as her primary care giver under the new regulated system. Leigh's experience of laboring without pain medication was a profoundly empowering one, her own individual accomplishment. She attributes this to midwifery's unique "world view" of birth, which "has everything to do" with her confidence in her body during pregnancy and birth. For Leigh, midwifery offers a way to rethink pregnancy and birth, especially the pain of labor and the fear of complications.

> Most of the women I know are terrified of birth. Terrified of the pain. Terrified of the difficulty. Really competent, interesting, smart women are terrified of birth. It is terrible that they look at birth that way; it is a difficult experience but it is also exhilarating. . . . I felt really powerful after I had Martha. I felt really powerful after I had Zoe. I felt fantastic. I felt like it was my marathon. It was something that I had done and I found it intensely interesting, too.

> "Even in the moment? Even as you were laboring?" I asked her.

> Yes, even in the moment. When you are in labor and you are trying to figure out how you can go with the labor, how you can help yourself dilate, how you can carry on through it, how you can let it happen—there is a long time in labor when you are dilating when you have to do all that work. And it's work that you can do. I mean your body helps you do it. And if you do it—at least for me—it is a very positive experience and then at the end there is no more work because your body runs the show. But it's a very enriching experience because you end up thinking "I did this! This was really hard and I did this!" And you can do it because your body will help you do it. You don't have to doubt that you can do it, if you believe that about yourself.

Leigh's sense of having a healthy pregnancy and feeling strong and confident also derives from accepting the limitations that come with pregnancy and "giving in" to labor: "The whole thing was a lesson to me. The pregnancy was a lesson to me, and the labor was a lesson to me. And it is a lesson in being almost someone not from our century." When asked to explain, she said that our medicalized, technologized view of the world leads us to believe incorrectly that we can and should override the body in pregnancy and labor through tests and medications rather than "take the guidance of the body."

> [My physician] had an almost antithetical approach which is check, recheck, don't trust, trust means nothing, faith means nothing, gut feelings mean nothing. So that with Zoe even when I was eight centimeters dilated and I was home all day and wasn't even at the hospital yet, my doctor phoned and asked if I wanted an epidural! And it was not a great insult. He was trying to be helpful because that's his orientation. But that, in a way, is defeating because it is very hard to be eight centimeters dilated and I didn't even want the question asked. And that's why I was at home because I wanted to do that work without all that. And had I been in the hospital I probably would have taken an epidural at that point.
>
> "Why was it so important to not take the epidural?" I inquired.
>
> The reason I wouldn't want to take the epidural is because I want to do the work myself. I wanted to have that experience myself and I feel much richer for that experience. And I feel like I've seen something that I haven't seen before, I feel like I've gained an insight into my body. And I feel richer for it.

The determination to give birth without pain medication was for Leigh, in her words, "a route to my power." She notes a clear difference between being in control of birth—something that she thinks is not totally possible on the physical level, and something that midwives encourage women to give up—and being "in control of the circumstances of birth"—something that is possible to a great extent and something that Leigh and many other women cite as key to feelings of empowerment, strength, and even wisdom derived from midwifery care and birth.

But does her birth without pain medication constitute a natural birth? Leigh says that while in labor she is "guided by something very primitive, but I'm not just a primitive woman." When Leigh describes the situation during her second birth—the planned home birth that ended up in a hospital—her ambivalence about the definition of natural birth surfaces and the line between nature and medical interventions becomes blurred. Because her first baby born in hospital had meconium staining,[22] Leigh was aware of the possibility of this happening again and refers to it in her description of how she labored at home with her second baby.

> After six hours I got [my midwife] to break the waters—partly because I had that meconium thing in my head and partly because I didn't want six more hours of labor. Frederick Leboyer would hate me because he said that birth is violence and that breaking the waters would make birth more violent. I was worried about the meconium and I didn't really care about Frederick Leboyer. And also [my baby] was seven days overdue. So that makes the risks higher. So it didn't seem to me to be a bad thing to do. . . . So I don't think that breaking the waters is terribly unnatural—people have been doing that for a really long time, you know? And if I feel like I want to break the waters because that labor is long and something else is niggling at me—which is what was going on—then I guess that's not unnatural.

Leigh's story illustrates the midwifery philosophy that birth is a route to the personal and collective empowerment of women. First, it involves the expectation that giving birth is hard but satisfying work that women are completely capable of performing. Birth is something that women do, rather than something that is done

to them. Second, Leigh says that she felt a sense of control over her circumstances because she labored at home, away from doctors offering epidurals, and so on. Yet her sense of control over her circumstances included asking her midwife to break her waters because she was exhausted and worried about meconium staining. (As it turns out, she was right.) She would argue, as I do here, that a flexible rather than fixed construction of natural birth strengthens rather than weakens its empowering potential because it involves women's gut feelings and choices—including asking for an intervention—in a clinically informed and supportive context.

## Natural Interventions?

Do interventions always disrupt the natural process of pregnancy and birth? Leigh's story would seem to indicate otherwise. However, the common wisdom in midwifery is that one intervention begets another. For example, if a woman has her labor artificially induced or augmented with intravenous oxytocin—commonly referred to by its trade name Pitocin or simply as a "Pit drip"—her contractions may come on so fast and strong that she is more likely to need pain medication, which, in turn, makes her less likely to be able to push her baby out, which may result in prolonged third stage of labor, which may cause fetal distress and the need for a caesarian section. A less extreme scenario is when a woman has an epidural, followed by an episiotomy and then delivers a healthy baby vaginally, but her recovery time is much longer than if she had neither and her baby may be less alert and less likely to nurse right away. There is evidence to suggest that the routine use of many interventions is clinically unnecessary and does not change the outcome for either mother or baby (Sleep et al. 1989). Further, midwives and women in my study often stated the belief that our tendency to rely on—or be subjected to—medical technology has destroyed our natural instincts about pregnancy and birth.

Midwives do use technology during prenatal care and during delivery, whether they are in hospital or at home. They use handheld ultrasound devices, for example, to listen to fetal heartbeats. They order ultrasounds to confirm gestational age or to check for certain suspected conditions. At home births they carry oxygen for both mother and baby, if necessary, as well as intramuscular oxytocin injections to stop uterine bleeding. Indeed, since legislation, midwives have an expanded scope of practice, much of it involving the use of medical technology prenatally or during labor. At hospital births, for example, they may administer fluids and some medications such as antibiotics intravenously as ordered by physicians. (They can also do this at home births in some instances.) Some midwives are even seeking certification to manage laboring women with epidurals or to perform vacuum extractions (Kornelsen 2004:5).

Another woman in my study, Kelly, shed more light on what constitutes natural birth in the setting of regulation and increased access to medical interventions. Kelly is a woman in her early thirties living in a medium-sized city in Ontario. Her first child, Clara, was born at home under the care of midwives. I met Kelly at her spacious apartment on the third floor of a low-rise building in a suburban part of the city. She tells me that her interest in midwifery and her knowledge of "the way things should be" come from deep within her. She says that she has always known that birth was meant to be "totally natural and joyous, not frightening," and she grounds

this faith in a kind of biological determinism that posits women as naturally strong and capable: "As females—it seems very simple to me—we are born with these parts with this purpose of our biology and that's it. It's a process that happens and it's supposed to happen. It's just biologically natural."

It was through a course to become a doula that Kelly first met other women who shared her views about pregnancy and birth. Using her own experience as an example of natural pregnancy and birth, she tells me that during pregnancy she did not take any medication or have an episiotomy because

> an episiotomy is unnatural unless it's absolutely necessary. And there *are* a very small number of cases where that would be necessary. . . . Now, for example, if a woman went through the whole labor without any medicinal type things then I would say that she had a natural birth even if she had an episiotomy because that was just part of her, of who she is, her physiology. But it goes beyond the physical sphere of things. It includes your state of mind, too. And if you stay at home to have your baby, you can add to the naturalness of it.

In Kelly's view, if an intervention is done because it is absolutely necessary, and not simply convenient or expedient, then the birth could still be considered natural. Moreover, she is suggesting that there are degrees of naturalness. One evening at the prenatal classes I attended at a local midwifery practice, a discussion arose about tears that can occur in the labia and vagina when a woman is pushing her baby out. Ingrid, the midwife instructor, reported that scientific research had recently confirmed what midwives knew all along: that routine episiotomies were unnecessary and that most women did not require them. She then made a surprising comment: that most women tear during the pushing stage of labor. I suppose we were expecting to hear that most women do not tear during the pushing stage, a piece of information that would confirm the routine use of episiotomy as brutally unnatural. Her point was that most tears are small and either repair themselves or require just a few stitches. Even deep tears, in her opinion, are preferable to large episiotomies because the tissue tears only as far as it needs to and then heals more efficiently. One woman in the class asked her, "Are tears, then, a natural thing?" to which Ingrid responded, "I would have to say yes."

The room was quiet for a moment after that. The discussion then turned to what midwives do to prevent tears. It starts with perineal massage in the prenatal period, something that pregnant women and their partners do at home, to stretch the tissues that will have to stretch during birth. During the birth itself, midwives use hot compresses and apply pressure to the perineum to support it as the baby's head descends, crowns, and is born. They massage and stretch the tissues with olive oil to ease the baby's head out of the vagina. Midwives will often ask a woman to stop pushing altogether for a moment so that the baby does not come out too quickly. One of my study participants, Giselle, remembers this part of giving birth clearly.

> So with Georgia when her head was pressing very hard against the perineum, [my midwife] stopped me, and she used olive oil. She massaged. And she gently worked her head out—slowly and gently stretching me. I remember

> the sensation—the widest part of the baby's head had passed, and I didn't tear. I didn't tear at all! And they said, "That was beautiful!" It stretched so nicely and there was no damage. It was just perfect.

Giselle contrasted her awe and appreciation of this esoteric midwifery skill to the experience of delivering her first baby in hospital with her family doctor. She described with anger how her perineum had torn badly when the baby came whooshing out to a chorus of nurses and her doctor chanting, "Push, push, push, push!" Giselle who was proud of having delivered her second child at home naturally, admits that interrupting the urge to push and massaging the perineum during birth are interventions. But she added, "If I was giving birth in the woods I guess I would have just pushed as hard as I could because natural instinct tells you 'Get that baby out!' So you would want to naturally push like crazy at one point." So, somewhat ironically, the intervention of her midwife in averting the instinct to push as hard as she could is what helped Giselle achieve her "perfect" natural birth.

## Natural Intentions

The intention of the caregiver is another critical factor in determining the perceived naturalness of birth or at least the status of a particular intervention. The case of artificial rupture of the membranes is a good example of the way in which intention and context matter. Although this intervention may be viewed as unnatural, and recalled with anger or disappointment when experienced at the hands of a physician without being consulted first, women in the care of midwives do not ordinarily regard it as a problem. This is one example of the way in which midwifery is almost a gloss for what is natural, but this is not always the case.

In a clinic visit during my fieldwork, a couple—Marielle and Tom—came in with their newborn baby for a postpartum visit with their midwife, Isobel. The rapport between them was warm and sincere; Isobel had been there for their first two babies, and throughout the pregnancy of their third but did not attend the actual birth. As they discussed the birth, Marielle began to cry recalling how, long into the labor, the alternate midwife had told her she was not working hard enough. "I know she just said it to inspire me, but it hurt my feelings, and it wasn't true." Marielle was even more upset that this midwife had insisted on breaking her waters to "get things moving." She described how different this was from the births of her first and second babies, when her waters had burst naturally in the pushing stage. Marielle recalled how the excitement of those moments inspired her and renewed her flagging energy. She felt that the alternate midwife had not respected her natural birth process. She was suspicious of her intentions and this played a role in her evaluation of the artificial rupture of the membranes as an unnatural intervention. Thus, the exception to the trusting relationship between midwife and client reinforces the centrality of caring and trust in midwifery care itself as integral to natural pregnancy and birth.

## Conclusion

> At the heart of any "cultural system of reproduction" in any society are gendered messages.
>
> —Yanagisako and Delaney, 1995

In this article, I have shown how midwives in Ontario and the women they attend are engaged in culturally productive strategies (both discursive and clinical) that challenge the powerful discourses of science and medicine and the institutions of maternity care that have shaped women's embodied subjectivity. Do midwives and their clients perceive natural birth as the opposite of medical birth? The answer is, sometimes. But as these midwifery narratives reveal, what constitutes natural birth is being reconceived and relived in ways that are more individual, contextual, and contingent. Given that midwifery philosophy stresses that every birth is different, individual meanings of what is natural are derived more from the perspective of birthing women themselves rather than from any rigid criteria. The discursive framework of midwifery rejects the taken-for-granted notion of natural birth for the reason that it fixes too firmly nature against culture, nature against medical and technological interventions, and sometimes, nature against women themselves (in the case of the failure to birth "naturally"). Such reworkings may also reflect a growing comfort with the omnipresence of technology in our midst, and quite literally, in our bodies. The new professional context of midwifery and the influx of a more mainstream clientele have no doubt been factors as well.

Despite the clear acknowledgment from midwives that natural birth is a slippery concept, it is still such a powerful concept that what both midwives and their clients hope for and work for is often articulated in its terms. In many ways, the idea of natural birth stands for midwifery itself and for a particular set of gender expectations: that women's bodies are naturally competent; that with proper support women can handle the pain of labor and even find it empowering; and that women can trust their gut feelings in a context in which choice is paramount, interventions are negotiable, and trust characterizes the midwife–client relationship. In this way, midwifery's discursive framework for the body posits a new set of social and cultural meanings and expectations for gender that are naturalized in the body through the process of pregnancy and giving birth. These gender expectations of natural birth are performed: repeated within the alternative framework of midwifery as subversive rearticulations that are deeply personal and yet highly political. In the end, we are reminded through these narratives from Ontario that midwifery cannot be construed, as it so often has, solely terms of "the romance of resistance" (to borrow Abu-Lughod's [1990] phrase) against a demonized biomedical system. Rather, as Marilyn Strathern has said, "Nature cannot survive without cultural intervention" (1992:174).

## Notes

1. Midwives argue that natural birth is empowering for families, too, in various ways, for example, allowing fathers, other children, and even grandparents a greater role in the process.

2. Throughout this article, I do not use quotes around the word *natural,* but it should be clear to the reader that I am critically deconstructing the term as it used in contemporary midwifery.

3. The exception to this were the British-trained nurse–midwives who were recruited to staff nursing outposts in remote and northern regions up until the 1960s (Kaufert and O'Neil 1993; Plummer 2000).

4. Their work was home based for both practical and ideological reasons: Midwives had no access to the hospital except through a very few cooperative physicians or the emergency room.

5. It is one of several dozen vignettes produced by Heritage Canada that depict important events and characters in Canadian society and history. For a longer description and analysis of the vignette, see MacDonald 2004.

6. Vicki Van Wagner argues that the term *lay midwife,* which was in common use at the time, was inaccurate and often used as a pejorative (1991:74). She points out that the term *community midwife* speaks to an understanding of health that takes social and economic conditions into account, focuses on health promotion, and shows concern for access to care. The term *independent midwife* is used in the United States to distinguish them from certified nurse–midwives (CNMs). Midwives who are not nurses may also refer to themselves as *direct entry midwives.* In Canada, midwives are officially known as *registered midwives* and may still call themselves community midwives informally.

7. See Elizabeth Barrington (1985) as a primary source showing the intersection of 1970s and 1980s health movements within Canadian midwifery and Ivy Lynn Bourgeault (2006) for a sociological perspective.

8. For a thorough sociological description of this process in Ontario, see Bourgeault and M. Fynes (1996–97). Midwifery is now legalized in several other provinces including British Columbia, Alberta, and Quebec. For descriptions of midwifery legislation in other Canadian provinces, territories and communities see Bourgeault et al. (2004) and Farah Shroff (1997).

9. Authenticity becomes something that is (or should be) consumed in the process of contemporary childbirth and motherhood. Gertrude Fraser reflects on a similar process, whereby traditional granny midwifery in the U.S. South is "recuperated" and "recast" in terms of contemporary black women's desires to reconnect to their roots (1995:51). Anthropologists have recently begun to write very fruitfully on the subject of midwifery as a kind of middle-class consumption (see, e.g., Taylor et al. 2004).

10. See, for example, Carol Delaney on conception theories (1991), Sarah Franklin on assisted reproduction (1997), Margaret Lock on menopause (1993), and Emily Martin on the reproductive life cycle from conception (1991) to pregnancy and birth (1987).

11. Who, by the way, all my study participants had read. See also Suzanne Arms (1975) and Barrington (1985).

12. Helene Michie and Naomi Cahn's 2000 critical analysis of the alternative childbirth literature is an important exception.

13. Participant-observation at midwifery clinics allowed me to observe midwives and clients in both casual and clinical interaction and to make contact with women for informal discussions and potential interviews. Here I was also able to access documentary and visual materials relating to the education of midwives, clients, and the public about midwifery philosophy and practice; these materials assisted my understanding of how and what midwives communicate to each other and to clients about pregnancy and birth as well as the politics of midwifery in Ontario and abroad.

14. All interviews were audio-recorded and lasted from 1.5 to 3 hours.

15. See S. Nestel (1996–97) for a discussion of "racialized exclusions" in the professionalization of midwifery.

16. For more details and methodological reflections on this process, see MacDonald and Bourgeault (2000).

17. The names of all informants used in this article are pseudonyms.

18. Michel Odent is a French physician and the author of *Birth Reborn* (1984). He is considered one of the most important figures behind the natural childbirth movement.

19. Doula is the name given to the person who cares for the new mother after childbirth and who may also assist at the birth. It is an informal role usually taken on by close female

relatives, neighbors, and friends. It is a very important role, providing support for successful early mothering, especially breastfeeding (Raphael 1993). Since the 1980s, some women have offered doula services for a fee or barter. Doula-training programs and professional associations now exist in both Canada and the United States.

20. The term *abruptio placenta* refers to a condition that occurs during pregnancy or labor in which the placenta pulls away from the uterus, causing bleeding and an emergency situation.

21. The case of a woman with a history of sexual abuse is a good example of how a planned intervention may be essential to ensure a woman's sense of safety and control with regard to her body.

22. Meconium is the first stool excreted by the infant. Interuterine excretion (which can only be detected after the amniotic waters have broken) is associated with fetal distress. Meconium aspiration is a potentially dangerous situation for the baby and requires hospital-based intervention (Raines 1993:244).

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