Telling Stories, Shaping Lives: Media Representations of Midwifery Debates in Ontario and Quebec During the 1970s, '80s, and '90s

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Abstract: Ontario and Quebec were the first two provinces to legalize midwifery, integrating the services into their respective healthcare systems. In both provinces, the pre-legislative periods were marked by intense debates between state-actors, medical health professionals, and midwifery supporters, debates which took place in discursive spaces which were shaped not only by the dominance of medical-scientific discourse, but also by the particular socio-political discourses of each province. How these debates played out in media is an important part of the construction of contemporary midwifery. Yet, although the literature on midwifery, especially the Ontario case, continues to flourish, no literature to date explores the role of the media as a key actor in shaping the debate. In this paper, we seek to address this gap by investigating the ways in which media representations aligned midwifery with broader provincial-level discourses, thereby constituting midwifery as a 'policy problem' requiring (particular forms of) state intervention. In so doing, we demonstrate how such representations, and the power relations implicated in them, legitimized the provincial state.

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Ontario and Quebec were the first two provinces to legalize and integrate midwifery into provincial healthcare systems after long periods of activism on the part of women's and feminist groups. In Ontario, the *Midwifery Act* came into effect on January 1, 1994, enabling licensed midwives to catch[1] babies in homes, birthing clinics, or hospitals. Similarly, the Quebec government passed the *Midwives Act* in 1999, after a series of pilot projects taking place from 1993-1998, allowing licensed midwives to catch babies in homes and birthing clinics. Homes births were subsequently written into the legislation.

Although these acts have been tremendously successful, with waiting lists for midwifery services common in many regions, the legalization and regulation of midwifery was contentious in both jurisdictions. Indeed, debates in Ontario and Quebec surrounded almost every level of policy formulation, including questions such as whether or not to regulate; if so, how; educational systems; and governance and funding structures, and involved bureaucrats, midwives and their supporters, and healthcare professionals such as physicians, nurses and hospital administrators.

How these debates played out in media is important. Indeed, there is widespread agreement among policy scholars of the importance of media in contextualizing and framing debates, with a key role in issue identification and agenda setting (see, for example, Soroka 2002, 2007; Walgrave et al 2008). At the same time, however, the role of media within the policy process remains undertheorized (C. Murray, 2007). Recently, critical scholars (Marston 2004, Hajer 2009) have explored the challenges of policy and politics in the 'mediatized' world, exploring the ways in which governance is 'performed' through media, as well as the ways in which media representations disrupt or reproduce relations of ruling. Within this context, media structures debate and plays a legitimating function for the state.

Building on this work, we explore various midwifery frames produced within print news media surrounding key events during the period of 1975 to 2000. We suggest that the frames produced by newspapers during this period played a key role in perpetuating the dominance of scientific and gendered discourses, aligned with broader provincial political discourses, which served to reproduce gendered hierarchies within midwifery debates. In so doing, media representations of midwifery positioned various actors within these discursive fields, demarcating various discourse coalitions within the politics of midwifery, and established a discursive context in which the state had to 'act on' midwifery and midwives. Following a brief historical overview of the re-emergence of midwifery within Ontario and Quebec, we discuss the role of the media in representing 'policy problems' using print media from each jurisdiction.

Provincial Histories: Midwifery in Ontario and Quebec

Although the decline and reemergence of midwifery occurred during similar time periods throughout Canada, one must be cautious about making broad generalized statements about inter- and intra-provincial experiences in reproductive politics. Indeed, while to

[1] Part of midwifery discourse is to emphasize the active role of women in birthing. Thus, they tend to use terms such as 'catching' rather than 'delivering', to refocus attention on the centrality of parturient women in the process of birth.

date there is little in the way of nation-wide comparative analyses of midwifery (see Biggs 2004 for an exception), single case studies reveal important differences in the political trajectories of the issue (see Bourgeault et al 2004 and Shroff 1997 for edited volumes). For example, unlike other parts of Canada, Maritime midwifery proved much more resistant in the face of attempts to 'modernize' reproductive health (Biggs 2004; Benoit 1987, 1997). In addition, the value and status accorded to midwives varies by time and space. For example, in Quebec and Newfoundland, midwifery was recognized as a form of work, with a distinct skill set (Biggs 2004: 23-24). Similarly, Aboriginal midwives were accorded considerable status within their communities, despite significant differences between Aboriginal groups (Biggs 2004: 25-26; Daviss 1997). Not surprisingly, the modes of skills acquisition, as well as demand for midwifery services, also varied across and within jurisdictions (Biggs 2004; Benoit 1991, Mason 1990).

These important differences no doubt explain some of the important political differences between provinces. For the purposes of the present study, the focus on Ontario and Quebec reveals important political nuances that illuminate the relationship between the reproductive politics and provincial-level political discourses. In both Ontario and Quebec, the mid-19th century marked the beginning of the decline of midwifery. Medical science began to dominate reproduction as it was prohibited to practice medicine without a license. Midwifery, or obstretics, was one of the first fields of healthcare claimed by physicians (Biggs 1983; Mitchinson 1991; Rushing 1991; Giroux 2008).[2] Despite pockets of midwifery activity throughout the provinces, often practicing clandestinely (see Fannin 2007, 172), by the early to mid-20th century, the vast majority of babies were born in hospitals.[3]

A number of factors contributed to the reemergence of midwifery throughout Canada. First, the 1940s and 50s witnessed the emergence of the natural birth movement, beginning with the publication of Dr. Grantly Dick-Read's *Natural Childbirth* (1933) and *Childbirth without Fear* (1942). These and subsequent publications, such as Goodrich's *Natural Childbirth: A Manual for Expectant Parents* (1950), sought to reduce or limit obstretric interventions, encouraging women to eschew pain relief measures in favour of attitudinal changes towards birth. The movement fostered women's participation in 'natural' childbirth activism; for example, the La Leche League was influential in organizing around breastfeeding and natural childbirth. The first Canadian chapter of La Leche League was established in Quebec in 1960.

Second, the natural birth movement literature was appropriated in the late 1960s and early 1970s by emerging feminist and women's health movements seeking to reclaim the means of reproduction. Indeed, where the natural birth movement literature maintained the authority of obstetricians, thereby reinforcing medical modes of sexist

[2] It is important to note, however, that the 'medical take over', while certainly an important factor, was neither the only, nor necessarily the primary, cause of the decline of midwifery. See Mitchinson 1991 and Biggs 2004 for discussions.

[3] For example, government-run programs provided nurse-midwives to rural communities. Similarly, religious and ethnic groups continued to use midwifery services. See Mason 1990, Bourgeault 1996, 2006; Nestel 2006; Biggs 2004.

oppression, the alternative birth movement (ABM), sought to reclaim 'colonized wombs' and take control over childbirth (see Lang 1972; Arms 1974; Gaskin 1977; for academic overviews, see Mason 1990, Daviss 2001, Paterson forthcoming). Emphasis was not only on natural birth, but also on control of the birth process, calling attention to the ways in which modern obstetrics was premised on and reproduced gender-based oppression (Paterson forthcoming). The ABM was premised on inter-provincial and international ties between women's groups, and eventually led to the (re)emergence of lay or community midwifery: midwives with little or no formal training (personal interview 2010).

Compounding the growing dissatisfaction among healthcare 'consumers', especially in the area of reproduction, was neoliberal discourse within the politics of health emphasizing an emergent crisis in healthcare. Talk of inefficiencies and spiraling, unsustainable costs established a discursive space in which 'solutions' to these impending 'crises' were sought by governments across Canada. Paradoxically, this opened a space in which to consider midwifery as a viable alternative to expensive, 'high tech' doctors.

Despite these similarities in the reemergence of midwifery between Ontario and Quebec, important differences characterize their experiences. First, and perhaps most importantly, calls for legal recognition of midwifery in Quebec came from the government (Fannin 2007, 177). In the 1970's, the government began considering the 'humanization' of childbirth as a focus of maternal health-care policy (Fannin 2007, 177). In 1973 and 1974, the Ministry of Social Affairs published two reports that examined the reorganization of obstetrical services and the role of the Ministry in childbirth (Fannin 2007, 177), which in turn, fueled the debates about midwifery. In 1979 the Council on Social Affairs and the Family published a report suggesting that the practice of midwifery may help to increase the birth rate, a major concern among nationalists (Fannin 2007, 177).

Government activity spurred the creation of grass-roots groups dedicated to the cause. The Association des sages-femmes (1975) and the Collectif de Saint-Léandre were the first two organizations to actively promote midwifery (Fannin 177). These were followed by the creation of Naissance-Renaissance (Birth-Rebirth) in 1978 and the Association des sages-femmes du Québec (ASFQ) in 1980 (Giroux 2008, 29). The ASFQ was able to mobilize midwives who had been trained in Quebec to work overseas and those working in remote regions. In 1986, another midwives association was created that worked in close collaboration with Naissance-Renaissance: l'Alliance québécoise des sages-femmes practiciennes (AQSFP). This group consisted primarily of lay midwives who had begun practicing in the 1970s (Vadeboncoeur 2004, 92). These groups advocated for the legalization of midwifery.

In contrast, calls for recognition of midwifery in Ontario began with civil society groups and tended to arise later than those in Quebec. For example, two key organizations were formed in the 1970s: the Ontario-Nurse Midwives Association

(1973) and the Home Birth Task Force (1976).[4] While these groups were not necessarily dedicated to community midwifery, their creation and entry into public dialogue over midwifery services opened the door for midwifery activism, leading to the creation of the Ontario Association of Midwives (1981), and the Midwifery Task Force of Ontario (1983).[5] In 1985, the ONMA and the OAM merged to form the Association of Ontario Midwives (AOM). These organizations, together and separately, began advocating for the legal recognition of midwifery.

Unlike the Quebec experience, it was only after the creation of these groups, as well as two very public inquests in the province, both of which led to reports from the Office of the Chief Coroner recommending legalized midwifery, that the Ontario government decided to explore the role of midwifery within provincial healthcare service. What's more, unlike the Quebec government, the Ontario government was ambivalent to midwifery, preferring to undertake extensive studies on costing and safety before making a decision. In 1983 the Progressive Conservative Party announced a major review and administrative overhaul of health services in the province. The Health Professions Legislative Review (HPLR) provided organized midwives with the opportunity to submit a proposal for a self-regulation system. The HPLR, while giving midwives an opportunity to establish a solid case for legalization and regulation, also provided the government with a stalling mechanism. This ambivalence led to the defeat of a Private Members Bill in the Ontario legislature in 1984, introduced by New Democratic Party backbencher, Dave Cooke.

Support, however, came quickly after a very public inquest in 1984-85 and the decision by the HPLR Committee, which determined that midwifery should be a self-regulated healthcare profession and recommended that a task force be established to determine various governance models and implementation schemes. The Task Force for the Implementation of Midwifery in Ontario (TFIMO), established in 1986 under the Liberal government (also labeled as a stalling mechanism by opposition parties), issued its final report in 1987, recommending a direct-entry, self-regulated midwifery profession in Ontario (Eberts 1987). In 1991, the newly elected New Democratic Party,[6] proclaimed the *Midwifery Act*, establishing a curriculum, which included both university-based and

[4] The Task Force was established in response to the government's decision to reduce funding for the Victoria Order of Nurses. The VON was established by the National Council of Women in the late 19th century to address the general scarcity of health services throughout the province and had been providing midwifery services by trained nurses (and continued home birthing services) to various groups of women (Biggs 2004; Bourgeault 2006).

[5] As I've noted elsewhere, each of these organizations had very different functions and served different interests. The ONMA was mostly interested in improving maternity services generally, with little consideration given to home births. The OAM served the professional interests of increasing number of community/lay midwives and the MTFO represented 'consumers' and supporters of midwives. See Paterson, forthcoming, as well as Sharpe 1997, Bourgeault 2000, 2006, and Bourgeault et al 2004, Nestel 2006 for extensive overviews.

[6] The change in government during this period in Ontario politics was particularly striking. The Liberals were elected in 1985 for only one term, ending a long period of Conservative rule in the province. Immediately following, the New Democratic Party was elected in 1990 and lasted only one term before being replaced by another Conservative government.

prior-learning assessment systems, a licensing system, and the College of Midwives of Ontario (CMO).

While there was considerable debate in Ontario, especially regarding home births, educational requirements and governance structures, by the time the TFIMO was established, the question of whether or not to regulate had already been decided (Spoel and James 2006). In contrast, the question of whether or not to regulate was subject to vociferous debate throughout the legislative process in Quebec, despite unwavering, if not apprehensive, government support. As early as 1985, the Parti Quebecois government announced that it intended to introduce legislation that would establish the role of midwives and stipulate necessary training. The government lost an election soon after and the legislation was never introduced. The issue was brought back to public attention when a Quebec doctor was suspended for allowing midwife Isabelle Brabant to attend and assist at a hospital birth under his supervision. Six months later a baby died after a home birth that had also been attended by Isabelle Brabant, which became a major media story.

Despite (and perhaps because of) enduring aggressive opposition to the legalization and regulation of midwifery by the Canadian Medical Association and the Quebec Corporation of Physicians, the Liberal government introduced legislation in 1989 that would allow midwifery to be permitted on an experimental basis. Following an election, Loi 4, which permitted midwifery within pilot projects was passed in June 1990 (Giroux 2008, 32). The pilot projects were to be free standing birth centers with agreements with a local hospital that would handle emergencies. Because of the strong opposition from the Corporation of Physicians and their associated professional groups, it took four years before any projects were up and running (Vadeboncoeur 2004, 95). The professional associations, including both physicians and pharmacists, banned their members from supporting midwifery in any way (Vadeboncoeur 2005, 95). Home births were not permitted under the legislation (Comité Femmes-Sages-Femmes, 2002, 4).

The experimental period allowed the government to observe and conduct research on midwifery, as well as placate hostile physicians, before making a decision about whether to fully legalize the practice. The pilot projects also enabled key players to determine what kind of education and training would be required for midwives. There was continued disagreement between midwives, the government, and professional groups during the period (Blais et al. 1994, 691). In April 1998, a joint report by the Ministry of Justice and the Ministry of Health and Social Services recommended that midwifery be officially recognized in Quebec and that an autonomous professional for midwives be created.

The Quebec College of Physicians finally declared in 1998 that the pilot projects had proven themselves and they dropped their long-standing opposition to the legalization of midwifery (Vadeboncoeur 2005, 99). In 1999, l'Université du Québec à Trois-Rivières was chosen to provide the university program required for midwives. In June of 1999, the National Assembly adopted the *Midwives Act* (Bill 28), enabling

licensed midwives to attend births in hospitals and birthing clinics. Home births were brought into legislation in 2006.

These brief histories reveal both similarities and differences between Ontario and Quebec. In Quebec, government support for midwifery initiated midwifery activism and remained strong throughout the pre-legislative period. At the same time, however, the prolonged vehemence of physicians necessitated conciliatory politics on the part of provincial health ministers. In contrast, in Ontario, activism and coroner's inquests prompted government action, which remained largely ambivalent until the establishment of the TFIMO in 1986. Moreover, while in both provinces, issues such as home births were contentious, the Quebec government, despite its unwavering support for midwifery, hesitated on the practice. The contentiousness with which midwifery was received suggests an important role for 'intermediaries' in communicating and packaging healthcare reforms. With focus on media, to this we now turn.

Midwifery Politics in Mediatized Contexts

The literature on midwifery in Canada is growing, with particular attention to (and tendency to conflate the Canadian experience with) the Ontario case. Surprisingly little attention has been paid to the Quebec case, despite its uniqueness within the Canadian experience (for important exceptions, see Vadeboncouer 2004, Vadeboncouer et al 1996, Fannin 2007, Giroux 2008). Much of the literature on midwifery explores its decline and reemergence on the Canadian landscape, with emphasis on the advocacy of women (for examples, see Bourgeault 1996, 2001, 2006; Bourgeault et al 2004; Biggs 2004; Daviss 1999, 2001; James 1997; Mason 1987, 1990; Spoel and James 2006; for the Quebec case, see Giroux 2008; Fannin 2007; LaForce 1990; Vadeboncouer 2004). In addition, many studies have recently emerged tracing the shifting relationships between midwives and the women they serve (for examples, see Sharpe 1997, 2004a, 2004b; Bourgeault 1996, 2006; Fannin 2007; MacDonald 2006; Paterson 2004, forthcoming).

Relatively little attention has been paid to the discursive politics of midwifery and the various ways in which 'issues' and 'interests' are represented in policy debates and subsequent texts (for important exceptions, see Fannin 2007; MacDonald 2006; Spoel 2006; Spoel and James 2006; and Paterson forthcoming). Students of critical policy studies, however, point to the importance of such undertaking for understanding the ways in which power works through policy, creating, sustaining and potentially transforming unequal social relations, while at the same time obscuring their bases (see Bacchi 1999/2005, 2000, 2009; and B.K. Murray 2007). The discursive contexts in which midwifery debates played out were characterized by various factors, including micro-level discourses surrounding science and competence, as well as macro-level provincial discourses such as neoliberalism, especially pronounced in Ontario (see Abu Laban and Gabriel 2002 for a discussion of the ways in which even the NDP subscribed to neoliberal discourse), and pronatalism and nationalism, in Quebec.

Emphasizing discursive politics prompts us to identify key actors ('meaning makers') in political contests. Within the literature on midwifery, these actors are typically identified as bureaucrats, elected officials, physicians, nurses, midwives and

their supporters (see, for example, Bourgeault et al 2001; Taylor and Nesday 1994; Paterson forthcoming). Although this work contributes to our understanding of advocacy efforts surrounding midwifery, there remains an important analytical blindspot: All of this work neglects the role of the media as a key actor in midwifery debates.

Attention to media within policy studies is not new; indeed, despite a general lack of theorizing (see, for example, C. Murray 2007), there is widespread recognition of the role media play in the policy process, especially in agenda setting (see Soroka 2007 and Walgrave et al 2008 for recent overviews). In addition, critical policy scholars have demonstrated the ways in which media produce discursive 'packages' which invite actors to interpret the issue at hand, making sense of the world around them (see Edelman 1988 and Gamson and Modigliani 1989 for examples). More recently, critical policy scholars explore the ways in which media are implicated in legitimating the state (see Marston 2004 and Hajer 2009). Within this work, the power of media resides in its ability to frame complex issues, reducing complex issues to 'problems' that can be understood and acted on; that is, to make issues 'governable'. Frames are ordering devices that organize our attention to some dimensions of an issue, while organizing our attention away from others (Hajer and Laws 2006).[7] As explained by Entman (1979: 52), "Framing essentially involves *selection* and *salience*. To frame is to *select some aspects of a perceived reality and make them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation* for the item described" (see also Failler 2010 and Jiwani and Young 2006).

Frames are at once cognitive (enabling individuals a basis for understanding), communicative (signaling what is the issue), and productive (discursively constituting what 'is' the issue and what 'ought' to be done about it). As communicative and productive devices, frames are also positional, assigning responsibility or blame, deservedness, and so on (Bacchi 1999/2005; Stone 2002; Hajer 1993, 1995). Essentially, frames limit the scope of issues by restricting the discursive space to those dimensions of the issue deemed relevant. By implication, frames invite some participants into the discussion, while neglecting others. In framing issues in particular ways, then, media serves to structure public dialogue, by limiting what can be talked about and by positioning various agents within discursive fields, establishing, maintaining or transforming group boundaries and power relations. As Entman (2003, cited in Sief 2003: 265) explains, "Reporters attempt to write news stories objectively, reporting the facts as they occur. There are times when merely reporting the event, without any additional explanation or analysis, can serve to reinforce existing ideas and stereotypes." In so doing, media representations 'naturalize' relations of ruling, thereby legitimizing contemporary social and political arrangements. Thus, Marston (2004: 77) explains (citing Fairclough): "One of the social functions of the media is to legitimize existing

[7] It is important to note that there is debate in the frame analysis literature about the intentionality of framing. Social movement scholars typically emphasize 'strategic framing', while critical scholars emphasize the socio-cultural grounding of frames (see Bacchi 2009 and Hajer and Laws 2006 for overviews and discussions). For this study, while we do not rule out the possibility that frames are intentional, we assume that the use of particular frames is unintentional.

asymmetrical power relationships by putting across the views of the powerful actors as if they were the voices of 'common sense'."

This suggests that the role of the media within public policy resides in its discursive power. That is, complex power relations that get problematized or reinforced through media representations of issues and actors. Media representations of particular issues and initiatives are not neutral. Rather, such representations 'create' issues and initiatives, shaping them in ways that demonstrate their (dis)continuity with broader socio-political discourses. Thus, media play a key role in facilitating public acceptance of policy initiatives and in communicating that acceptance (or not) to policy makers.

To explore these issues within the politics of midwifery, our analysis focuses on news reporting and editorials, excluding letters from readers. Using the Factivia, Proquest, and Eureka databases, more than 150 hits were returned for Ontario, and more than 120 for Quebec (68 French media, 54 English media). To narrow our focus, we directed our analysis to key events taking place during the pre-legislative era in each province. In Ontario, we focused on the Task Force for the Implementation of Midwifery in Ontario (TFIMO). Analysis was based on 37 newspaper articles, most of which originated from the two major Toronto area newspapers, the regional *Toronto Sun* and the national *Globe and Mail*. In Quebec, we focused on the pilot projects, analyzing both French and English media. Analysis was based on 56 articles, coming mostly from the *Montreal Gazette* and *La Press*, but also included reports from the national *Globe and Mail*. Our decision to focus on these events was based on the fact that both of these events were established to determine how midwifery should be implemented within the respective provinces. As a result, they both generated intense discussion and media scrutiny. Thus, how these discussions were represented in media will illuminate an interesting part of the discursive constitution of midwifery within each jurisdiction.

Framing Ontario and Quebec Midwifery: The TFIMO and the Pilot Projects

The TFIMO was a by-product of the Health Professions Legislative Review, led by Allen Schwartz, a bureaucrat within the Ontario Ministry of Health. The HPLR was designed to be an administrative overhaul of healthcare throughout Ontario, seeking to offer better services to citizens ('consumers') and to make the healthcare system more efficient by streamlining healthcare governance. After careful consideration, the HPLR committee determined that midwifery should indeed become a self-regulating profession, but was unique among other healthcare professions and therefore required a specific task force to assess various governance and implementation regimes.

In contrast, the introduction of midwifery in Quebec was not part of a larger health care review. The Quebec government authorized midwifery pilot projects in 1990, rather than choosing to legalize the profession outright, as an experimental initiative through which to assess the benefits of midwifery, as well as to consider possible education and governance systems. The pilot projects were to be administered by local community health centres (CLSCs) or by a hospital and CLSC together (Vadeboncoeur 2004, 93). The pilot projects were envisioned as freestanding birth centres with agreements with a nearby hospital that stipulated transfer arrangements for emergency

situations. It is generally agreed upon that the pilot projects were an attempt to appease the medical organizations in Quebec, who vehemently opposed the legalization of midwifery (Vadeboncoeur 2004, 93).

With both the TFIMO and the pilot projects, three phases of reporting were analyzed, including the establishment of the initiatives, the proceedings, and the final reports. Several differences and similarities emerge in media representations of midwifery in Ontario and Quebec. In Ontario, for example, the key filter through which midwifery and the task force were presented was the 'public interest'. Within this context, a dominant 'legal' frame emerges seeking to justify the need for midwifery regulation and the task force in determining the basis for regulation. In representing midwifery as a legal issue, other important dimensions are obscured from view. First, midwifery is removed from the arena of gender politics. The genealogy of midwifery as an issue is obscured and the power of medical science and its role in the domination of women is neglected. Second, throughout coverage of the TFIMO, 'legal' or 'regulated' becomes synonymous with 'safety' and 'competence'. That is, the 'problem' with midwifery is that it is 'alegal'. Its 'alegal' status has led to 'complications', 'confusion' and potential 'incompetence'. The 'solution', then, is to 'regulate' midwifery, which will in turn be 'safe'.

We see this logic in one of the earliest newspaper articles reporting the creation of the TFIMO, appearing in the *Toronto Star* on January 24, 1986. Entitled, "Midwifery to get legal status: Elston," author Bill Walker points to safety and professional boundary issues arising from midwifery's alegal and potentially 'dangerous' status. Recalling the McLaughlin Harris Inquest, Walker writes,

> At the time, Coroner James Young said [midwifery] should be legalized because "the current unclear position on midwifery is dangerous, as no set standards exist for education or practice." Yesterday, Elston echoed those concerns, saying the development of midwifery services has been hampered by "its uncertain legal status" and many of those trained in the service in other countries were not able to practice freely here because they worked on obstetrical wards in hospitals. "Established professions and institutions involved with pregnancy care are frequently wary of involvement with midwifery practice because of potential legal problems and uncertainty about the competence of practitioners," he said.

Reinforcing the primacy of established healthcare professionals (and medical science), the passage suggests that midwifery regulation is as much about preserving these professions (and, indeed, getting their approval) as it is about establishing midwifery as a legitimate alternative for 'safe' obstetric care.

Media representations in Quebec, in contrast, did not explicitly problematize the alegal status of midwifery. Instead, media represented the issue as a boundary dispute between professional groups. This is immediately evident in a *Globe and Mail* article published on May 11, 1989, after the government of Quebec announced its intention to proceed with pilot projects despite resistance from the medical community. The article entitled "Quebec MDs spurn legalizing midwifery," shows the vehement resistance of the medical establishment to the legalization of midwifery. Andre Picard reports:

> "You might as well make prostitution legal. More people are asking for prostitutes than midwives ," Augustin Roy, president of the 16,500-member Quebec Corporation of Physicians, said in an interview. Clement Richer, president of the 9,600-member Quebec Federation of General Practitioners was equally incredulous: "It's like letting an apprentice pilot take charge of a Boeing 747 loaded with passengers."

The boundaries depicted in this passage are interesting on a number of levels. On one level, doctors are positioned with respect to midwives in terms of 'skill'. The term 'apprentice' suggests an individual who is not ready to adopt the tasks of their occupation. Similarly, an 'apprentice' has a 'teacher', from who they learn and to whom they remain subordinate. In this case, physicians are depicted as those holding the authoritative knowledge in which to direct births, while midwives are mere handmaidens. On another level, the quotation of Dr. Roy link prostitutes to midwives, invoking images of 'degenerate' and 'illegitimate' women, maintaining boundaries of acceptable and unacceptable behaviour, as well as authority to determine the distinctions between them. Both dimensions are based on (and reinforce) gendered discourses, discussed in more detail below.

That these boundaries are gendered is in many exacerbated by the ideological differences separating these groups. Later in the same article, it is reported:

> Helene Cornellier, president of the 60-member Quebec Alliance of Practicing Midwives, dismissed the reaction as "insipid and insulting. . . It really shows how little respect the medical establishment has for women." She said doctors' fears of midwifery are based purely on financial self-interest, and said they are "determined to maintain a monopoly on what they call medicine." […] Mrs. Cornellier agreed that the battle was an ideological one, and said doctors were out-of-touch with modern thinking: "Pregnancy is not an illness and childbirth is not a medical procedure. Doctors who think so are living in the Middle Ages."

Here we see that the basis of the boundary dispute is ideological, in which midwives question the authority of physicians in birth.

Boundary frames were also employed in Ontario, but in a much different way. Ontario midwives were represented not so much as an ideological threat, but rather a material threat. For example, an article in the *Globe and Mail* in June 1987, claims,

> An Ontario Government task force will recommend that midwives be self- regulating professionals trained separately from doctors and nurses, says an organization that has lobbied on behalf of midwives. […] The recommendations are likely to meet resistance from nurses, obstetricians and other doctors.

Within this passage, midwifery is constituted as a threat to the professional 'territory' of medicine (in part because it is assumed that birth is a medical event), including both doctors and nurses. In addition, midwifery is placed in a precarious position, subject to territorial and professional scrutiny by healthcare professionals.

This is also apparent in an article written by Lillian Newbury, who wrote extensively about midwifery during this period, appearing in the *Toronto Star* in October 1987, entitled, "Let midwives set up shop task force urges Ontario". The metaphor of a

'shop' invites the reader to link healthcare to markets. Markets are, by definition, competitive institutions. We are thus invited to infer that midwives are 'staking a claim' in healthcare service provision; that is, midwives are 'competition' for doctors or nurses. This discursive turn reinforces the boundaries between groups and reduces midwifery to an issue of 'healthcare' and medical service, attending to a medical event, rather than a social service attending to reproductive autonomy and general well-being.

Thus, in Ontario, framing the issue as a boundary dispute serves to remove midwifery from claims for reproductive autonomy, failing to account for the gendered critique of obstetric medicine upon which midwifery is premised, which claims that birth is not a medical event, but rather a social and relational experience. In representing the issue as a question of boundaries, 'medicine' is left unchallenged and ideological and philosophical debates about women's (dis)embodied experiences of pregnancy and birth are muted. Instead, midwives are represented as offering particular 'healthcare' services, such as 'emotional care', 'advocacy', or 'home birth', to help 'fine-tune' the healthcare system.

In Quebec, however, this critique is the very basis of the boundary frame. Midwives are 'different' from doctors not because they provide alternative healthcare services, but because they challenge the very claim that birth is a question of healthcare in the first place, calling into question physicians' authoritative knowledge in the area of pregnancy and birth. In Ontario, hegemonic discourses of medical science are imported uncritically into representations of midwifery (in which midwives are constructed as alternative 'medical professionals'), whereas in Quebec, early media representations of midwifery decentre this discourse, offering a new space in which to discuss pregnancy and childbirth beyond the gaze of medical science. This might in part account for subsequent discursive shifts among Ontario midwifery advocates, who adopted medical discourse to illuminate their expertise in 'normal births' in contrast to physicians' expertise in 'abnormal' or 'high risk births' (Paterson, forthcoming). These shifts are not obvious among Quebec midwifery advocates, who continue to use terms such as 'humanizing' childbirth. In the Ontario representation, we can see openings for reconciliation and cooperation; in the Quebec representation, we see an irreconcilable gap between two groups.

Underlying these frames are gendered discourses, but, like the frames themselves, they are invoked in different ways. In Ontario, representations of midwifery invoke gendered discourses in terms of ways of caring. For example, in an early article entitled, "Hearing seeks rules on midwives," it is claimed that:

> According to briefs from dozens of women and couples, midwifery has become a sought-after addition or alternative to hospital-based obstetrical care, which they see as dehumanized and authoritarian.

Similarly, the article, "Women demanding better care in childbirth, nurse tells hearing," published on October 8, 1986, reveals the ways in which 'women's needs', an important counterframe, entered the discussion about midwifery services:

> Parents are in need of a "birth advocate" to negotiate with the medical establishment within the hospital and that's one of the functions of midwives, the nurses said. "Another area where the health care establishment is deficient is in providing needed emotional support through the pregnancy, birth and early post-partum period."

This passage not only takes as given the 'stages' of pregnancy ('pregnancy', 'birth', 'post-partum period') determined by the medical model, but also represents a midwife's expertise as residing in her 'emotional' labour and her ability to 'negotiate' and communicate with the medical establishment. The midwife becomes an intermediary rather than a primary caregiver, navigating a complex system and filling gaps ('emotional care') in the medical establishment (which provides 'rational care' based on 'scientific' evidence) rather than a challenge to it. This stands in stark contrast to the passage provided above from Quebec representing the debate between Augustin Roy and Helene Cornellier, which discursively situates midwifery as a debate between physicians (i.e., men) and midwives and mothers (i.e., women).

Gendered discourses are also reinforced in both jurisdictions through the discursive positioning of midwives in the debates. For example, media representations in both provinces positioned midwives defensively with respect to physicians and government officials. That is, where doctors (and nurses in Ontario) and government officials were represented as 'framing' the debate, midwives were discursively positioned in 'response' to these frames. For example, during the TFIMO proceedings, we see headlines such as, "Midwives oppose taking training as nurses first," appearing in the *Toronto Star* in October 10, 1986, which represent midwives as reacting to proposals rather than making them. Similarly, an article appearing in the same newspaper the previous day, "Specialists' group opposes home births, probe told," explains that members of the Society of Obstetricians and Gynecologists of Canada argue that home births are unsafe. In response, the article presents the following passage:

> But Dr. Nikki Colodny, speaking for the Ontario Association for Abortion Clinics, said if home births are not officially recognized, some women will continue to choose them nonetheless and home birth will be driven underground in isolation from the health-care system. Such a move would make women more "dissatisfied and distrustful" of the health system than ever.

Here the midwifery advocate is positioned defensively, unable to reframe the debate around the safety of home births (a claim that is central to midwifery philosophy).

This is also apparent in Quebec. As an example, although the government of Quebec passed legislation to create midwifery pilot projects, it took two years to operationalize due to boycotts among the medical associations, including both physicians and pharmacists. An article from *la Presse* entitled « Les médecins de CLSC résistent à la venue des sages-femmes » reports:

> M. Payette explique la résistance des médecins par une «méconnaissance de la loi» lorsqu'ils évoquent le manque de sécurité pour les femmes et enfants comme principal argument pour refuser de collaborer aux projets. Il déplore le légalisme de leur position et leur fausse interprétation de l'essence de la loi qui vise la reconnaissance des sages-femmes comme professionnels de la maternité.

As in Ontario, the position of Payette is defensive, simply responding to the actions of physicians rather than providing a new frame or scope of debate.

Similarly, as opposition to midwifery continued, media representations in Quebec often removed midwives from the debate, instead representing midwifery as an issue between government and physicians. For example, in an article appearing in the *Montreal Gazette* on March 10, 1993, Tu Thanh Ha and Kate Dunn write:

> A clash is looming between Quebec doctors and Health Minister Marc-Yvan Cote, who warned yesterday that he will go ahead and legalize midwifery even if he doesn't get the doctors' co- operation… "We won't back down on that issue," Cote told reporters in Quebec City yesterday as he entered a legislature committee hearing on alternative medicine. "Starting Monday, decisions will be made. "Midwives will practice in Quebec, whether through pilot projects or through a law, as in Ontario."

And again:

> Bowing to pressure from the province's doctors, the Quebec government will not authorize the practice of midwifery except on an experimental basis. The Minister of Health and Social Services, Marc-Yvan Cote, said yesterday the government will continue working within the framework of five-year pilot projects set up under legislation adopted in June of 1990. "Considering the evolution it will take for the medical profession to accept the practice, we've decided to wait," Mr. Cote said.

These passages remove midwives as agents, instead portraying the debate as a battle between the state and physicians, suggesting that these are the two appropriate groups to decide the future of midwifery. Here midwives and midwifery (invoking images of women) are being 'acted on' by government and physicians (invoking images of men). In a context where boundaries are ideological and midwives are challenging the authority of physicians to direct births, this discursive move serves to limit the threat posed by otherwise 'unruly' women.

In both Ontario and Quebec, midwifery was represented as something that requires state intervention, "[…] as an appropriate response to crises in the rational government of reproduction" (Fannin 2007: 187).[8] In Ontario, midwifery was represented as an issue that needs to be controlled; that is, midwifery is 'inherently' unsafe. In particular, home births must be regulated because, as previous quoted, "some women will continue to choose them nonetheless". Thus, legalization became the vehicle through which to control these otherwise 'unruly women'. In Quebec, justification of state intervention was more complex. Early discussions link midwifery with pronatalism, but, as discussed above, during the coverage of the pilot projects, representations of

[8] This quotation reflects an assessment of the experimental period in Quebec, in which Fannin explains, "The emergence of midwifery in Que´bec was characterized by a period of experimentation that constituted midwifery as an appropriate response to crises in the rational government of reproduction, reflecting the implementation of techniques of enhanced communication in which the midwife is a privileged interlocutor." We feel, however, that this statement also reflects the role of the media in both provinces.

midwifery were emblematic of a boundary dispute in which the state acted as arbiter. At the same time, issues of safety (as well as 'unruly women') were implied through representations of midwifery that occlude home birth as central to midwifery practice, and through representations emphasizing the need to secure the 'cooperation' of physicians. Thus, despite opening an alternative discursive space in which to discuss childbirth as a non-medical event, media representations that eventually silenced the voices of midwives in the debate served to reproduce and reinforce hegemonic medical discourse in reproductive politics. In both jurisdictions, media representations of midwives failed to decentre the dominance of medical and gendered discourses in debates about midwifery.

Concluding Remarks

The preceding analysis reveals significant differences and similarities in media representations of midwifery in Ontario and Quebec. While both employed boundary frames, the bases of those frames were very different. In Ontario, media representations of midwifery linked boundaries to the material costs and savings associated with midwifery in terms of healthcare service provision. In effect, media representations depoliticized midwifery, removing it from the arena of gender politics, and drawing on hegemonic neoliberal and medical discourses to construct midwifery as a viable healthcare alternative. In Quebec, however, boundaries were based on the ideological differences between midwives and physicians, serving to highlight the 'politics' of midwifery. At the same time, however, representations in both jurisdictions drew on gendered/ing discourses to construct midwifery as something that needed to be 'controlled'. In Ontario, we see this through the use of legal frames, as well as though the discursive positioning of midwives within the debates, responding to but never providing frames. In Quebec, we see this through the discursive positioning of midwives with respect to physicians and government, rendered invisible within midwifery debates. In reasserting masculine dominance over midwives, the 'threat' presented by midwifery was limited and legalization is constituted as an appropriate response to crises in healthcare management.

In different ways, then, media representations in both jurisdictions aligned midwifery with broader provincial-level discourses, reproducing and reinforcing the hegemonic discourses of medical science, expertise, and gendered systems of power. Such discursive bridging muted the otherwise controversial and 'disruptive' potential of midwifery, making it palatable to the broader public; midwifery was represented as something that needed state intervention. In effect, in both jurisdictions, media representations of midwifery legitimized state action within the arena of reproductive politics, as well as relations of ruling on which they are based.

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