Health Care for Women International
Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t713723020

"We Wanted a Birth Experience, not a Medical Experience": Exploring Canadian Women's Use of Midwifery

Diana C. Parry[a]
[a] Department of Recreation and Leisure Studies, University of Waterloo, Waterloo, Canada

To cite this Article Parry, Diana C.(2008) '"We Wanted a Birth Experience, not a Medical Experience": Exploring Canadian Women's Use of Midwifery', Health Care for Women International, 29: 8, 784 — 806
To link to this Article: DOI: 10.1080/07399330802269451
URL: http://dx.doi.org/10.1080/07399330802269451

Health Care for Women International, 29:784–806, 2008

ISSN: 0739-9332 print / 1096-4665 online
DOI: 10.1080/07399330802269451

Routledge
Taylor & Francis Group

"We Wanted a Birth Experience, not a Medical Experience": Exploring Canadian Women's Use of Midwifery

DIANA C. PARRY

Department of Recreation and Leisure Studies, University of Waterloo, Waterloo, Canada

In this study I explore Canadian women's use of midwifery to examine whether their choice represents a resistance to the medicalization of pregnancy/childbirth. Through my analysis of the data I identified eight ways the women's deliberate decision to pursue midwifery care represented resistance to medicalization. In so doing, I demonstrate how women actively assert their agency over reproduction thus shaping their own reproductive health experiences. The outcome of their resistance and resultant use of midwifery was empowerment. Theoretically the research contributes to understanding the intentionality of resistance and a continuum of resistant behavior.

The popular media coverage of optional caesarean sections, increased medical inductions, and the growing list of contraindications for vaginal births, has brought new awareness of the emotionally charged decisions faced by pregnant women. For example, the following headlines appeared in a popular Canadian parenting magazine: "Whatever happened to normal birth?" and "Is normal birth at risk?" (Haaf, 2005). These types of headlines are partly responsible for bringing the medicalization of pregnancy and childbirth to the forefront of Canadian health issues. According to the Canadian Institute for Health Information, every year approximately 333,000 babies are born in Canada. Of those births, 99% take place in a hospital and three out of four women undergo some form of medical procedure. Moreover, 22.5% of those deliveries are caesarean sections. These statistics demonstrate that

Received 11 September 2006; accepted 28 February 2007.
Address correspondence to Diana C. Parry, Department of Recreation and Leisure Studies, University of Waterloo, 200 University Avenue, Waterloo, Ontario, N2L 3G1, Canada. E-mail: dcparry@healthy.uwaterloo.ca

while pregnancy and childbirth are important life events for many Canadian women, so too is the medicalization of their experiences.[1]

Inhorn (2006) defines medicalization as the "biomedical tendency to pathologize otherwise normal bodily processes and states. Such pathologization leads to incumbent medical management" (p. 354). Medicalization is a social process whereby an expert-based biomedical paradigm dominates discussion of health and frames it in negative ways, usually as illness experiences understood as biological and individualistic (Walters, 1994). The process of medicalization occurs when life events come to be understood as questions of illness and are then subject to the authority of medical institutions with their cadre of experts from whom we expect proper diagnosis and isolation of our health problems. Once a life event becomes medicalized, it is described in medical terminology, treated in medical institutions, and people affected by it are regarded as patients (Greil, 1991). Idealizing a medicalized vision of health is a reality for most people, as demonstrated by the ease with which we transform ourselves into patients and allow the expertise of medical institutions to shape our life events (Lorber, 1997). Critics of medicalization argue that biological frameworks are narrowly focused and ignore other ways for people to make sense of their health and well-being. Recognizing that medicalization as an ideology is spreading, social movements slowly have emerged to assert alternative ways to appreciate health and influence our well-being (Boston Women's Health Collective, 2005).

Many life events and health issues have been medicalized, but Zadoroznyj (1999) argues that women's experiences with pregnancy epitomize the process of medicalization. Once considered a natural, normal, woman-centered event, pregnancy currently is conceptualized as a dangerous time wherein a woman and her fetus are at risk and in need of constant medical monitoring and intervention. Woliver (2002) stated, "Modern society's medicalization of pregnancy . . . [is] subtly altering women's role in reproduction by making conception, gestation, birth, and genetic inheritance something that predominantly . . . scientists monitor, examine and control" (p. 7).

Women are not ignorant to the changes occurring in reproductive politics or simply submissive recipients of medicalization. Woliver (2002) explained, "Disobedient women in doctors' offices, often described as 'noncompliant' and 'difficult' are asserting their agency over reproduction when they refuse tests, question procedures and medical protocols, and try to shape their own reproductive and health experiences" (p. 24). Woliver's comments suggest that some women *actively* and *intentionally*

[1] I have focused solely on Canadian statistics because this research was conducted in Canada.

resist the medicalization of pregnancy and childbirth. Yet scant research has explored women's perceptions of medicalization, their experiences with medicalization, and specific ways that women resist the medicalization of pregnancy, childbirth, or both— the purpose of this research. Accordingly, I review the literature on the medicalization of pregnancy; second, I present literature on women's resistance to ideologies, including medicalization; third, I review the literature on midwifery, and, finally, I articulate the findings of a research project on women's use of midwifery as resistance to medicalization.

RELEVANT LITERATURE AND PERSPECTIVES

The Medicalization of Pregnancy

The increased use of ultrasounds during pregnancy, fetal heart monitors, high caesarean rates, and expanded use of amniocentesis demonstrate many ways that women's experiences with pregnancy and childbirth have been medicalized (Mitchell, 2001; Woliver, 2002). The driving force behind the medicalization of pregnancy is the assumption of risk connected to fetal, and sometimes maternal, health. Mitchell (2001) explained that within medical and social discourse pregnancy currently is conceptualized as a time of risk and danger. Woliver (2002) noted pregnancy and childbirth, previously considered natural or normal, have been transformed into an unnatural condition or illness whereby there is an assumption of risk to both maternal and fetal health. Such risk is the focus of medical professionals who determine, control, and rectify potential or actual problems during pregnancy and childbirth. Young (2001) argues the medicalization of pregnancy and childbirth leads to alienation. "Alienation here," Young explains, "means the objectification or appropriation by one subject of another subject's body, action, or product of action" (p. 280). Young believes physicians develop and control knowledge in three ways: (1) by defining pregnancy as a medical disorder, (2) by using medical instruments to understand internal processes, and (3) through employing a medical setting, which discounts a woman's control and expertise over her own pregnancy. Young's third point demonstrates that within medicalized contexts women's lived experiences with pregnancy are pushed to the periphery, ensuring women's perspectives and insights are rarely told, heard, or given any authority. Woliver noted, "Shifting control from the pregnant woman to doctors and other medical professionals brings with it increased power of 'experts' at the expense of women" (p. 30). Davis-Floyd (1992) also noted the impact of medicalization in North America where biomedical and technological knowledge is privileged, thus allowing physicians to play a key role as the medical authority of women's experiences of pregnancy. In her study of the history of medical treatment of pregnant women, Oakley (1984) found

pregnant women were seen as deficient in that they lacked the proper education, responsibility, and intelligence necessary to take an active role in the management of their pregnancies. Based upon this conceptualization of pregnancy, women must draw upon medical expertise.

When women's voices are ignored in the construction of knowledge pertaining to pregnancy and childbirth, they become alienated from the experience. Young (2001) explained that women become a container for a developing fetus; objectifying the experience as a "condition" during which she must take care of herself (p. 274). Consequently, Mitchell (2001) argues pregnant women have become "living fetal monitors":

> Refusing prenatal diagnosis, giving birth at home, and even drinking coffee may be interpreted as signs that a woman has made the "wrong" choices or lacks the "right" information. ... Those who engage in these taboo activities risk being excluded from the category of "good mothers" and may be subject to increased surveillance, restriction, and instruction.

Taken together, these studies suggest that medicalization is a powerful force that shapes women's experiences with pregnancy.

Women's Resistance

Pregnant women, however, may resist the medicalization of their pregnancies/childbirth experiences. Resistance is conceptualized as a challenge to ideologies that perpetuate unequal power distributions or the ways power is implemented (Shaw, 2001). Women's resistance is based on two theoretical assumptions: "first, the idea of agency, ... which allows for the view that women are social actors who perceive and interpret social situations and actively determine, in each setting, how they will respond" (Shaw, 1994, p. 15); and, second, the notion of relatively free choice. That is, two key characteristics of resistance, personal choice and self-determination, have been associated with resistance to traditionally prescribed gender identities, stereotypes, and roles by enabling women to exert personal control and power (Shaw, 2001; Wearing, 1990, 1995). Shaw (2001) explained, "An important aspect of resistance ... is resistance to dominant ideologies, associated with factors as gender, race, the family or sexuality. Challenging ideologies are thus a challenge to underlying power relations" (p. 189). According to Earle (2003), "the pregnant body has been traditionally seen, by feminists and others, as a potential site of resistance to wholesale objectification and commodification of women's bodies within modern Western societies" (p. 250). Pregnant women who chose alternatives to the medical birth, such as midwifery, may be resisting medicalization.

The Midwifery Option

In their book, *The Midwifery Option*, Hawkins and Knox (2003) highlight how midwifery is woman-centered care that recognizes and celebrates the transition to motherhood for women and their families. The primary birth attendants in North America and Europe prior to the 1860s, midwives were removed from practice with the onset of technology and the professionalization of modern medicine around 1950 (Paterson, 2004). Inhorn (2006) explained the following:

> In the 19th century, women's health care was literally wrestled from the hands of women healers—including midwives, spiritualists, and other lay women's healers—to create a lucrative ob-gyn profession controlled by men. Such biomedical hegemony was achieved in part by force—for example by making lay midwifery practice illegal in many states. But this switch from midwifery to ob–gyn was also achieved by consent, as birthing women became convinced that biomedicine had something useful to offer them. (pp. 356–357)

By the 1970s women were disenchanted by the medicalization of birth, which lead to midwifery experiencing a "rebirth." Women were demanding control over their bodies, their experiences of childbirth, the location of births, and their choice of birth attendants. The women's health movement also was gaining prominence during this time, and there were broad social changes occurring around notions of science, the roles of medicine, and the roles of consumers in medicine (Rushing, 1993). This period of time was characterized by rapidly developing technological care that emphasized the role of the obstetrician, yet also by a return to more natural values including recognition by women of the unique role of midwives (Houston & Weatherspoon, 1986). Consequently, the 1970s are seen as a seminal period during which time an alternative birthing movement was developed that embraced partner-assisted, intervention-free births that took place in the home or hospital (Inhorn, 2006).

The market forces within Canada, however, did not provide an environment in which midwifery could flourish. Rushing (1993) explained that national health insurance, a low birth rate, and a surplus of physicians and nurses combined to constrain midwives' professional development. Consequently, Canadian midwives were not as "successful as their U.S. counterparts in either gaining independence from physicians or becoming established in the health care system" (Rushing, 1993, p. 50).

Closely linked to the lack of professional development within Canada was the lack of educational opportunities for midwives. In contrast, within the United States midwives had made major advancements into the American health care system as evidenced by their own professional organization (Midwives' Alliance of North America) and training schools (Rushing, 1993).

In their search for formal training opportunities, some Canadians went to the United States where formal training had been established; others studied abroad or through correspondence courses. Some women entered nursing programs believing they would learn important information about childbirth and the health care system in Canada (Relyea, 1992). As more midwives started practicing within Canada, a community apprenticeship developed providing the much-desired educational opportunities (Relyea, 1992). Despite the progress, the apprenticeships were considered fragmented and incomplete, which was connected to the lack of political recognition and legislation for midwifery.

Legislation was supported by many arguing it would protect women from unskilled practitioners. Others recognized the potential pitfalls of legislation and, thus, did not support such a move (Gross, 1984). More specifically, some women "had serious concerns that midwifery would become institutionalized and lose its egalitarian and woman-centred roots" (Hawkins & Knox, 2003, p. 37). Despite opposing views, the legislation for legal practice was spearheaded and these groups lobbied for legislation in support of autonomous midwifery (Relyea, 1992). Consumers of midwifery care played a key role in this process. Rushing (1993) explained that they demonstrated, wrote letters, organized conferences, raised money, and lobbied on behalf of the legalization of midwifery.

Within Canada, the first province to legislate and fund midwifery was Ontario in 1993 (Hawkins & Knox, 2003). Currently, within Canada, six out of 13 provinces have licensed midwives and four are fully funded by the government (one is partially funded). Registered midwives have been practicing within Ontario since 1994. By 2002 Ontario had 250 registered midwives providing care in 30 cities throughout the province. Despite the demand for midwives in Ontario and across Canada, Hawkins and Knox (2003) related the following occurrence:

> The number of babies caught by Canadian midwives is only a handful compared to countries with a more established midwifery system. In comparison to that in the 75 percent of the world's babies caught by midwives . . .Ontario [had]. . . about 4.5 percent of babies born to women under the care . . . of midwives (p. 39–40).

Thus, although midwifery has become recognized and integrated into many health care systems within Canada and Ontario specifically, a doctor-assisted birth remains the norm. Accordingly, Raisler (2000)concluded that a key area for future research includes women's experience of birth and midwifery care.

Midwifery, which means "to be with women," is based upon a philosophy of care whereby responsibility for a pregnancy is shared between the woman and her midwife. Indeed, Canadian midwives are governed by

informed choice, which means, "You have the right to make decisions about your own care, based upon the information given to you by experienced professionals—in this case midwives" (Hawkins & Knox, 2003, p. 6). Paterson (2004) builds upon this approach and adds "continuity of care" and "choice about place of birth" to the philosophical underpinnings of woman-centered care. More specifically, midwives provide prenatal care, attend births, and are responsible for infant care for the first 6 weeks of life. Midwives also support a woman's choice as to where—home or hospital—she would like to give birth. Although midwifery care is dynamic and thus undergoing changes (Bourgeault, 2000), it nonetheless is focused on shared responsibility and mutual decision-making processes, which falls in sharp contrast to the medicalized pregnancy and childbirth experience wherein professionals are seen as the experts. Turner (2004) explained within a medical model, "the doctor is placed at the center of the healing act. The doctor conducts an examination, makes a diagnosis, and determines the course of treatment" (p. 646). With its focus on shared decision making, midwifery offers women an alternative choice to medicalized pregnancy and childbirth.

The philosophical underpinnings of midwifery seem based upon the theoretical foundations of resistance, namely, women's agency and choice. Indeed, Woliver (2002) stated the "use of alternative medicine [which Turner (2004) notes includes midwifery], herbs, vitamins, and such *might* also be a political statement about disentangling oneself from the Western modern health care industry and asserting one's own agency" (p. 24, my emphasis). In this sense, midwifery could provide the context in which pregnant women resist the medicalization of pregnancy and childbirth. Women's use of midwifery as resistance to medicalization remains unclear, however.

PURPOSE OF THE STUDY AND RESEARCH QUESTIONS

My purpose was to explore women's choice of midwifery, including their perceptions and experiences with medicalization. Overall, the guiding question for my research was, "Does women's use of midwifery reflect a resistance to the medicalization of pregnancy and childbirth?" And, if so, is the resistance intentional? I sought to locate the potential for resistance by "looking at the different ways in which women are being affected by . . . the material conditions of their lives, their own descriptions of their needs, and of their experiences of pregnancy and childbirth" (Sawicki, 1999, p. 196). In locating resistance in the material conditions of women's lives, I was able to focus on women's lived experiences with pregnancy and childbirth.

THEORETICAL ORIENTATION: FEMINIST STANDPOINT THEORY

Feminist standpoint theory provided the guiding epistemological framework to address the above research questions. Woliver (2002) argued that

feminist standpoint theory is particularly important in regard to issues of reproduction. She noted that only women can experience reproduction, including menstruation, pregnancy, birth, and lactation directly, so their voices and perspectives on these issues are of central feminist concern. According to Woliver, feminist standpoint theory is focused on uncovering assumptions about power differentials within a patriarchal society. One of the key components of power is knowledge, which is socially situated and compressed of a culture's beliefs and opinions (Harding, 1991). Feminist standpoint theorists argue that women have been left out of the social construction of knowledge as a result of their marginalized status within patriarchal society (Woliver, 2002). Consequently, feminist standpoint theorists posit that knowledge needs to be grounded in the lived experiences of women. In short, a feminist standpoint involves "observations and theory that start from [and] . . . look at the world from the perspective of women's lives" (Harding, 1991, p. 124). Harding (1991) argues that this theoretical approach is particularly relevant to research connected to how women resist patriarchal institutions and ideologies. In her words, "Trying to reconstruct the story from the perspective of the lives of those who resist oppression . . . we can come to understand hidden aspects of social relations between the genders and institutions that support these relations" (pp. 126–127).

Feminist standpoint clearly makes the personal political. Hartsock (1998) argues that it allows researchers to incorporate social, natural, and embodied human experience into our politics. Lofland and Lofland (1995) argue that "we make problematic in our research matters that are problematic in our lives" (p. 13), which was the case for me with this research. More specifically, when I began this research project, I was 5 months pregnant with my first child. Similar to other women who have studied reproductive issues while pregnant, I found my pregnancy affected the process and product of my research (cf. Reich, 2003). Specifically, my pregnancy enabled me to access participants and facilitated the development of rapport and discussion of lived experiences. In this sense, my experiences were similar to those noted by Warren (1988),who found that the marriages, pregnancies, and experiences of parenthood of female researchers offered access to woman-centered worlds and participants.

RESEARCH DESIGN: GATHERING DATA

Participants for the research were selected purposefully so that they were a rich source of information who "illuminated the questions under study" (Patton, 1990, p. 169). More specifically, I utilized criterion sampling. The rationale behind criterion sampling is to include participants who meet "some predetermined criterion of importance" (Patton, 1990, p. 176). Given my

interest in women's choice of midwifery as resistance to medicalization, I sought participants who had utilized midwifery care.

I recruited participants for the study in three ways. First, I posted an advertisement at a local midwifery clinic in a medium-sized city in southwestern Ontario, Canada. Second, I handed out an advertisement at a prenatal workshop in which I was participating. Third, I utilized snowball sampling. A total of eight women volunteered for the study. Although this is a small group of participants, the interviews were lengthy and illuminating. Each interview lasted between 1- and 2- and-a-half hours and yielded large amounts of data. The participants were reflexive, thoughtful, articulate, and willing to engage in discussion about their lived experiences. In addition, the group of women was relatively homogeneous and the goals of the research were fairly narrow. Under these conditions, Guest, Bunce, and Johnson (2006) suggest that six participants will suffice, which made me confident that eight participants was sufficient.

Seven of the women were pregnant at the time of the interview, and the other participant recently had given birth. Four of the women were expecting their first child, and the others had previous pregnancies to draw upon throughout the interviews. The women ranged in age from late twenties to early forties. One of the participants was a stay-at-home parent, while the rest were employed outside the home in a variety of careers, including accountant, social worker, teacher, professor, and office worker. All of the women were in committed relationships with men. Moreover, all the participants had postsecondary education and were Caucasian.

Consistent with feminist standpoint theory, the study was based on active interviews, which Dupuis (1998) described as conversational as nature. Most importantly, Dupuis explained, active interviews foster and value a dynamic interplay between researchers and respondents. Consequently, active interviews "involve mutual disclosure, a sharing of information and insight in the meaning-making process" (p. 57). Based upon this premise, the research participants and I discussed our lived experiences with pregnancy including our decision to pursue midwifery care. Thus, the active interview created a space where the women could share their own narratives and explain their own experiences (Kaufman, 1992), which was one of the goals of this research. In this sense, "knowledge was generated through dialogue, listening, and talking" (Thompson, 1992, p. 10).

All of the interviews were audiotape recorded and later transcribed. To keep the data confidential, each woman was assigned a pseudonym, and all other identifying information (names of partners, friends, family members, midwives, etc.) was changed. I explained to each participant my interest in the topic stemmed from my own experiences as a pregnant woman. Because I wanted to focus on the potential for resistance by exploring the ways women are affected by the material conditions of their lives and their descriptions of their needs and their experiences of pregnancy and childbirth,

I started each interview asking participants to "discuss her experiences with pregnancy." From there, consistent with an active interview approach, I let each interview unfold naturally, but I found that each participant raised her experiences with midwifery. Consequently, the second topic of conversation connected to how each participant decided upon midwifery. From there the women and I typically discussed experiences with midwifery versus a medical model or perceptions of a medical model. For example, for those participants who had had a previous birth under the care of a physician or obstetrician, I asked them, "How do your current experiences with midwifery compare to your previous pregnancy with an obstetrician?" After hearing the responses, I typically probed further by encouraging participants to talk in specific ways, either positively or negatively, about their choice of midwifery care, the benefits they received, and reactions to their decision by friends, family, or both. Again, consistent with an active interview, I was able to share my own experiences throughout our discussions, which facilitated the shared insight into the meaning-making process.

DATA ANALYSIS

Guided by my research question on women's use of midwifery, I focused on identifying, categorizing, classifying, and labeling patterns in the women's responses (Patton, 2002). To begin, I read each transcript a number of times; then I started coding using an open process to develop initial descriptive categories, such as *perceptions of a medical model*. Next, I compared these categories, both within and between interviews, to look for conceptual themes (Glaser & Strauss, 1967). Subsequently, I examined patterns of relationship among themes. In this regard, I felt confident that the themes were inclusive of data across the interviews. Data analysis and coding processes proceeded simultaneously with the data collection (Ambert, Adler, Adler, & Detzner, 1995), so that initial interview data were examined and analyzed as I arranged and conducted subsequent interviews.

I invited each participant to be as involved in the data analysis as she had the desire and time to do so. After the interview, each participant was sent her transcript with my analysis and invited to provide any feedback or additional comments or to change any information. Upon completion of the study, all the participants were sent the overall findings of the study and again were asked to provide any feedback or additional comments or change any information. All but one of the women replied to the overall findings. In all cases, the responses by the women were positive and supportive of my findings. For example, one woman stated, "Thank you for this information. It is so interesting and I am glad I had the opportunity to participate in your research." Another woman replied, "Very interesting study. I don't have any changes to provide." The responses I received were positive, but brief,

which I suspect was due to the fact that all of these women had newborns for which they were caring. Consequently, they did not have a lot of time to devote to their feedback. Having said that, by reading over the transcripts and findings of the study, I concluded that the participants indicated their support for the findings (Denzin & Lincoln, 2005).

FINDINGS

All of the participants discussed the pervasiveness of a medical model. For example, one participant stated, "It's [medicalization] so systemic that it's not even questioned." Another participant's comments were of a similar nature. In discussing her opinion of why women continue with a medical model birth, she said:

> I think it's so ingrained, that that's the way birth is, that it's really hard for people to get their head around the fact that there is another way and that all these other countries are doing it the original way. Why do we think that we need all this stuff?

Similarly, another participant remarked: "I definitely think that, yeah, [pregnancy] has become less of a natural event. I think things have become more medicalized and I don't think they need to be [medically] managed; usually they don't." These types of comments were common throughout the interviews, indicating the pervasiveness of medicalization.

The participants discussed specific ways that pregnancy and childbirth had been medicalized. For example, the participants discussed pregnancy being viewed and treated as illness as opposed to a natural event. One woman remarked, "I didn't want all the medical intervention 'cause I felt like being pregnant is not an illness." Along the same lines, another participant said, "Personally, I don't think being pregnant is an illness, and a lot of the [medical] interventions are unnecessary, in my opinion." Another woman commented that while she was pregnant, her life carried on as usual:

> Some people don't even lift a bag of groceries, or walk down the street. I just think [pregnancy] is not life altering, like, for the most part you do everything you did before. There's certainly things you need to cut back on and changes you need to make, but for the most part, you know, it's not life altering. I didn't feel it was a time in my life when things turned upside down or things really changed.

In sum, the women discussed a change in the way pregnancy is viewed and treated. Their comments suggested a critical view of pregnancy as an illness or a condition. Instead, the women in this study viewed pregnancy

as a "natural" or "normal" life event. Based upon this conceptualization of pregnancy, the women sought out midwifery care.

Choice of Midwifery as Resistance

The decision to utilize midwifery care was a conscious choice. For example, one participant who was pregnant with her second child discussed her first pregnancy, which was under the care of an obstetrician:

> I found them [doctors and nurses] very condescending. They didn't explain things to me, and I think when you're in labour, you're kind of in a trance. It's like nothing you've ever experienced before, and you're receptive to suggestion and I think it should be a positive suggestion. The problem with hospitals is, often, the comments or whatever are often negative. I wanted an approach that was positive towards birth, so I went with midwifery.

This participant highlighted what she did not appreciate within a medical model (lack of communication, negative approach) and clearly stated her decision to seek out a more positive experience. Another woman who was expecting her first child explained her decision to use a midwife:

> I don't think medical intervention just with pregnancy is an issue. I think Western society in general relies way too much on drugs. I didn't want that for my pregnancy, so I went with a midwife.

This woman identified her disapproval of over reliance on medication and instead sought out midwifery. Another woman stated, "I don't want a doctor to dictate to me, or anybody to dictate to me this isn't happening the way it should be because I got something else to do. So you need to have an epidural and then you need to have these drugs." Thus, this participant decided upon midwifery because she wanted personal control, which is not pervasive within a medicalized context. Another woman demonstrated her resistance to medicalization when she made the following comment about her decision to use a midwife: "I'm very conventional in a lot ways, and this is doing something that is not status quo. An OB would be the status quo." When discussing her choice of midwifery in a society in which medicalized births are the norm, one woman said, "Because we choose midwifery, then we're the ones that have to give the explanations and we're going against the grain, we're the hippie witch, you know, bra burning woman." Last, another participant commented, "I've heard comments that I am being ignorant by even going with a midwife or even thinking of having my child at home. But, the more I learned about what a midwife does, I just thought, 'That's what I want.' These quotes are examples of the type of comments that occur within

a medicalized context whereby women are expected to have a medicalized birth. The participants in this study, however, resisted those comments and medicalization by making a decision that was better for them.

Through my analysis of the data I identified eight ways the women's decision to pursue midwifery care represented resistance to a medicalization for the women in this study: (1) a natural approach to pregnancy/childbirth, (2) continuity of care, (3) woman-centered care, (4) informed choice/shared decision making, (5) emotional care, (6) professional ability, (7) family friendly policies and practices, and (8) personal control. Each will be explored in more detail, beginning with a natural approach to pregnancy.

The natural approach

All of the participants sought out midwifery, in part, because of their desire for a more natural approach to pregnancy and childbirth. For example, in discussing her decision to pursue midwifery care as opposed to obstetrical care, one participant said, "It's [pregnancy/childbirth] a very natural process, and the midwife helped me create that as much as possible." Another participant expressed criticisms of medical interventions, which reflected her desire for a more natural approach, when she commented, "Women had babies for hundreds of years without any of that stuff." When asked why she decided on a midwife as opposed to other options, including obstetrical care or a family physician assisted birth, one woman stated, "We were really interested in more of the natural childbirth sort of things." All told, the participants sought out midwifery care to follow a more natural path and avoid what they deemed unnecessary medical interventions.

Continuity of care

The women also discussed seeking out midwifery for continuity of care. For some participants it was the prenatal care that was the most important aspect. For example, one participant remarked, "I think that the care, the pregnancy care was the big thing that swayed me." For other participants, continuity of care during labor and delivery was most important. One woman noted, "I didn't like the idea of going into a hospital, having a nursing staff deal with you that I've never met before." A participant who was pregnant with her second child commented, "I didn't want to go through labor with the nurses as I did before. They kept changing shifts, so there was always someone new. I thought it's better to go with a midwife." Others sought out midwifery for the postnatal care. For example, a woman explained, "We were really interested in the postnatal care because we don't know anything about raising a baby. She'd [the midwife] be with us for 6 weeks after the birth and we could access her and she'd come to the house and things like

that, which you're not going to get with an obstetrician." These comments clearly indicate how these women selected midwifery care for the continuity of care, thus resisting what they believed to be fragmented and limited care one would receive with an obstetrician or family physician.

Woman-centered care

While some participants sought out midwifery care for the continuity of care, others wanted care that was focused on them and their needs. As one participant remarked, "I really wanted more of a focus on me and what, you know, what was best for me." When asked how she decided to pursue midwifery care, one woman said, "definitely the focus on the woman." Another participant sought out what she described as "individualistic care" by which she meant care that catered to an individual woman and her unique situation. In her words, "I appreciated the individualistic approach to it, you know, what are your risk factors, how are things going in your pregnancy, rather than just sort of a blanket approach to everybody that comes in." Last, one participant commented that with midwifery you are treated as a whole person, not simply a pregnancy.

Informed choice and shared decision-making

Informed choice and shared decision making was another common reason that led many women to seek out midwifery care. More specifically, midwives encourage women to take an active role in their own health and well-being, including the power to make decisions, as the following comments demonstrate: "I really like that I could go to the midwife and we could discuss things. If something came up, like a concern, we would talk about it and I felt a part of the decision." A part of this process includes 45-minute appointments to ensure there is time to discuss information: "I needed to discuss everything as it happened, and you just don't get that with an obstetrician. You get 5 minutes, if you're lucky. I needed that time to discuss what happened previously to get my confidence up for the birth." Moreover, midwives provide a library of books and videos so that women can read and learn about issues connected to pregnancy, labor, delivery, and parenting. About the library materials, one participant remarked, "I love the midwife experience because you go to their office and they have books and videos and when I talked to women that go to the doctors, they say, 'What books? Where do I get that?' Many participants felt the library enabled them to take the active role they wanted throughout their pregnancy and reduced the fear of the unknown.

Emotional care

Emotional care was another key component to the participants' choice of midwifery. More specifically, many participants talked about the importance of the relationships that one develops with midwives. For example, in discussing her relationship with her midwife, one woman stated,

> I kind of had a breakdown at that point, but I feel like I can bring that to her, whereas, with my physician, who I have had for a number of years, my appointments with her are always rushed. I'm in/out and I could see myself in a doctor/patient relationship putting a lot of that stuff on the back burner.

This participant was able to share her feelings with her midwife, which she did not believe would occur with her physician. Another woman noted that the emotional care was what made each pregnancy unique. In her words, "The physical; it's just natural. I can read a book and I know that everything's happening the way it is, but everyone's emotional experience I think is a little bit different. Midwives do that. They meet your emotional needs." Along a similar line, one participant commented, "The midwife is just so much more involved in the care, and your appointments are 45 minutes, an hour long, whereas your doctor you're, you're in and out." Perhaps this participant summed up the emotional care best when she stated,

> What it really is, it's the relationships. I cried every time after 6 weeks, after leaving my midwives. In fact, I feel teary-eyed now just thinking about it. I love my midwives. They're very dedicated to what they do, and they really take the time to listen to your concerns and I really feel like they treat you as a person, rather than just a pregnancy.

These comments suggest how pregnancy, delivery, and motherhood are much more than just a physical experience, which is recognized within midwifery through the emotional care they provide for women.

Professional ability

While the participants were drawn to the emotional ability of midwives, they were equally impressed by their professional skills. For example, in describing her midwife, one participant said, "They're so well trained" and another said, "They know what to do at the right time." When asked about the skills of her midwife another participant said this: "I never had an ultrasound with my first son. I trusted my midwives that they could do all the palpating and understand where he was and stuff and so there wasn't any time where I was concerned about his health as a fetus." This woman's comments illustrate her trust in a midwife's professional ability. Last, one woman described her

midwife as "really, really, knowledgeable." When asked how professional ability contributed to her pregnancy, one woman replied, "It made me feel comfortable." The participants respected the professional experience and knowledge midwives brought to their care, which gave the participants confidence in the care they received.

Family-friendly policies and practices

The women also discussed family-friendly policies associated with midwifery care. Many women discussed how their husbands attended their appointments and were always treated as an important component of the pregnancy experience. For example, one woman commented,

> It was really nice that I could go in to the midwife and she had allotted 30 to 45 minutes for our appointment, and my husband was able to make most of the appointments, and we both came with our list of questions and we never felt rushed.

Similarly, another participant offered the following comments about her husband's involvement in her pregnancy: "He wouldn't have been nearly as involved if I hadn't had midwives. And so it's family involvement." Last, a woman who was having her third child commented, "They take your whole family—your partner, your children. Whenever I had family there, they'd talk to the family about what was going on." Thus, many participants appreciated that their midwives recognized a pregnancy was a family event and treated it as such.

Personal control

The participants also discussed how midwifery met their needs for control over their bodies, their pregnancies, and their experiences with childbirth. One of the participants who had a previous pregnancy under the care of an obstetrician made the following comment: "It scares me that they would push on you when you're in your most vulnerable state, these major medical interventions, because it might be more convenient for their schedule." Another woman said, "I just wanted to be able to be in control of what was going on with my body." One participant commented, "I just didn't want to get a bum steer during my pregnancy. I tend to be a person with a lot of questions and I want answers and I want peace of mind." These types of comments reflect the women's desire for personal control. All the women believed they would have more control of their experiences as a result of the shared decision making facilitated by midwifery.

In sum, a natural approach to pregnancy/childbirth, continuity of care, woman-centered care, informed choice/shared decision making, emotional care, professional ability, family friendly policies and practices, and personal control represent the aspect of medicalization that the women were resisting through their decision to pursue midwifery care.

The participants did not completely resist medicalization, however. Many of the women believed medical interventions have a place in pregnancy and childbirth. For example, one participant commented, "I certainly believe medical intervention has a place. I'm sure there are a lot of babies that wouldn't be here if it wasn't for that, but I think for the most part it's not necessary." This sentiment was very common across this group of women and speaks to the complexity of resistance. Thus, the participants saw a place for medical interventions in pregnancy and childbirth, but they resisted it in their own experiences or what they believed to be "regular births."

Empowerment as an Outcome of Resistance

Their choice of midwifery served to empower the women by contributing to their sense of control over their bodies and their sense of physical and emotional wellness. Feelings of empowerment often were revealed by the women through comments connected to personal strength. For example, one woman noted her decision to pursue midwifery care taught her that she is stronger than she had believed herself to be. In her words, "I may be stronger than, you know, not necessarily physically, but, you know, emotionally stronger than I ever thought I was." Empowerment also was revealed by the women when they discussed feeling confident about becoming a mother. For example, one participant noted she felt supported as a result of her midwife: "If I was feeling alone and isolated and not supported, I would feel very different about this pregnancy. I would feel a lot more scared and worried and anxious." This participant went on to say she felt confident about becoming a mother—a confidence she gained in part through the education she gained throughout her pregnancy. Another woman revealed the empowerment she felt when she said, "Before we had really given serious consideration to having children, I never really thought that I would give so much thought to even getting through a pregnancy or the fact that I would deliver and I would do everything I could to deliver naturally." Similarly, a participant remarked, "I just get the feeling that I can do this and it's really not that big of a deal." When asked how her decision to pursue midwifery made her feel, one woman said, "Well, you feel empowered as a woman, that you have control over your own body rather than someone telling you what to do." Last, one woman revealed the empowerment she gained when she made the following comment: "I'm pretty outspoken. I've developed a

lot of confidence now that I have gone through two healthy pregnancies." In sum, the women in this study gained confidence and felt empowered by their decision to pursue midwifery thereby resisting the medicalization of their pregnancy.

DISCUSSION

My purpose was to explore women's use of midwifery to understand whether it represented resistance to medicalization. The women demonstrated a deliberate and conscious choice to seek midwifery care over a medically assisted birth. Through my analysis of the data I identified eight aspects of medicalization the women were resisting through their choice of midwifery. In so doing, I demonstrate how women actively assert their agency over reproduction, thus shaping their own reproductive health experiences. The research provides initial insights for understanding the intentionality of resistance to ideologies.

The women's choice of midwifery reflected a deliberate or conscious choice, which sheds light on intentions—an aspect of resistance that has yet to be adequately explored or understood. Shaw (2001) stated, "Since empowerment and resistance are seen to be associated with self-expression and self-determination, this would seemto imply that resistance is a deliberate or conscious choice made by the participant or actor. This idea, though, has not been fully explored" (p. 192). The resistance demonstrated by the women in this study was indeed a deliberate and conscious choice to the medicalization of their pregnancy and childbirth experiences. What remains unclear, however, was whether the women were attempting to resist medicalization solely because it better met their personal needs or whether they also were resisting societal attitudes toward women's role in reproduction. In other words, was the women's resistance also linked to a desire to create social change, which is another aspect of resistance that is not well understood (Shaw, 2001). Thus, the women in this study provide an initial insight to the intentionality of resistance, but this area warrants further exploration.

The women's resistance seemed to fall along a continuum. That is, although all of the women intentionally resisted the medicalization of pregnancy, they did so to varying degrees. Most of the women were clear that medical interventions were not "usually" necessary, but they believed certain cases or situations warranted essential medical care. Indeed, two of the women in the current study said their lives had been saved as a direct result of the medical interventions they had received while giving birth. Similarly, in their study of pregnant women's compliance with prenatal norms, Root and Browner (2001) sought to "discern the fine gradations within resistance and compliance; and even more narrowly, beneath the

rubric of pure resistance and pure compliance, those acts which appear to constitute both" (p. 197). Because the women in this study made a conscious or deliberate choice to resist medicalization by choosing midwifery, it may be presumed they are demonstrating absolute resistance. The women's varying degrees of resistance to the medicalization of pregnancy, however, highlight the need for the "fine gradations" associated with women's resistance to be fully explored. That is, for some women, resisting dominant ideologies —although a deliberate and conscious choice—may not be absolute resistance.

The focus of this study was on the use of midwifery as a form of resistance to medicalization, but the participants' resistance was not solely connected to medicalization. The women also discussed ways they sought to resist the ideology of motherhood and the closely linked fetocentric (focus on the fetus) nature of pregnancy. The women's actions demonstrate their desire to resist multiple ideologies. More specifically, the women in this study actively resisted medicalization, the ideology of motherhood, and fetocentrism. This finding suggests a number of further research questions to be explored, including, Are people who resist one type of ideology more inclined to resist other types as well? That is, does resistant behavior have a carry-over effect insofar as people who resist one type of ideology are more inclined to recognize and resist other underlying power structures as well?

The women in this study took an active role in acquiring an understanding of medicalzation and the alternative, midwifery, so that they could make informed decisions about their situation. In doing so, the women developed and illustrated their right to determine their own choices in life. As a result of their resistance and use of midwifery, the women developed an internal strength and confidence. Empowerment, therefore, was evident in our discussions, both as a process and an outcome of the women's resistance of medicalization and use of midwifery (Braithwaite, 2000). The implications of women feeling empowered as a result of their resistance to medicalization and resultant use of midwifery is significant because empowerment is central to the women's movement. Bunch and Frost (2000) posited, "Clearly the concept of empowerment has been of vital importance to women's efforts to improve their standing in society. It has been a critical factor enabling women to move from seeing themselves simply as victims to seeing themselves as self-conscious actors who can work, both individually and collaboratively, to change and shape the world in which they live" (p. 555). Midwifery, therefore, could be an important component of the women's movement in Canada and lead to social change beyond the individual level.

The findings and discussion should be interpreted alongside the limitations of the study. All the data presented herein represent women's lived experiences with pregnancy in Western society, which is technologically advanced. As Young (2001) eloquently states,

> [Such a perspective] presupposes that pregnancy can be experienced for its own sake, noticed, and savored. This entails that pregnancy can be chosen by the woman, either as an explicit decision to become pregnant or at least as choosing to be identified with and positively accepting of it. Most women in human history have not chosen their pregnancies in this sense. (p. 275)

Given that women all over the world give birth under a variety of circumstance, international perspectives need to be heard and might provide a different view, given differences in culture, religion, and access to health care. Moreover, the women who participated in this study were a relatively homogeneous group in terms of their cultural background, educational and economic level, sexual orientation, and martial status. Clearly, research is needed to see if medicalization is an issue for pregnant women internationally or women in different life circumstances.

CONCLUSION

Further exploration on women's lived experiences with pregnancy will broaden an understanding of women's experiences with pregnancy in a medicalized ideological context. The findings reinforce previous criticisms of the medicalization of pregnancy (Woliver, 2002) and further indicate the inadequacy of a narrow medical model for understanding women's experiences with pregnancy. Clearly, pregnancy and childbirth are life-altering events for women—the memories of which will accompany her a lifetime (Lundgren, 2004). Given that motherhood represents such a life-defining change for women around the world, understanding pregnancy is vital as it is such an important transition point (Fox & Worts, 1999). Moreover, Woliver (2002) noted, "The modern women's movement includes a women's health component, disenchanted with many medical practices and seeking to empower women to be better informed and more assertive consumers of health care" (p. 41). Clearly, research on women's resistance takes up and explores how women can be more active and assertive consumers of health, which is needed now as much as ever. Perhaps Inhorn (2006) sums up this perspective best when she states, "The technological excesses of biomedicine in the face of ongoing medicalization require constant surveillance and vigilance to prevent unnecessary medical control over women's lives" (p. 356).

REFERENCES

Ambert, A., Adler, P. A., Adler, P., & Detzner, D. F. (1995). Understanding and evaluating qualitative research. *Journal of Marriage and the Family*, *57*(4), 879–893.

Boston Women's Health Collective. (2005). *Our bodies, ourselves*. New York: Simon and Schuster.

Bourgeault, I. L. (2000). Delivering the "new" Canadian midwifery: The impact on midwifery integration into the Ontario health care system. *Sociology of Health and Illness*, *22*(2), 172–196.

Braithwaite, R. L. (2000). Empowerment. In A. E. Kazdin (Ed.), *Encyclopedia of psychology* (pp. 193–194). New York: Oxford University Press.

Bunch, C., & Frost, S. (2000). Empowerment. In C. Kramarae & D. Spender (Eds.), *Routledge encyclopedia of women: Global women' issues and knowledge* (pp. 554–555). New York: Routledge.

Davis-Floyd, R. E. (1992). *Birth as an American rite of passage*. Berkeley: University of California Press.

Denzin, N. K., & Lincoln, Y. S. (2005). Introduction: The discipline and practice of qualitative research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 1–29). Thousand Oaks, CA: Sage.

Dupuis, S. (1998). Naked truths: Towards a reflexive methodology in leisure research. *Leisure Sciences*, *21*, 43–64.

Earle, S. (2003). "Bumps and boobs"; Fatness and women's experiences of pregnancy. *Women's Studies International Forum*, *26*(3), 245–252.

Fox, B., & Worts, D. (1999). Revisiting the critique of medicalized childbirth: A contribution to the sociology of birth. *Gender and Society*, *13*(3), 326–346.

Glaser, B. G., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.

Greil, A. L. (1991). *Not yet pregnant: Infertile couples in contemporary America*. New Brunswick, NJ: Rutgers University Press.

Gross, S. J. (1984). *Of foxes and hen houses: Licensing and the health professions*. London: Quorum Books.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, *18*(1), 59–82.

Haaf, W. (2005, Spring). Is normal birth at risk? *Today's Parent*, 23–30.

Harding, S. (1991). *Whose science? Whose knowledge?* Ithaca, NY: Cornell University Press.

Hartsock, N. C. M. (1998). *The feminist standpoint revisited and other essays*. Boulder, CO: Westview.

Hawkins, M., & Knox, S. (2003). *The midwifery option: A Canadian guide to the birth experience*. Toronto, Ontario: Harper Collins.

Houston, M., & Weatherspoon, L. (1986). Creating change in midwifery: Integrating theory and practice through practice-based research groups. *Midwifery*, *2*, 65–70.

Inhorn, M. C. (2006). Defining women's health: A dozen messages from more than 150 ethnographies. *Medical Anthropology Quarterly*, *20*(3), 345–378.

Kaufman, B. J. (1992). Feminist facts: Interview strategies and political subjects in ethnography. *Communication Theory*, *2*(3), 187–206.

Lofland, J., & Lofland, L. (1995). *Analyzing social settings: A guide to qualitative observation and analysis*. Belmont, CA: Wadsworth Press.

Lorber, J. (1997). *Gender and the social construction of illness*. Thousand Oaks, CA: Sage.

Lundgren, I. (2004). Releasing and relieving encounters: Experiences with pregnancy and childbirth. *Scandinavian Journal of Caring Science*, *18*, 368–375.

Mitchell, L. M. (2001). *Baby's first picture: Ultrasound and the politics of fetal subjects*. Toronto, ON: University of Toronto Press.

Oakley, A. (1984). *The captured womb: A history of the medical care of pregnant women*. Oxford: Basil Blackwell.

Paterson, S. L. (2004). Ontario midwives: Reflections on a decade of midwifery. *Canadian Woman Studies: Women's Health and Well-Being*, *24*(1), 153–157.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Thousand Oaks, CA: Sage.

Patton, M. Q. (2002). *Qualitative research and evaluation*. Thousand Oaks, CA: Sage.

Raisler, J. (2000). Midwifery care research: What questions are being asked? What lessons have been learned? *Journal of Midwifery and Women's Health*, *45*(1), 20–36.

Reich, J. A. (2003). Pregnant with possibility: Reflections on embodiment, access and inclusion in field research. *Qualitative Sociology*, *26*(3), 351–367.

Relyea, M. J. (1992). The rebirth of midwifery in Canada: An historical perspective. *Midwifery*, *8*, 159–169.

Root, R., & Browner, C. H. (2001). Practices of the pregnant self: Compliance with and resistance to prenatal norms. *Culture, Medicine, and Psychiatry*, *25*, 195–223.

Rushing, B. (1993). Ideology in re-emergence of North American midwifery. *Work and Occupation*, *20*(1), 46–67.

Sawicki, J. (1999). Disciplining mothers: Feminism and the new reproductive technologies. In J. Price & M. Shildrick (Eds.), *Feminist theory and the body: A reader* (pp. 190–202). New York: Routledge.

Shaw, S. M. (1994). Gender, leisure, and constraint: Towards a framework for the analysis of women's leisure. *Journal of Leisure Research*, *26*, 8–22.

Shaw, S. M. (2001). Conceptualizing resistance: Women's leisure as political practice. *Journal of Leisure Research*, *33*(2), 186–201.

Thompson, L. (1992). Feminist methodology for family studies. *Journal of Marriage and the Family*, *54*(1), 3–18.

Turner, P. K. (2004). Mainstreaming alternative medicine: Doing midwifery at the intersection. *Qualitative Health Research*, *14*(5), 644–662.

Walters, V. (1994). Women's perceptions regarding health and illness. In B. S. Bolaria & H. D. Dickinson (Eds.), *Health, illness and health care in Canada* (pp. 307–325). Toronto, Canada: Hartcourt Brace.

Warren, C. (1988). *Gender issues in field research*. Thousand Oaks, CA: Sage.

Wearing, B. (1990). Beyond the ideology of motherhood: Leisure as resistance. *Australian and New Zealand Journal of Sociology*, *26*, 36–58.

Wearing, B. (1995). Leisure and resistance in an aging society. *Leisure Studies*, *14*, 263–279.

Woliver, L. R. (2002). *The political geographies of pregnancy*. Urbana: University of Illinois Press.

Young, I. (2001). Pregnant embodiment. In D. Welton (Ed.), *Body and flesh: A philosophical reader* (pp. 274–285). Oxford, UK: Blackwell Publishers.

Zadoroznyj, M. (1999). Social class, social selves and social control in childbirth. *Sociology of Health and Illness*, *21*(3), 267–289.