

MIDWIFERY: AN APPROPRIATE(D) SYMBOL OF WOMEN'S REPRODUCTIVE RIGHTS?

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Synopsis – The prospect of midwifery legislation in the Canadian Province, Ontario, is investigated in light of other reproductive legislation, especially that concerning new reproductive technologies. The idea that midwifery symbolizes a woman-centered approach to birth is criticized and related to a number of reproductive issues in the hope that the lack of concern for and control by women can be exposed and overturned: the financial convenience of legislating midwifery in light of cutbacks to healthcare, the socialization of birth so that a male perspective on reproduction continues to rule women's ability to control their actual procreative experience as well as to define its meaning, and the opposition of fetal personhood to the personhood of women.

Midwifery has become a contemporary symbol of women's reappropriation of birth. After centuries of locating pregnancy and birth management increasingly within a male-dominated medical profession (Rich, 1986), women are attempting to take back their control over this aspect of their reproductivity. In the province of Ontario, Canada, the government has decreed that midwifery shall be recognized for the first time as legal medical practice and that the appropriate steps to establish a profession of midwives should be taken (*Report of Midwifery Task Force*, 1987). This announcement is largely regarded by proponents of alternative birthing as a coup in promoting birth as a natural process rather than as a pathological condition, requiring medical treatment. This is coincident with the alternative birth movement which attempts to redefine and return to a language of birth that counters that which is spoken by the medical model of reproduction. Midwifery is converted into a romanticized symbol and attempts to recover a woman-centered birthing practice associated with pre-Renaissance Europe, before the rise of scientific rationality and medical practice.

Accompanying midwifery legislation in one of Canada's largest and wealthiest provinces, Ontario, is the development of legislation of the new reproductive technologies including in vitro fertilization (IVF), embryo transfer, genetic screening, and artificial insemination by donor (AID) in both the provincial and federal spheres of government (Ontario Law Reform Commission,

1985). The tone and implications of an Ontario pre-legislative text and the initial proceedings of a federal Royal Commission that is currently investigating new reproductive technologies (along with recent developments in abortion legislation), sustain a highly controlled view of female bodies and women's role in human reproduction. This paper investigates the establishment of legalized midwifery in Ontario and the development of legislation of new reproductive technologies and abortion in Ontario and Canada as consistent in their conservation of traditional reproductive values where women hardly determine or define conception, abortion, foetal personhood, pregnancy, and birth actually as well as symbolically.

MIDWIFERY

Midwifery is not currently legal as a separate profession anywhere in Canada despite a long history of its practice in early Canadian settlements and rural areas. Midwifery was routinely practised in non-native communities in Newfoundland up until the 1960s, while in Quebec and Nova Scotia the practice was legal until after the First World War (*A History of Midwifery in Canada*, 1987). Native Canadians, due to the fact that they live in isolated, rural areas, rely on midwifery today. It is practised, in these special cases, by specially trained government nurses and has evolved as a quasi-medical profession due more to the inadequate medical service supplied to native and

rural peoples in Canada than to women-centered birth control.

Midwifery practice in Canada, as in Europe, was steadily replaced by the medical profession where the removal of midwifery is seen as a part of the European colonization of Canada (A History of Midwifery in Canada, 1987). When the question of updating the Ontario Medical Act, 1795, arose, which included the possibility to legalize midwifery (until then it was practised without legislative sanction and in a spotty manner), the established and male-dominated medical profession objected (1874) and midwifery remained illegal and occurred less frequently (A History of Midwifery in Canada, 1987).

Now, the midwifery legislation in Ontario is under serious consideration at precisely the same time the legislation of new reproductive technologies is being considered. The motivations underlying midwifery legislation and new reproductive technology legislation are distinct but far from unrelated in a social context which increasingly controls and commodifies birth and children. There is interest in legalizing midwifery as a way of cutting back on health costs, particularly in Ontario. The Honorary Mrs. Caplan, Ontario's Health Minister in 1988, admitted as much: "Obviously, funding priorities and funding allocations have to be rethought and redirected in order to meet the new health care era in which we find ourselves" (*Proceedings of the Legislative Assembly of Ontario*, 1988). Part of this new age of healthcare is a recognition that birth can be taken out of mainstream medical practice at considerable savings as the high cost of physicians' salaries can be drastically reduced with more midwifery-attendance at births.

In 1982, the Province of Ontario's Ministry of Health announced a major review of its public health care system, the Ontario Health Insurance Plan (OHIP). This review was designed to provide an updated scope of acceptable medical practice and included midwifery. This formal recognition of midwifery coincided with a growing alternative birth movement that promoted midwifery as a radically different approach to birth than that taken by traditional medicine.

Midwifery has gained almost a cult status across North America (Gaskin, 1990; Kitzinger, 1988). It has become most visible in the past 10 years as a progressive movement within the white

middle class as opposed to the practice of midwifery amongst lower classes, ethnic minorities, and regionally isolated peoples, which has proceeded quietly throughout this century. There is a stark difference between this brand of midwifery that comes out of unevenly distributed healthcare resources and the apparent seizure of control by women of birthing, which the latest movement is meant to represent.

Ena May Gaskin's now classical text on midwifery, *Spiritual Midwifery*, is in its third printing (Gaskin, 1990). On one hand it represents the new vision of birth as a natural and spiritual happening. Gaskin claims we are actually out of touch with our bodies and our feelings, especially around birth, and that we must re-establish contact. For example, she offers a new language for describing birth happenings and refers, for example, to a *pussy* instead of the medical term *vulva* and a *rush* instead of *labour* (Gaskin, 1990).

On the other hand, a strong sense of male permission pervades the popular text. The cover is filled with images of a male buddha and the introductory words are either by Stephen Gaskill, Ena May's husband, or are about his spiritual influence on her. The introduction reads, along with the images on the cover, as male direction and approval of women's attempts to reunite the physical and the spiritual according to a male ideal. Ena May speaks:

When I decided to learn about midwifery and was attending those first births, I applied the principles I had learned from [Stephen]. He taught me respect for life force and truth and holiness, how to manage spiritual energy, how to be compassionate even when it's hard to be that way, how not to be afraid, and how to help people relax. . . . My hope is that the collection of information that follows will aid women in attaining the insight that can lead to power that equals that of men. (Gaskin, 1990)

The male guru is a common figure in the alternative birth movement. For example, Ferdinand Lamaze is one of the best-known proponents of a gentle birthing environment for the baby and active involvement by the mother in birth that became popular in the United States in the 1960s. His methods have become so widely accepted that even in mainstream hospitals *Lamaze*

refers now to a general shift in birth procedures (i.e., no more pubic shaving) and more involvement of the male partner (attendance in the delivery room) (Wertz & Wertz, 1979).

Lamaze is preceded by Grantley Dick-Read, who, in the 1930s, based all human progress on the “perfection of motherhood” (Dick-Read, 1984). In turn, motherhood, was best achieved without fear, something Dick-Read blamed mothers and other women for generating in labouring women: “. . . We have to recognize that very few daughters learn much that is likely to be helpful from their mothers” (Dick-Read, 1984). His task as a general practitioner was to alleviate this misplaced fear of childbirth in women and consequently to ensure nothing less than the future of human morality.

Frederick Leboyer emphasizes birth as a symbol for general human welfare with his approach to birth without violence. Here women’s role in birth is manipulated as concern for the foetus/newborn’s well-being is stressed. A remarkable shift from the Lamaze, idealized and prescribed, experience of birth for women to an idealized and prescribed experience of birth for the baby takes place. In the images that fill Leboyer’s text, *Birth without Violence*, women are barely visible, as almost all images in this pictorial essay focus on the pained or placid expressions of newborn infants (depending on the degree of violence in their birthing experience). The objectification of women as vessel (full and empty) is obvious in Leboyer’s description of where to place the newborn: “Her belly has the infant’s exact shape and dimension. Swelling a moment before, hollow now, the belly seems to lie there waiting, like a nest” (Leboyer, 1975).

For the release from the traditional medical model of childbirth and in the best interests of the baby, women are expected to be attentive to a new, male-led doctrine of alternative birth and to be grateful. The risk of revoking their right to create and control their ideal birthing environment and the broader meaning of reproduction is often overlooked.

The birth of a child is a small part of a larger story. There are the contexts of conception and child-rearing to consider as well. Gaskin, Lamaze, Dick-Read, and Leboyer’s visions of alternative birth emphasizes birth within marriage and otherwise heterosexual relationships. Also, the naturalizing of the birthing process once again

places women closer than men to nature as well as nurture and reinforces the social stereotype of mothers as primary child-rearers. This in itself is not necessarily problematic but becomes so when seen in context of a patriarchal and materialistic society that undervalues mothers and children and assigns value to the natural environment according to potential economic return. Most importantly, this is not a women-led trend and is powered by an image of women as potentially interfering in a newly idealized view of birth. Creating birthing alternatives may oppose normative birth-management, but does little in disarming a male author/ization of birth. Hence, the possibility that the new wave of legalized midwifery in Ontario will actually empower women in regard to their procreativity and check patriarchal stereotypes is doubtful.

Besides the assumptions inherent in the contemporary alternative birth movement, which embraces midwifery, are the questionable motives behind the Ontario Government’s midwifery initiative given the problematization of rising healthcare costs. The link between the Ministry of Health’s program of rationalization and recognition of midwifery and a perceived need to drastically cut the cost of the health care system cannot be ignored.

The history of the most recent attempt to legalize midwifery in Ontario begins in 1982 with the Health Professions Legislative Review, which was established by the Ontario Premier’s Council on Health Strategy. *Strategy* is a key word and refers to the government’s motivation for eventually encouraging the professionalization of midwifery. In 1986, the Council reported to the government on its findings and remarked that, “Canada and Ontario spend more on health care (on a per capita basis) than any other industrialized country with national health insurance” (Executive Summary, 1987). Thus, this recent recognition of midwifery becomes less the result of pressure applied by any feminist lobby and more the result of government cutbacks. The centre of power remains in a nonfeminist sphere which becomes especially apparent in the committees which have been set up to deal with the organization of midwifery legislation and training.

THE PROCESS OF LEGITIMATION AND PROFESSIONALIZATION

Early in 1990, the Ontario's Curriculum Development Committee of Midwifery Taskforce began to meet to establish a format, a location, and a curriculum for the teaching of midwifery. The Committee was made up of practising midwives, women who have used midwifery, general practitioners, medical specialists, and government administrators. Within this group the difficulties in realizing women's true emancipation in birthing became obvious.

On March 6th, 1990, the Committee met to discuss essential criteria for establishing a midwifery training program. During this discussion the issue of legitimacy arose. Despite the commitment of many in the room to midwifery as a step towards more women-controlled birth, the sway of normative medical epistemology held firm. The Committee decided that a degree would be necessary not to those already convinced of the merits of midwifery but to those who are suspicious of quackery. "Desirable, but not essential" was the final view on accreditation voiced by most members of the Committee. It would help sell midwifery to a wider audience as well as protect midwives from legal retribution.

Legal actions brought against midwives practising in Canada emphasize their marginality and give real concern for legal protection. Currently two midwives from British Columbia, Gloria Lemay and Mary Sullivan, are fighting a case which was originally brought against them in 1985. The charges are novel, especially in relation to most charges against midwives which tend to involve practising medicine without a license or negligence. In the Lemay and Sullivan case, the British Columbia court ruled that a fetus was still part of a woman when it entered the birth canal (Court Case May Be Key to Future of Midwifery, 1990), which translated, the death of a child during childbirth into an assault on the mother. Given the developed state of assault law on persons versus the precarious personhood status of the unborn child, this ruling provided an immediate loophole which ensured a successful case against these particular midwives and their practice. The Supreme Court of Canada is now hearing the midwives' appeal.

The limits to women-controlled birth in the current professionalization of midwifery in Ontario and the limits to the establishment of a woman's culture of birthing also are delineated by what is not acceptable. Hilary Monk, a member of various midwifery community groups in the city of Toronto, has written an account of what a woman-centered view of midwifery education would be like. In *Midwifery Education: An Alternative Approach* (Monk, 1989), Monk offers an alternative to the medical model of professional health-worker training. Like Ena May Gaskell, she emphasizes a different way of speaking of birth and pregnant women and challenges many assumptions made by the medical profession, which generally seeks to pathologize both. Also, traditional medical training denies the importance of more gradual learning by example or what Monk refers to as "absorption." Many midwives in Ontario have been trained through an apprenticeship approach where they must attend 50 births with a qualified midwife before practicing on their own. The gamut of emotions present with pregnant and labouring women, and experienced by all those around them, including midwives, is considered something to be revealed and resolved rather than suppressed or denied.

The power to differ in redefining the experience of birth is undermined by pressure from outside the midwives' community. There is already in place lines of authority stemming from the medical profession and legislators of medical practice over midwives who are currently in practice. As Monk points out, this subtle policing is now a problem among midwives:

Fear is already insinuating itself into the professional midwifery community – fear of being blacklisted for having expressed dissent, fear of being overheard by those "in power" who do not agree. (Monk, 1989)

In stark contrast to approaches such as Monk's is the sentiment of the preliminary report which indicates the likely direction of midwifery legislation and midwifery education programmes for Ontario (*Report of Midwifery Task Force*, 1987). Here a close relationship with established medical professions and other experts is proposed to control standards of practice:

The Task Force recommends that the standards of practice for midwives include criteria for consultations with and referrals to physicians. We recommend that the governing body for midwives prepare these standards of practice in consultation with the College of Physicians and Surgeons of Ontario, the Society of Obstetricians and Gynecologists of Canada and appropriate experts in the disciplines of medicine and midwifery. (*Report of Midwifery Task Force*, 1987)

Given that these parameters of appropriate practice are likely to be defined by those supporting the current ethics of the medical model, a radical departure from the norm/al treatment of birth is dubious. Such boundaries will also have direct consequences for the regulation of midwifery where the newly established profession will proceed as an addendum to the medical protocols of birth.

Another important consideration in the implementation of licensed midwifery is the relationship of the new profession to nursing which, due its history of high female representation, could be seen as midwifery's strongest potential ally in providing women-centered healthcare. Unfortunately, the pressure from the middle-class body of women and men who argue that birth is not pathological and therefore should not be in the sphere of medicine (although we have just seen how proximate to medicine it is likely to be) has ostracized the Ontario Nursing profession. According to Rita Maloney, the Dean of the Nursing School at Queen's University, Ontario, the Ontario Nursing Association has refused to provide any training sites for midwifery because of its criticism of the medical model upon which nursing practice is based (Maloney, 1990).

It must also be mentioned that according to the recommendations for legislation of both nursing and midwifery made in the Health Professions Legislative Review (*Striking a New Balance*, 1987), midwifery would gain substantially more scope in practice than nurses. The revised Nursing Act stipulates that nurses may only perform procedures beyond the "dermis" (skin) and "mucous membranes" in relation to a patient when an order is authorized by a practitioner legally qualified to do so, such as a physician. The scope

of practice for midwives however, would include the performance of minor operations such as episiotomies, the use of drugs as specified by regulation, and the performance of "invasive instrumentation, including manual and digital instrumentation beyond the labia majora during pregnancy, labour and the post partum period" (*Striking a New Balance*, 1987).

The alternative birth movement, including midwifery, approaches birth as something spiritual and nonpathological yet its effectiveness as a true alternative to the medical model is questionable especially in regards to who defines *alternative*. But the move away from birth-as-pathology, contained in the alternative movement's rhetoric, is enough to stimulate resentment in the nursing profession. The small amount of power given to midwives in terms of their scope of practice acts more as a wedge between women who predominantly practice as midwives and nurses than as an indicator of women-defined birth. Midwifery as women's emancipation from a patriarchal definition of reproduction is caught between a divisive medical model and a male-authorized alternative to the practice and meaning of birth.

NEW REPRODUCTIVITY TECHNOLOGY LEGISLATION

The legislation of new reproductive technology is a further deterrent to more women-centered approaches to birth. The whole area of "assisted conception" techniques, which includes in vitro fertilization (IVF), embryo transfer, and the pre-implantation genetic engineering of embryos, heralds a new site of medical and scientific intervention in the reproductive cycle: conception. Control over this moment in the creation of life is deemed more important and demands a higher status than the management of birth or what is seen by many medical practitioners as the end of the reproductive cycle. It is possible that control over birth can be relinquished to the mid-wives at this point as control over conception rises and the new area of reproductive medicine is established.

These notions of beginning and ends are of course themselves managed by a system of belief which decenters women's procreative experience. Very few women see birth as the end of a cycle but the beginning of caring for a child that involves the woman for many years after the moment of birth.

As Mary O'Brien has pointed out in her political analysis of the meaning of birth in society (O'Brien, 1981), women's lives are made up of reproductive moments: menstruation, pregnancy, birth, lactation, and menopause. Here, one moment is contextualized as part of a series of moments from which women make meaning or philosophize. The difference in the medical definition of the moment of birth is that the timing is based on a prescribed, scientific routine which does not recognize the continuum of women's procreativity.

The scientific timing of procreation focuses on actual or fictionalized out-of-body aspects of reproduction and divides the biological from the social. This is not a call for sociobiological predictions of the meaning of life – that has trapped women and other marginalized groups for far too long. This is the recognition that reproduction can be construed in terms which separate conception and parturition from childcare and parent-and-child relationships. Nor is this a revival of religious belief that it is a god-given duty to procreate in order to ensure the future of sin and salvation. It is a protest against a definition of human reproduction where the child is reproduced (in a certain moment and as embryo) but not the mother.

New reproductive technology makes a spectacle of conception by visualizing what had long been hidden from control. Human sperm and ovum (gametes) are now actually externalized from men's and women's bodies in IVF and gamete intrafallopian transfer (GIFT). The ripening of women's eggs is visualized on ultrasound screens and tracked with immunoassays. Yet at the same time, as more of the reproductive process becomes visible, women's bodies are obliterated by references to them as "endocrine environments." The actual illumination of the process of conception normally veiled by the bodies of women is applauded as medical and scientific process as words and techniques apparently make these obstacles disappear.

The potential legislation of new reproductive technologies reinforces women's bodies in reproduction as problematic and increasingly renders them invisible. The Ontario Law Reform Commission requested a report on the technologies in 1982. The completed report was submitted to the Attorney General of the Province in 1985. The

Report, as with many similar attempts at making sense of the implications of new reproductive technologies, struggles with expanding boundaries of family and sites of childbirth and childrearing. In terms of access to reproductive technologies:

Eligibility to participate in an artificial conception programme should be limited to stable single women and to stable men and stable women in stable marital or nonmarital unions. (Ontario Law Reform Commission, 1985)

Stability and heterosexuality are obvious prerequisites for access to treatment by the new reproductive technologies which are to be enforced through social control, "... a type of social and psychological screening of applicants" (Ontario Law Reform Commission, 1985). The recognition of single women as candidates for new reproductive technologies is less a sign of enlightened views on family ties and more the result of adherence to both the Canadian Charter of Rights (1982) and the Ontario Human Rights Code (1981). Both the code and charter prevent discrimination on the basis of marital status. Also, the Ontario Report on new reproductive technologies is bound by trends in adoption law where single women can adopt.

Any inclination to read access to single women as women-centered legislation is quickly checked by the report's recommendation regarding surrogacy. Here the role of women in reproduction is severely restricted to the nuclear family setting and motherhood is superceded by principles of contract law. The proposed regulatory scheme for surrogate motherhood as set out in Recommendation 49 reads as follows:

A child born pursuant to an approved surrogate motherhood arrangement shall be surrendered immediately upon birth to the social parents. Where a surrogate mother refuses to transfer the child, the court should order that the child be delivered to the social parent. (Ontario Law Reform Commission, 1985)

A Royal Commission (a federal, consultative process used in Canada prior to policy-making and legislation) on New Reproductive Technologies was created on October 25, 1989. The Commission

was established largely due to pressure exerted on the Government of Canada by a coalition of feminists who felt the Royal Commission procedure would bring criticism of the new reproductive technologies into the public consciousness. Part of the coalition's position was for there to be a high representation of feminists on the Commission. Opposing feminists criticised the chosen procedure for examination of the technologies and claimed, rightly so as it turns out, that the Commissioners chosen by the Prime Minister were unlikely to be feminist. Only one person on the Commission identifies herself as feminist: Louise Vandulac.

Public hearings concluded in December 1990, and a final report is not expected until October 1991. The proceedings to date reflect a variety of responses to new reproductive technologies and indicate the difficulty in vocalizing a feminist response within the Royal Commission context. A thoughtful and feminist report (National Action Committee on the Status of Women, 1990) presented by the National Action Committee on the Status of Women (a federally sponsored group which is the closest thing Canada has to a ministry of women) was undermined by an emotional plea of a woman holding her child conceived through IVF. The plight of an individual woman made desperate by her infertility outweighed the more difficult arguments that identify women as members of the same community whether they suffer from infertility or not.

Several presentations by women's groups attempted to present a women-centered critique of new reproductive technologies where the argument for individual women's choice was replaced with concern for all women. For example, the National Action Committee on the Status of Women's presentation called for a halt to the opening of any new IVF centres given the low rates of success, potential health risks to women in the programs, and the disproportionate amount of public health funds which support such programs in relation to infertility prevention (National Action Committee, 1990). The presentation made by the Ontario Advisory Council on Women's Issues is summarized as follows:

The recommendations that we make puts the focus in reproduction back where it belongs; in prioritizing the health and security needs of

birth mothers, their children, and birth families, and in discouraging the use of contracts or technologies that commodity women or children. (Ontario Advisory Council on Women's Issues, 1990)

The presentation of the Federation du Quebec pour le Planning des Naissances mirrors both statements above in calling for a moratorium on all IVF practices and related research and to proceed instead with investigations into infertility and "a truly public debate on the fundamental questions underlying the development of new reproductive technologies" (Presentation de la Federation du Quebec, 1990).

ABORTION AND EMBRYO PERSONHOOD

The issue of reproductive autonomy also spills over into abortion law and an extension of personhood to embryos. A report produced by the Law Reform Commission of Canada entitled "Crimes Against the Foetus," attempts to homogenize all legislation regarding women's pregnancy and further threatens women's corporal autonomy (Law Reform Commission of Canada, 1989). It is indicative of the foetal-centeredness of the report that the "unborn child" is emphasized and the pregnant woman denied. The purpose of the report is to replace existent legislation in the Canadian Criminal Code which refers to "all matters concerning the protection of life" (including abortion) with a single legislation that creates legal status for the unborn child (Law Reform Commission of Canada, 1989).

A pluralist definition of Canadian society becomes rationale for the creation of rights for yet another Canadian citizen, the foetus. Abortion, in this context, is restricted to cases where the mother's physical or mental health are threatened or in cases of severe foetal malformation and deformity. Medical authorities would decide the validity of each abortion request. The notion that embryos are entitled to human rights in the face of abortion laws which severely limit women's control of their procreativity fractures the experience of motherhood between women's increasingly controlled reproductive experience and public concern for the newly defined member of society, the foetus.

CONCLUSIONS

Current trends in Ontario and Canadian legislation in regard to human procreativity, particularly that concerned with midwifery, new reproductive technologies, and abortion indicate the absence of a consistent political context which would enable a woman-authorized approach to birth. The intent underlying current attempts to legislate midwifery in Ontario is to reduce healthcare costs rather than to turn over the traditional site of birth management to a newly recognized profession of midwives. It is also likely that the profession will be kept close to the spirit of the medical model to ensure its effective control by the well-established medical professions. Midwives will be allowed to deviate from typical nursing practices, however, with the result that they will be virtually alienated from any support from the more-established, and commonly female-run profession. Further, within the history of recent alternative birth movements, there is little to indicate a true alternative to traditional, patriarchal approaches to birth. There, male authority, though arguably more feeling and caring, dominates and indicates a new, but not radically different, ideal of birth and women's procreativity. There is also a risk of increased foetal-centeredness which ties with conservative approaches to mothering and new reproductive technologies.

Proposals for the legislation of new reproductive technologies (as well as abortion) in Ontario and Canada indicate a heightened awareness and social concern for foetal personhood and well-being, while women are effectively erased or problematized. Especially in regard to Ontario's handling of surrogate contracts, a clear move towards the commodification of motherhood and children is signalled. Birth mothers who want to claim their child after birth are legislated against in favour of upholding the letter of contract law.

Against such a background of women's experience of birth, at best authorized by caring men in favour of less violent birth (for the baby) and at worst completely fractured along lines of male reproductive consciousness and commodification, it is difficult if not impossible to view the legalization of midwifery as a hopeful sign. A number of interrelated issues need to be addressed concurrently so that the lack of concern

for, and control by, women can be exposed and overturned: the financial convenience of legislating midwifery in light of cutbacks to healthcare, the socialization of birth is so that a male perspective on reproduction continues to rule women's ability to control their actual procreative experience as well as to define its meaning, and the opposition of foetal personhood to the personhood of women. Now more than ever, given the ineffectivity of the legalization of midwifery as woman-centered birth, the invasive nature at both the physical and metaphysical levels of new reproductive technologies, and the continuous determination that women may not make decisions on pregnancy (i.e., via abortion), women need to reappropriate both the actuality and sense of birth as their own.

REFERENCES

- A history of midwifery in Canada. (1987). In *Report of the Task Force on the Implementation of Midwifery in Ontario*. Ontario: Task Force on the Implementation of Midwifery in Ontario.
- Court case may be key to future of midwifery: (1990, October 25). *The Toronto Star*, p. 000.
- Dick-Read, Grantley. (1984). *Childbirth without fear: the original approach to childbirth*, 5th ed. New York: Harper and Row.
- Executive summary. (1987). In *Ontario Premier's Council on Health Strategy, from vision to action: report of the Health Care System Committee*. Ontario: Health Care System Committee.
- Gaskin, Ena May. (1990). *Spiritual midwifery*. Summertown, TN: The Book Publishing Co.
- Kitzinger, Sheila. (Ed.). (1988). *The midwifery challenge*. London: Pandora.
- Law Reform Commission of Canada. (1989). Crimes against the foetus, a Working Paper 58. Ottawa: Author.
- Leboyer, Frederick. (1975). *Birth without violence*. New York: Knopf.
- Maloney, Rita. (1990, March). Dean of Nursing, Queen's University, Ontario, Canada. Personal interview.
- Monk, Hilary. (1989). A submission to the Interim Regulatory Council and the Curriculum Design Committee of the Task Force on the Implementation of Midwifery in Ontario. Unpublished paper, Toronto.
- National Action Committee on the Status of Women. (1990, October). The new reproductive technologies: a technological handmaid's tale. A brief presented to the Royal Commission on New Reproductive Technologies, Toronto.
- O'Brien, Mary. (1981). *The politics of reproduction*. New York: Routledge, Kegan and Paul.
- Ontario Advisory Council on Women's Issues. (1990, October). A brief presented to the Royal Commission on New Reproductive Technologies, Toronto.
- Ontario Law Reform Commission. (1985). *Report on*

Human Artificial Reproduction and Related Matters. Ontario: Ontario Ministry of the Attorney General.

Présentation de la Fédération du Québec pour le planning des naissances aux audiences de la Commission royale d'enquête sur les nouvelles techniques de reproduction humaine. (1990, November 21). Montreal: (Translated by the author)

Proceedings of the Legislative Assembly of Ontario. (1988, November 14). Column 1509.

Report of the Task Force on the Implementation of Midwifery in Ontario. (1987). Ontario: Task Force on the Implementation of Midwifery in Ontario.

Rich, Adrienne. (1986). *Of woman born.* London: Virago.

Striking a new balance: a blueprint for the regulation of Ontario's health professions. (1987). Ontario Government.

Wertz, Richard, & Wertz, Dorothy. (1979). *Lying-in: a history of childbirth in America.* New York: Schocken Books