

Essentialism as a Contributing Factor in Ideological Resonance and Dissonance Between Women and Their Midwives in Ontario, Canada

L'essentialisme en tant qu'élément ayant contribué à la résonance et la dissonance idéologiques entre les femmes et leurs sages-femmes en Ontario au Canada.

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ABSTRACT

The social reform movement that led to the regulation of midwifery care in Ontario benefited from a discourse that tended to essentialize depictions of the woman receiving midwifery care, the midwife and the woman-midwife relationship. The *Philosophy of Midwifery Care in Ontario* document for women and midwives reflects this history and supports certain essentialist tendencies. Examining the experiences of women and midwives in midwifery care post-legislation through life history qualitative research reveals ways in which this culture persists within contemporary midwifery discourse. However, the experiences of women and midwives also reveal contradictions within the philosophy of midwifery care document which tend to create problems for essentialism while supporting the element of choice in midwifery care.

KEY WORDS

essentialism, informed choice, Ontario model of care, social reform, woman-midwife relationship

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RÉSUMÉ

Le mouvement de réforme sociale qui mena à la réglementation de la profession sage-femme en Ontario a bénéficié d'un discours qui tendait à essentialiser les représentations de la femme recevant un suivi sage-femme, de la sage-femme ainsi que de la relation de la femme et de la sage-femme. Le document « *Principes fondamentaux des soins de sage-femme en Ontario* » destiné aux femmes et aux sages-femmes reflète cette histoire et appuie certaines tendances essentialistes. L'examen de l'expérience des femmes et des sages-femmes au chapitre du suivi sage-femme durant la période suivant la législation, dans le cadre d'études qualitatives sur le vécu, montre les facettes de cette culture qui persiste toujours à l'intérieur du discours contemporain des sages-femmes. Cependant, l'expérience des femmes et des sages-femmes révèle aussi les contradictions existant dans le document relatif à la philosophie des soins, qui a tendance à problématiser l'essentialisme tout en encourageant l'élément du choix dans le cadre du suivi sage-femme.

MOTS CLÉS

essentialism, choix au courant, modèle d'Ontario de soin, réforme sociale, rapport de femme-sage-femme

Cet article a été évalué par des pairs.

Introduction

With the regulation of midwifery in the province in 1994, the College of Midwives of Ontario (CMO) produced a series of documents that continue to guide the conduct of its members and establish a line of accountability to the philosophy, model of practice, and regulatory standards of the profession. The CMO documents also embody an image and discourse of midwifery that emerged with the rise of the "natural" childbirth and grassroots midwifery movements in the 1970s and 1980s and called for an alternative to the medicalization of childbirth. These documents reflect strongly held beliefs and shared ideologies that developed at a specific time and place among a small, predominantly white middle-class group of a-legally practicing Ontario midwives in concert with a consumer body that helped make midwifery legislation a reality.¹

Ontario women and midwives attest to the perpetuation of a culture of essentialism within midwifery care.² Among post-legislation midwives and midwifery students, continued alignment with the values and ideologies associated with pre-legislation midwifery appears to be perpetuated by what Cecilia Benoit describes as an informal socialization process "by which a person, influenced by teachers, peers, and society becomes a member of an occupation and acquires its values, beliefs, attitudes, behaviour patterns, and social identity."³

With midwifery care now integrated into the Ontario health care system and funded provincially, midwifery clients represent a much wider and less uniform demographic of women. These women choose to access midwifery services for a variety of reasons that may or may not include awareness and support for core midwifery values that include its feminist, woman-centred and birth-as-normal founding principles.

The following paper addresses the theme of essentialism in midwifery and the contradictions that may arise when it is viewed in relation to principles guiding midwifery care as outlined in the CMO's document entitled "*Philosophy of Midwifery Care in Ontario*."⁴ We explore the dilemmas that face midwives when a woman's values around pregnancy and childbirth don't correspond with those of her midwife. In particular, we explore the ways in which

the philosophical boundaries of the profession can encourage and discourage the nurturance of some women's specific needs. Much of the driving force behind this paper comes from insights offered by midwives and women in Ontario regarding the meaning of the woman-midwife relationship.² The work draws upon the in-depth interviews and from focus groups with women and midwives undertaken by Mary Sharpe in the course of her qualitative research for her dissertation.¹ Essentialism marks an important theme that emerged from the interviews that warranted further exploration.

Essentialism defined

Essentialism is understood as the tendency to view entities according to a set of distinct and limiting characteristics, or essences.⁵ Furthermore, an essentialist approach regards these characteristics or essences as inherently true or correct. To illustrate, we might consider some common essentialist views of women that mobilize many Western feminists, such as the notion that women are "emotional" or are "made to be mothers." Essentialism relies on the belief that shared experiences arise through perceived commonalities such as gender, race, ethnicity, culture and belief systems. As Trina Grillo notes:

An essentialist outlook assumes that the experience of being a member of the group under discussion is a stable one, one with clear meaning, a meaning constant through time, space and different historical, social, political and personal contexts.⁶

The strength of essentialism lies in its ability to assign any group shared characteristics that might motivate collective action. Critics of essentialism question its tendency to fix views, erase individuality and discount the possibility of change or variation within a group. According to Diane Fuss:

[O]pposing essentialism reminds us that a complex system of cultural, social, psychological, and historical differences, and not a set of pre-existent human essences, position and constitute the subject.⁷

There are problems with a stridently anti-essentialist approach, however, since anti-essentialist arguments tend to relativize identities, dismiss the political

potential of essentialism and therein reinforce oppressive hierarchies. As Landry notes: "One cannot simply assert, 'I will be anti-essentialist' and make that stick.... [T]he critique of essentialism is predicated upon essentialism."⁸

Essentialist tendencies within the Ontario midwifery model

The CMO's document on its philosophy of midwifery care in Ontario outlines the philosophy that it recommends should guide midwives in their approach to women and childbirth and the midwifery profession in its collective decision-making processes. Key elements of the current model of Ontario midwifery practice emerged from the midwifery advocacy movement of the 1970s and early 1980s and include the woman-centred principles of continuity of care, informed choice and choice of birth place.⁹ These ideologically based principles were originally motivated by a desire to restore women's trust in their ability to give birth normally and empower women to feel in control of the birth process. Furthermore, these principles served to challenge obstetrical practices that many women who gave birth in hospital settings experienced as authoritarian and patriarchal.¹⁰

Essentialist depictions of midwifery are found in some of the early writings of the history of midwives in Ontario^{12, 13} and appear to have had an influential role in defining the contemporary midwife that emerged with legislation. The process of bringing about legislation demanded that midwives be seen as a unified group with a common purpose. Margaret MacDonald suggests that essentialism was used strategically to "condense what midwifery stands for and what it stands against."¹⁰ Essentialism can be seen to have facilitated the development of the Ontario midwifery model. On the one hand, it helped motivate women to lobby and advocate for midwifery legislation by providing an image of midwifery that was partly embellished with romanticized notions of the "traditional" midwife,¹⁰ and on the other hand it symbolized a feminist cause and a moral high-ground that understood "the struggle for midwifery to be part of the larger feminist health agenda, presumed to be beneficial to all women."¹²

The CMO's "*Philosophy of Midwifery Care in Ontario*" reflects the history of midwifery in Ontario and illustrates the essentialist tendencies that persist post-legislation. While the values embedded within the document, when viewed pragmatically, simply set ideals for practice, they also tend to support a culture of essentialism within the midwifery community by making certain assumptions about the meaning of midwifery care, the women who seek midwifery care and the nature of the woman-midwife relationship. To illustrate, we begin with the following statements that demonstrate instances where the midwifery profession positions itself in opposition to the pathology-oriented care commonly associated with medical birth (*italics added*):

Midwifery care is based on a respect for pregnancy as a state of *health* and childbirth as a *normal physiological process* and a profound event in a woman's life.⁴

The maintenance and promotion of health throughout the childbearing cycle are central to midwifery care. Midwives focus on *preventive care* and *appropriate use of technology*.⁴

By implicitly positioning the beneficiaries and providers of midwifery care in opposition to the care commonly associated with medical birth, the document sets up binaries between a woman's experience in midwifery care and a woman's experience in obstetrical care. Such binaries have the tendency to create essentializing definitions of midwife, physician and woman. The following statement from the CMO's "*Philosophy of Midwifery Care in Ontario*" also illustrates how these binaries persist and perpetuate essentializing definitions of midwives and the woman-midwife relationship:

Care is *continuous, personalized and non-authoritarian*. It responds to a woman's social, emotional and cultural as well as physical needs.⁴

Implicit in this statement is the tendency to perceive obstetrical care as impersonal and authoritarian.

Furthermore, the notion that a woman who is inherently disempowered by the medical system and desires empowerment to feel in control of the birth process essentializes women and their motive for seeking midwifery care. The essentialist depiction of a midwife who is capable of instilling trust in all women she cares for, relating to the woman on a personal level and responding to all of a woman's needs is also noted in the CMO's model of midwifery practice in Ontario in the following statement (*italics added*):

The midwife coordinating the woman's care ... must make the time commitment necessary to develop a relationship of *trust* with the woman during pregnancy, to be able to provide safe, individualized care, *fully support* the woman during labour and birth and to provide comprehensive care to mother and newborn throughout the postpartum period.⁴

The essentializing tendencies within the midwifery community are problematized when seen in concert with the following document statements:

Midwives encourage the woman to *actively participate* in her care throughout pregnancy, birth and postpartum period and *make choices* about the manner in which her care is provided.⁴

Midwifery care includes education and counselling, *enabling a woman to make informed choices*.⁴

The depiction of a midwife as capable of empowering a woman to give birth in a way that challenges medical obstetrical birth could paradoxically work against a midwifery model that offers choice to women, including the choice of whether or not a woman works within the boundaries of the CMO's "*Philosophy of Midwifery Care in Ontario*." These potential contradictions will be further explored later in this paper.

The phenomenon of essentialism as revealed in conversations with women and midwives

Midwife participants in Sharpe's research revealed that many essentialist notions rooted in the historical archotyping of midwifery persist today. For example, midwives demonstrated essentialist affinities when they spoke about the changes in their practices since midwifery regulation. Many experienced dismay and sadness when they described the shift in client values away from midwifery values associated with pre-legislation ideology, and expressed a clear preference for women who want to experience "normal" births, want home births, want to breastfeed their babies, make "healthy" lifestyle choices, make decisions about their care and want a relationship with the midwife. As midwife Georgia (pseudonym)ⁱⁱ said:

"I miss having clients who really want the natural, who know they can birth, are willing and aren't afraid."

MacDonald contends that the ideology of many midwives is inherently essentialist when she notes that:

Some midwives find it frustrating to encounter women seeking midwifery care without knowing anything about the clinical model of midwifery or believing in midwifery as a social and political movement.¹⁰

Midwife Aisha's remarks reflect the attitudes of many of the interviewed midwives and correspond to MacDonald's assertion:

"I find my joy and feel I have a purpose working with people who are really excited about helping themselves, use natural remedies to optimize their birth experience and to help shift things that are concerns, those who want to birth at home, want responsibility, who aren't afraid of birth, who are holistic in their approach about life and take responsibility."

Midwives in Sharpe's study mentioned "connecting," "clicking," "being in sync," experiencing "resonance" and having "common goals and beliefs" as being important to the woman-midwife relationship. As one midwife noted:

continued on page 23...

"If that commonality is lacking, it's hard to get up at three in the morning and run to their births when I don't feel a connection."

While some midwives interviewed stated that they were delighted to be able to provide care for the more diverse group of women seeking midwifery care after legislation including teenaged, disabled, immigrant, single and low income women, they nevertheless noted that they remained wary of those who do not overtly behave in ways that correspond to Ontario midwifery's stated values and philosophies. A close correspondence between a woman's values and those of her midwife appeared to be a strong connecting force for midwives. Some Ontario midwives indicated that they felt there are "ideal" or "peak" midwifery clients and that certain women are therefore particularly "deserving" of midwifery. It is perhaps worth noting that there seemed to be no evidence from midwives' comments that they treated any of the women with whom they work differently. Rather, they simply acknowledged that they prefer to work with certain women more than others. Vicki Van Wagner, an Ontario midwife and colleague at Ryerson University, contextualizes this essentialist tendency in post-legislation midwifery:

*"There is a real tension in the midwifery community between narrow essentialist views of women, midwives and birth, connected with the lure of the "natural" and other concepts such as choice and diversity. This tension is deep in the roots of midwifery in North America. In a countercultural movement such as midwifery, the need for strength to combat outer forces can create narrow views, dogmatism and a fear of diversity... [However, one] might say that midwifery regulation allowed for some escape from essentialism; there is now much more respect for diversity of beliefs."*¹¹

Throughout Sharpe's research process, it became apparent that women frequently used language similar to that of their midwives and, for the most part, expressed values in keeping with a "culture" of midwifery as espoused by the "Philosophy of Midwifery Care in Ontario" document. Although childbearing women experience the woman-midwife

relationship in diverse ways, many women in this study indicated that they highly valued this connection and noted that a positive rapport supported the care they received. Women often described their positive relationship experiences with midwives in terms of "friendship," "a meeting of minds," developing an "intimate connection" and "clicking" with one another. Some women noted that they projected onto midwives certain relationship roles that they needed or came to desire – including friend, sister, mother, auntie or teacher – and associated these experiences with midwifery care. One woman, Alma, spoke of the closeness of her relationship with her midwife:

"We've become friends. If I have a midwife question or a childrearing question or a question about a rash, I could call my midwife. She is always my midwife. It does not stop with the six-week visit. It's different than having a doctor or a veterinarian or a dentist. I don't know whether it's different from having a psychotherapist because I don't have one of those, though she functioned in that way as well."

The essentialist depiction of a midwife as being capable of instilling trust in all women she cares for, relating to women on a personal level and responding to all their needs is inherent in these statements.

As with midwives, women were found to project certain ideals onto midwives and onto their respective roles and any ideological disconnect tended to reveal these essentialist tendencies. This is demonstrated in the interview with a woman called Doreen, who expressed a desire to have an older midwife who represented the archetype of the "wise midwife" that she had become familiar with from watching TV interviews with Ontario midwives and from reading Ina May Gaskin's book *Spiritual Midwifery*.ⁱⁱⁱ Doreen felt that an older midwife would have the level of self-confidence and experience that would allow her to take control when necessary, back off when appropriate and be caring, supportive and gentle. She felt that with a younger midwife, the roles might be reversed such that the women would be educating the midwife. In her own words,

"A midwife who doesn't fit my image, doesn't mean that you are not a good midwife, but it means the relationship is not ideal for me."

As with midwives, a close correspondence between a woman's values and those of her midwife appeared to be a strong connecting force for women.

Helen Lenskyj, professor of Sociology and Equity Studies, however, warns of the dangers of essentialist depictions of midwives and women:

It does not serve women's interests well for midwifery supporters to essentialize women either mothers or midwives.... Such statements imply, or, in some instances, state explicitly, that midwives are *by nature*, as well as in and through their working lives, morally superior women, with an untiring capacity for caring, compassion, empathy and mothering. Where does this leave the non-conforming midwife who does not view her work as some kind of maternal calling? Or the non-conforming mother who does not view the midwife as her best friend or her "guardian"? ... One [also] needs to consider the messages that [such] rhetoric convey[s] to a woman who has no ... regrets about her conventional medicalized birth experience. Is she less female/ feminine/ feminist because she does not ... reflect on [her] birth experiences with feelings of anger, regret, mourning and loss?^{15,iv}

Conflicting ideologies and moral dilemmas that arise within aspects of the CMO philosophies

a) The history of midwifery care in North America

Several midwives in my study revealed their tendency toward essentialist depictions of midwifery in noting their concerns about the shifting sets of values that emerged within midwifery care post-legislation. With an increasingly diverse set of women accessing midwifery, the fear is that women with values that contradict elements of midwifery care might shift the model closer to the very medical model it worked to resist. As one midwife notes:

"The client base that came to us [pre-legislation] led to the development of the model.... It's changing. That's what will change the base of midwifery.... [W]e have to

continue to have that really strong relationship with consumers who care about the same model: the women who want the same thing. Their voice really made a difference for us in getting to where we are and it's their voice that will make the difference in keeping us who we are."

Concerns relating to the acculturation of midwifery into the dominant medicalized obstetrical model within North America may be warranted but are predicated on an essentialist depiction of the history of midwifery in Ontario. Leslie Biggs problematizes this essentialist depiction by recounting parallel histories of midwifery influenced by factors including race, class, gender, culture and colonization.¹⁴ She warns:

[B]y virtue of the fact that midwifery, maternity care, and childbirth centre on women's reproductive and biological status, it is all too easy to fall into the essentialist trap of assuming commonalities among women rather than examining their experiences in socio-cultural and historical contexts.¹⁴

Such an essentializing history, in fact, inherently contradicts elements of the following guideline in the "*Philosophy of Midwifery Care in Ontario*" document (italics added):

Midwifery care respects the diversity of women's needs and the *variety of personal and cultural meanings* which women, families and communities bring to the pregnancy, birth, and early parenting experience.⁴

b) The element of choice in midwifery care

An intriguing dilemma occurs for many midwives with respect to additional essentialist tendencies and aspects of values espoused by the College of Midwives of Ontario. In particular, let us examine the dilemma with respect to the aforementioned statement in the CMO's "*Philosophy of Midwifery Care in Ontario*" document relating to a woman's active participation in her care and the principle of choice. Deborah Harding noted in her research with British Columbian women who came to midwives that some women were reluctant collaborators with respect to choice. As one woman said:

"I came to the midwives so that I could feel safe and be told exactly what to do all the time. I don't want all this natural childbirth. I don't want all these choices. I want you to tell me what's best."¹⁶

Similar responses toward midwifery care were uncovered in this research with Ontario women. Midwife Tracey's observation exemplifies the potential contradictions raised by this revelation:

"Midwifery isn't for the type of person who wants to hand over responsibility for her pregnancy and birth someone who wants to be led. There are lots of women who say: "Why would you want to have input into that?"

Tracey's comments raise the question of whether women who wish to be less active in their approach to maternity care should be discouraged from midwifery care or whether they should be required to decide among the options regarding their care even if they are uncomfortable doing so. Can this principle of midwifery care paradoxically be constraining and anxiety-producing for some women? Can women not simply choose not to choose? Matters are complicated when this CMO statement is viewed in conjunction with the following *Philosophy of Midwifery Care in Ontario* document guideline: "Midwifery care respects the diversity of women's needs."⁴ The information that must be shared with women is at times complex and confusing, and research findings are at times conflicting. If a woman needs authoritative decision-making on the part of her midwife, is this not also in accordance with the latter CMO document guideline?

c) Ideological dissonance and emotional labour

Hunter observed that when midwives encountered women in their care with ideologies that conflicted with their own, a dissonance occurred that tended to lead the midwife to experience a variety of negative emotions, such as frustration, anxiety and anger, and resulted in what she calls "emotion work."¹⁷ Emotion work, or emotional labour, is a term first defined by Arlie Hochschild as, "the management of feeling to create a publicly observable facial and bodily display."¹⁷ In the context of service providers, it generally involves presenting an emotion in order to make the supported person feel a particular way out

of a sense of duty to his or her profession.^{18,19} De Castro, Agnew and Fitzgerald note that emotional labour can lead to job dissatisfaction and burnout since it can create:

routinized, processed feelings and emotional dissonance that threaten workers' sense of self, alienate workers from their true feelings, and produce an impression of "inauthenticity."²¹

When facing woman-midwife value differences, some midwives in Sharpe's study compensated emotionally by being jovial, polite and caring despite their discomfort. Some midwives attempted to subtly influence change in women by seeing this value difference as an opportunity for the midwife to educate the woman. Still other midwives facing woman-midwife value differences felt that it was their job to be attentive and make the additional effort to become educated about a woman's particular need and work creatively to respond to it. Several midwives noted that these emotional labour strategies were used in an attempt to adhere to the *"Philosophy of Midwifery Care in Ontario"* document statement relating to a respect for women's diverse needs.

Occasionally, midwives selected for care those women whose values aligned with their own, as revealed at their initial interview. For example, some midwives actively discouraged from midwifery care women who declared it likely that they would want an epidural during labour. The existence of this practice presents a particular dilemma for midwives when looked at in the context of the CMO document guideline relating to respect for the diversity of women's needs. However, if we consider that a midwife is to establish a positive relationship with her client and support her choices, a midwife who acknowledges that she will not be able to provide a supportive relationship for particular clients may indeed be a woman-centred midwife. This wish to choose a relationship that matches one's preferences may occur on the part of a woman as well. Indeed, one woman noted:

"I didn't want the appointments for that period of time. The physical stuff, the health stuff was done quite quickly, often by a self-serve process where I checked

my own urine and weight. The blood pressure check I could have done as easily with a visit to the neighbourhood Drug Mart. So then it seemed to me the purpose of the rest of the visit was to get around to the emotional stuff, but she wouldn't be the person that I'd do that with."

d) Systemic constraints

Midwifery in Ontario has successfully defined itself as an alternative to medical obstetrical care that nevertheless continues to attract some women who are not necessarily interested in normal or unmedicated childbirth and who could be said to be more inclined toward a medicalized approach to maternity care. To elaborate, let us consider some of the elements of midwifery care that may appeal to a broad spectrum of women. Midwifery care is publicly funded and free of charge to all women living in Ontario. Midwives offer extended pre- and postpartum clinic appointments of up to one hour in length, pre- and postnatal home visits and unlimited on-call access to a team of known care providers throughout the entire perinatal period. Midwifery care offers a woman a known primary health care provider who will attend her throughout her labour and attend to her and her baby's health care needs following her delivery. Midwives also aim to provide women and their babies with continuity of care-provider during the entire perinatal period including up to six weeks postpartum. This raises the issue of whether or not women who do not adhere to the philosophical principles of midwifery care ought to be supported by this model of care. Or, is this desire for philosophical conformity, in fact, another way in which essentialism persists in post-legislation midwifery? Considering the philosophy of midwifery care that pertains to choice and considering that many elements of midwifery care are woman-centred, the notion that midwives may be at liberty to turn away clients who do not support all the philosophical elements of midwifery care may be seen as restricting choice and limiting woman-centred care.

However, there is currently a crisis in maternity care in Ontario that pre-empts this discussion. Since legislation, the demand for midwifery services has continued to vastly exceed the supply of available

midwives, with midwives currently attending only 7% of births in Ontario.²² Fewer than half of all family physicians in Canada offer maternity care and only 12% of family physicians in Ontario are involved in obstetrics.²³ The number of obstetricians performing deliveries is also declining, albeit at a more modest rate than that of their family physician counterparts, while workload is increasing steadily due to the decline in physician involvement in obstetrical care.²⁴ Furthermore, it is predicted that by the year 2025, that in some areas of the province, there will be a 30% increase in the number of births and a resulting rise in demand for maternity care services.²² As a consequence of these human resource shortfalls in provincial maternity care, fewer and fewer women have the possibility of choosing any personal maternity caregiver – whether obstetrician, general practitioner or midwife. Not only is this crisis situation limiting women's ability to access care and exercise choice over primary care providers in general but it is also limiting women's access and choice to different models or philosophies of care. Furthermore, it raises several issues that relate to midwives' professional identity and client selection.

In the face of these human resource shortfalls, midwifery clinics must resort to some degree of client selection. The task therefore becomes one of attempting to provide all women with equitable access to midwifery care while upholding important elements relating to the midwifery model and CMO requirements. One factor regarding client intake selection criteria relates to the fact that midwives wish to maintain aspects of their professional identity and established culture that set them apart from the medical model they initially organized against. In addition, midwives face a practical consideration: they need to have a client base that will allow them to fulfill CMO requirements for primary care and attendance at a prescribed number of home births.

Another important consideration is the desire to preserve birth as a normal physiological event in the face of skyrocketing caesarean and instrumental birth rates, "cesareans-on-demand" and exceedingly high epidural rates. These considerations need to

be acknowledged in conjunction with the possibility that some women may access midwifery care under the guise of desiring a home birth, knowing that this assertion may help them obtain midwifery care. Furthermore, the possibility that women who are turned away from midwifery care may face subsequent challenges in locating a family physician or obstetrician who is available to provide care needs to be taken into account.

Ultimately, the challenge that emerges from an appraisal of the ideologies encoded in the CMO documents, as they are put into practice by its members, is this: how to adhere to a specific model of care that helped shape the culture of midwifery and defined itself as distinct from other maternity care models, while at the same time encouraging tolerance for many styles and interpretations of midwifery care and woman-midwife relationships? Both these directions are contained within the *"Philosophy of Midwifery Care in Ontario"* document in statements that are premised on a respect for childbirth as a normal physiological process and the honouring of women's choices.

Conclusion

Ontario's model of midwifery care reflects the essentialist tendencies of the feminist movements of the 1970s and 1980s that led to the legislation of midwifery in Ontario. Tensions inherent in aspects of the CMO's *"Philosophy of Midwifery Care in Ontario"* document tend to manifest as incongruencies in personal, professional and philosophical ideologies within the woman-midwife relationship. The essentialist tendencies revealed by the midwives and women in Sharpe's study tend to pose dilemmas for midwives in the manner in which care is provided, the manner in which women are selected for care and the ways in which the philosophy of midwifery care upheld. However, the dilemmas that arise from essentialism, as James and Spoel suggest, also have the possibility to:

[breathe] life into practice by prompting midwives to constantly examine their practices, their values and beliefs, and their relationships with women and with other health professionals.²⁵

As one midwife in Sharpe's earlier research noted:

"The Ontario model gives us a framework. There is the flexibility for us to be individual practitioners, the time to really play out options and choices, and it allows us to do a dance around so many issues."²⁶

As midwifery continues to evolve and expand in Ontario, midwives, childbearing women and other stakeholder groups such as the Midwifery Education Program, various consumer advocacy groups, the Association of Ontario Midwives (AOM) and the College of Midwives of Ontario (CMO) will ultimately help determine its future shape. Will mainstream and popular perceptions of the midwifery profession be redefined beyond the essentialist notions that played a part in the legalization and public funding of Ontario midwifery in the early 90s, but which today may present certain challenges and limitations to how women and midwives interact within the established culture and regulations of the profession? Helen Lenskyj is clear in her view:

It is not productive for midwifery's advocates to cling to exclusory or essentialist notions of woman and midwife. Rather, it is important to respect the feminist principle of choice in health care ... and to allow for diversity and difference among women, both midwives and clients.¹⁵

Allowance for diversity and difference must remain at the forefront of the woman-midwife relationship that both midwives and women strive to achieve.

FOOTNOTES

ⁱ For details regarding methodology, please see Mary Sharpe, *Intimate business: woman-midwife relationships in Ontario, Canada* [dissertation]. Toronto: University of Toronto, 2004.

ⁱⁱ In order to maintain the confidentiality of the women and midwife participants in this study, all the names used in this paper are pseudonyms.

ⁱⁱⁱ See Gaskin IM. *Spiritual midwifery*. Summertown TN: The Book Publishing Co., 1977.

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