SENSITIVITY AS EPISTEMOLOGY: THE ROLE OF SENSITIVITY IN MIDWIFERY CARE IN NEWFOUNDLAND AND LABRADOR

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Abstract

Research shows that midwifery care is more positive for birthing parents and their babies than biomedical birth care, leading to fewer medical interventions and more highly rated client experiences. In this thesis I argue that midwifery care in Newfoundland and Labrador (NL) treats sensitivity and embodied knowledge as a valid epistemological approach to care. By respecting the sensitivity of clients and their own understanding and awareness of their bodies, midwives provide their clients with a high quality of care. Sensitivity is defined here as being attuned to other peoples' needs, and prioritizing emotions, agency, and empathy. Midwives engage in 'deep acting' to provide sensitive care to their clients, which is reflected both in historical accounts of midwifery in NL, and in recent interviews conducted for this thesis. Sensitivity as the driving concept in this analysis centres voices and ways of knowing often excluded from epistemic authority, while questioning the institutionalization and medicalization of birth. Through narrative analysis of semi-structured interviews with ten midwifery clients in NL, four main themes emerged: Continuity of Care; Advocacy & Agency; Relationships; and Sensitivity & Emotions. These interviews share the significance of midwifery clients' stories and demonstrate that their embodied knowledge is essential to gaining a wholistic understanding of sensitivity in midwifery care.

General Summary

Midwifery care is shown to be more positive for birthing parents and their babies than traditional birth care. In this thesis I argue that midwifery care in Newfoundland and Labrador (NL) treats sensitivity and embodied knowledge as a valid way to understand and approach care. Sensitivity is defined here as being aware of other peoples' needs, and prioritizing emotions, agency, and empathy. By focusing on sensitivity, this research creates space for voices and ways of knowing that are often excluded from dominant research and healthcare practices. Analysis of stories shared during interviews with ten midwifery clients in NL led to four main themes: Continuity of Care; Advocacy & Agency; Relationships; and Sensitivity & Emotions. These interviews share the importance of midwifery clients' stories, showing that an understanding of their embodied experiences is needed to understand the role of sensitivity in midwifery care.

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Chapter 1: Introduction

In 2022, Elizabeth[1], who was in the third trimester of her pregnancy, found out that her baby was breach, and that she was no longer able to be under the care of the midwives in Gander, Newfoundland and Labrador (NL). At the time, the Gander obstetrics department was on diversion to Grand Falls, an hour and a half away, meaning that patients requiring their services were being sent to Grand Falls. However, the Grand Falls department was full. Elizabeth described her fear saying, "I went to that midwife appointment crying because I didn't know what was going to happen to me and I didn't know what was going to happen to my baby. I lived an hour away from the hospital. It was my second kid. She was upside down. If I went into labour naturally, it could have been so, so dangerous." Grand Falls was unable to schedule Elizabeth for a c-section unless it became urgent, which was not something she wanted to wait to have happen. She said, "I remember going home from that appointment, I was just sat in my car screeching. I can't believe this is happening. Healthcare is insane. This is just horrid.". Half an hour later, Elizabeth got a call from her midwife telling her to drop what she was doing and to go to Clarenville, because she had made some calls and arranged to have her admitted there. When she got to Clarenville, they told her she would not have lasted the weekend without going into labour, proving to her that she needed care right away.

Elizabeth lived only a two-minute walking distance to the Gander hospital, and she said "I had to drive an hour and a half to a functionable one. And that just makes me vicious. Honestly. There's no other word for it than anger." Elizabeth's use of the words *screeching*, *horrid, vicious,* and *anger* show how devastating and overwhelming this experience was for her.

[1] All interview participants provided pseudonyms of their choosing.

Because the Gander obstetrics unit was closed, her life and the life of her baby were put at risk. It is not uncommon to hear about people giving birth on the side of the road in Newfoundland and Labrador, and Elizabeth did not want to be one of those people, particularly due to the complications of her pregnancy. Her access to midwifery care lessened the danger of her lack of easy access to an obstetrics unit thanks to the advocacy of her midwife. Without the phone calls the midwife made to get Elizabeth into Clarenville for a c-section, her story could have gone very differently. Elizabeth credits the midwives with saving her baby's life.

Stories like Elizabeth's and those of my other research participants are not new. It is not groundbreaking to say that people living in NL need increased access to healthcare, as this is well known. Rather, participants' stories and archival research highlight how the province once had an effective birthing care system that included midwives, and a return to this system or something similar could strongly benefit parents and their babies.

In this thesis, I argue that midwifery care in NL treats sensitivity and embodied knowledge as a valid epistemological approach to care. By respecting the sensitivity of clients and their own understanding and awareness of their bodies, midwives provide clients with a high quality of care. I define sensitivity as being attuned to other peoples' needs, and prioritizing emotions, agency, and empathy. Midwives in NL are able to provide sensitive care to their clients by 'deep acting,' where they make "honest and sincere attempts to modify felt emotions in order to experience them authentically" (Drach-Zahavy, Buchnic, and Granot 2016, 169). Deep acting allows them to provide reassurance, comfort, support, and respect, and creates an environment where the midwives are attuned to their clients, providing prolonged, anti-hierarchical, educative, and participatory care. This work adds to existing literature on midwifery care in NL by pairing the historical context of midwifery with the current status of care offered in the

province, addressing how midwifery's ethics of care approach creates space for sensitivity and embodied knowledge, which in turn allows for culturally appropriate care in the context of Newfoundland and Labrador.

I am drawn to the concept of 'sensitivity' because it is often weaponized against women, conflated with being demanding or fragile, and often undervalued in medical models of care. Sensitivity as the driving concept in my analysis centres voices and ways of knowing often excluded from epistemic authority, placing them at the forefront of my knowledge production, while troubling hegemonic research practices. Research shows that midwifery care is more positive for mothers and birthing parents[2] and their babies than care in obstetric units (Shaw 2013, 530). I am curious about the extent to which midwives' sensitivity plays a role in positive patient experiences and outcomes, and the value of treating sensitive and embodied knowledge as epistemology.

I explore the role of sensitivity in midwifery by asking the following research questions:

- RQ1: To what extent is sensitivity currently a focus of midwifery care in Newfoundland and Labrador (NL)?
- RQ2: Can an increased focus on sensitivity on the part of registered midwives improve care and access?
- RQ3: Why is midwifery care more positive for clients, why does midwifery care lead to fewer medical interventions, and what role does sensitivity play here?

[2] I use the term 'birthing parent' alongside 'mother' and 'woman' because not all people who give birth are women or mothers, and not all women give birth. While my research participants are all women and mothers, it is important to me that my work is inclusive and uses the proper language to represent a diverse population. I exclusively use the terms 'mother' or 'woman' when gendered constructs are important to the argument.

My work not only focuses on the individual stories of midwifery clients, but also on the cultural, communal, and participatory aspects of sensitivity, storytelling, and midwifery, and the need for this sensitive care in NL. Informed by contemporary midwifery practices in Canada, my research draws on a reproductive justice framework to challenge preconceived, patriarchal notions of gender and health. This work is a timely intervention into the current state of midwifery in NL, as since the practice was regulated in 2018, there has been significant turnover of practicing midwives, as will be discussed throughout this thesis (Atlantic Midwifery Roundtable 2022). By focusing on sensitivity in midwifery care in this thesis, I am adding to current literature establishing the need for midwifery in NL, while exploring the role of sensitivity in midwifery care and reproductive justice and questioning the institutionalization and medicalization of birth, while treating sensitivity as a form of knowledge production.

This thesis explores not only the theory of sensitivity, but also the role of emotions in healthcare, deep acting, care theory, interdependent relationships, reproductive labour, and intersectionality. In this introductory chapter, I reflect on how identity and emotions play a crucial part in the epistemology of this work, by focusing on embodied, and individualized knowledge. I then contextualize midwifery care in Newfoundland and Labrador from historical records to present day. The deregulation and reinstatement of midwifery is then explored through the medicalization of birth, colonialism, and an intersectional approach to care. In chapter two, I address the theoretical foundations and key concepts of this work: care theory, reproductive justice, paid and un-paid care work, and relationships. Following the theory section, I address my methods and methodology: archival research and narrative analysis of interviews. Finally, in chapters three and four, I describe and analyze ten interviews I conducted with midwifery clients in NL through a narrative approach, focusing on stories and what was most important to these

clients. Through this analysis, four main themes emerged: Continuity of Care, Agency & Advocacy, Relationships, and Sensitivity & Emotions. Each of these themes brings to light what is working in midwifery care in NL, what makes their care sensitive, and what needs to be done to improve access to their services. My analysis makes clear how midwifery care in NL treats sensitivity and embodied knowledge as a valid epistemological approach to care, and how this care is culturally appropriate in the province. Before addressing these larger issues, I turn now to situating myself in relation to this research and explaining my understanding of sensitivity.

1.1 Sensitivity, Affect, & Feminism

I am a Highly Sensitive Person[3] which is what led me to my research questions. I approach everything I do with a great deal of empathy, which is especially important when discussing issues of emotions or the body. When beginning my research, I considered areas that interested me such as the ethics of care, bioethics, embodiment, and the concept of taking up emotional space. This process of writing down how I was feeling and writing about my interests is how I came to the topic of sensitivity.

I have often wished I was less sensitive, less empathetic, and more able to set emotional boundaries. I feel the emotions of those around me, which can be difficult, and I have wished for the ability to turn that part of my brain off. When I feel the need for an emotional retreat, I wish I could sympathize without sinking. But as I have grown older and more settled in myself, I have realized that this sinking is eased depending on who I am with. The people who bring out the

[3] Sensory Processing Sensitivity (SPS) or being a Highly Sensitive Person (HSP) is a personality trait present in around 20% of the population. An HSP can be characterized by being very aware of their surroundings and the emotions of others, being easily overstimulated, and emotionally reactive. Often confused with Sensory Processing Disorder, SPS is not a diagnosis or disorder but rather an inherent trait (Aron 2023).

best in me are those who can sink into emotions with me, and then together we help each other float to the surface. I feel validated and given space by people who don't dismiss sensitivity. I feel justified in spaces where instead of agreeing that I should be less sensitive, people ask 'what's the harm in it?' I have been asked that a few times in my life, and each one catches me off guard. In feminism I have found a space in which I can *feel* safely. I felt taken-in in my first gender studies class where everyone in the room felt strongly about what we were discussing. In this context, sensitivity was an asset, and stories and feelings were seen as valid. The room was filled with anger and sadness and fear and joy, and we would not have been able to have the conversations we were having without all those feelings. Those feelings made me who I am today, and they brought me to the Memorial University Gender Studies department. All of this helped me to understand that I cannot conduct research without feelings. If I am not emotionally invested, the work simply will not get done. So, at the risk of being overly sappy—something I am continuously coming to terms with—feeling big feelings and being sensitive is a large part of my research methods. I want to tell stories, hear stories, and be a part of stories. I want to learn and listen. I want my research to be creative and I want to be a part of a creative community. I want to work outside of the hegemonic academic system despite the fact that I am fully entrenched in it. I want my research to be messy, and overwhelming, and intimate. I find sensitivity to be a very embodied experience for me, which is a quality that has often felt dismissed or seen as dramatic. In my exploration of midwifery, embodied sensitivity seems to hold a prominent place in their care, which I explore further through interviews with midwifery clients.

When approaching my research questions, I spent some time thinking through terminology. The term 'affect' was suggested to me, and I also considered 'emotions' or

‘empathy,’ however I kept coming back to ‘sensitivity’. What draws me to feelings of sensitivity is the difficulty to pin them down, and the fact that they are different for each person in every situation. Does sensitivity mean an ability to feel things strongly, or understand other peoples’ emotions? Is it an accurate or reliable feeling? How does it influence our decision making? How is it different for different people? Sensitivity is different for each person as it is context specific, historically located, and embodied. While the term ‘affect’ has become widely used and discussed, there is often debate or lack of consensus on a clear definition. As Liljeström writes, “Those in the humanities and social sciences often prefer the notion of ‘emotion’ or ‘feeling’ when investigating problems of cognition, social, cultural, and subjective phenomena and their interpretation. In contrast, biologists—among others—who examine bodily questions mostly prefer the notion of affect” (Liljeström 2016, 23). Reading that quotation solidified that ‘affect’ doesn’t feel flexible enough for what I am exploring. The dismissal of emotions by more scientifically aligned research makes me more inclined to want to dive further into researching sensitivity. I am comfortable with my research being emotional and ‘un-scientific’, for as Sara Ahmed said, as feminists “We are dismissed as emotional. It is enough to make you emotional” (Ahmed 2017, 38). So, I am leaning into the emotions of my research through the lens of sensitivity, which can not only relate to emotions but also factors like gender, because many gender disparities exist in healthcare and “gender sensitivity” among healthcare professionals can greatly improve quality of care (Celik et al. 2011, 148).

While I am not basing my research around the concept of ‘affect’, the theory around it has provided me with a foundation for discussing sensitivity. In her writing on affect, Ahmed says “Emotions are not ‘after-thoughts’, but shape how bodies are moved by worlds they inhabit…While you can separate an affective response from an emotion that is attributed as

such…this does not mean in practice, or in everyday life, they are separate. In fact, they are contiguous; they slide into each other; they stick, and cohere, even when they are separated" (Ahmed 2010, 32). For example, she says that seeing a stranger out of the corner of your eye may elicit an affective response of goose bumps on your skin, and the emotion of fear may follow, but this emotion can be influenced by what type of physical situation you are in. However, she argues that the affective response can be influenced as well, as if you are in what is deemed a 'dangerous neighbourhood' you are already set up to have an affective and emotional response, showing how an affective response cannot be removed from an emotional response (Ahmed 2010, 32). Many other feminist writers highlight how impossible it is to separate physical feelings from emotional ones. For example, disability studies writer Eli Clare's exploration of the body and mind dichotomy complicates this separation:

> I followed the lead of many communities and spiritual traditions that recognize body and mind not as two entities but as one, resisting the dualism built into white Western culture…I settled on *body-mind* in order to recognize both the inextricable relationship between our bodies and our minds and the ways in which the ideology of cure operates as if the two are distinct—the mind superior to the body, the mind defining personhood, the mind separating humans from nonhumans. (Clare 2017, xvi)

So, when I am thinking about sensitivity and embodiment, I also consider what it means to have a *body-mind*. In the hegemonic view of mind vs. body, the mind is not emotions, but rather logic and reasoning, while the body is unruly and unpredictable and feels things that it 'should not'. Clare shows how simplistic and dismissive this dichotomy is. I consider embodied feelings and emotions to be part of my knowledge production by placing value on them while treating sensitivity as epistemology. Here sensitivity is not only an emotion, but also a way to create a broader understanding of our lived experiences and is a lens through which we can analyze physical and emotional feelings. It is a way to provide emotional support, an understanding of

people as individuals, and healthcare that meets specific needs. I am drawn to the idea of knowledge production not simply being a method with which to write more academic papers, but rather being about learning different and decolonial ways of knowing outside of the current hegemonic system. When asked about knowledge production, Alexis Pauline Gumbs and Leanne Simpson both spoke of the future and world building, with Gumbs saying that knowledge production outside of capitalism would involve "circles and stories and questions, and shared experiences of growth and insight, and people feeling profoundly loved for who they are" (qtd. in Jafri 2017, 131). Simpson also brought up feelings while addressing Nishnaabeg ways of knowing.

> [Theory] is not just theory, it's embodied through practice. You start to create different worlds, where everybody is a theorist and has the responsibility of finding meaning in their own lives through whatever mechanism is open to them and supportive of the larger community. I see that system as a beautiful system of diversity and empathy and consent that generated a world. (qtd. in Jafri 2017, 130)

Through words like 'love' and 'empathy,' both authors show the profound role that emotions can play in connection to knowledge production.

For me, feminism is inherently complicated, slippery, and hard to pin down, much like sensitivity. Feminist writing on emotions has often been met with resistance, for as Liljeström writes, the feminisation of affect or emotions has made it difficult for feminist writers exploring these areas. She says it can be hard to research emotions, "partly because of the dominant historical trajectory of connecting women with emotion in a repressive and dismissive way" (2016, 22-23). In *Living a Feminist Life*, Sara Ahmed elaborates on the emotional or sensory side of feminism. She says, "When you speak as a feminist, you are often identified as being too reactive, as overreacting, as if all you are doing is sensationalizing the facts of the matter" (2017,

21). She also says she came to feminism through embodied experiences of assault, both physical and emotional, meaning her feminism is at its core, sensory. A large part of her feminism also exists in being a killjoy, which is itself wrapped up in emotions. Taking on the role of feminist killjoy means challenging the happiness or positive reactions of others to comments or actions that you find problematic. To be a feminist killjoy, you have to "cause trouble, [and] get in the way of the happiness of others" (Ahmed 2017, 37). As a sensitive person, I initially found this concept empowering and yet difficult. Confrontation, especially with people who are threatening, or offensive can be very challenging. And yet, over time I have found that leaning into sensitivity in my feminism makes me a better killjoy. By feeling my beliefs very deeply, I am more inclined to say something and ruin the fun of others when it bothers me. By going with my sensitive, gut reaction, I aim to be better feminist, for as Ahmed says, "A gut has its own intelligence. A feminist gut might sense something is amiss" (2017, 27). I have often found myself taking on the role of the killjoy in conversations around healthcare and emotions, which is a position I continue to uphold throughout this research.

To provide context for the role of sensitivity specifically in midwifery care, the following section addresses the professional or clinical role of midwives, alongside a timeline of the profession's evolution in NL. Addressing colonialism, the medicalization of birth, and the deregulation and eventual reregulation of midwifery, situates the current role of sensitivity in midwifery practice in the province, helping to address why treating sensitivity and embodied knowledge as a valid epistemology of care is so important in Newfoundland and Labrador.

1.2 Context & Literature Review

Like family doctors, nurse practitioners, and obstetricians, midwives work with pregnant people and their babies. They are "primary care providers who provide prenatal, intrapartum

(labour and delivery) and postpartum care to low-risk clients and their babies" (College of Midwives of Newfoundland and Labrador 2023). Midwives are able to order laboratory tests, provide ultrasounds, admit and discharge from hospitals, and can prescribe medications related to minor complications for both birthing parents and babies (Government of Newfoundland and Labrador 2013, 9). Across Canada, midwives base their practice on three tenets: informed choice; choice of birthplace; and continuity of care. Their work is evidence-based, client-centered[4], and focuses heavily on education and agency. To become a midwife in Canada, a three-to-four year baccalaureate degree is required, followed by the Canadian Midwifery Registration Examination, which allows midwives to apply to be registered anywhere in Canada (CAM 2023). Once registered, midwives are primary care providers who follow clients from the very beginning of their pregnancy, all the way to six weeks post-partum. They work with clients and their families to provide education and emotional support throughout pregnancy and birth, even providing at-home visits, especially during the post-partum period. They work in small teams, allowing them to be on-call 24/7 so they are always available to answer clients questions and concerns (CAM 2023). Studies consistently show that midwifery care is favourable for parents and babies, and "no studies have found adverse consequences from midwifery care in circumstances where midwives are well integrated and supported" (Government of Newfoundland and Labrador 2013, 9). To gain a deeper understanding of the status of midwifery care in NL, this chapter will provide historical context of midwifery care in the province up to current day, alongside a literature review of the medicalization of birth and colonial health care practices in NL. It will then address the re-establishment of midwifery care that has emerged

[4] Midwives generally refer to 'clients' rather than 'patients' as they do not view pregnancy and birth as an illness, therefore the pregnant person is not 'sick' and not a 'patient'.

from the 1990s until present day, and the current focus on intersectionality taken up by midwives.

1.2.1 History of Midwifery in Newfoundland and Labrador

Midwives have a long history of working in Newfoundland and Labrador, playing an important role in Indigenous and settler communities. Upon hearing about my research, many Newfoundlanders I have met have a story to tell about their grandmother or mother having had midwives attend their births. Interview participant Josie fondly discussed the role midwives played in her own family history:

> My mom talked about—positively—about my nan receiving that kind of care…oral history is strong in Newfoundland, and you hear stories of cottage hospitals. My grandmother had [many] children, and I think majority of them were born by a midwife. And if they weren't, then the midwife was there, and the doctor showed up after…They're known in the community…we need to go back to our roots and get that on the go again. (Josie)

From both historical and current-day accounts, it is clear that midwives have played a significant role in the lives of many Newfoundland and Labrador families, and that their care is culturally appropriate in the province. Early midwives were important members of the community, often chosen to be midwives because they were competent and well respected.

In the late 19th and early 20th centuries, midwives had to travel to each patient's home. Most communities were small, isolated outports that were only accessible by boat. Midwives were expected to provide care around the house such as cooking, cleaning, and looking after other children, and they often went unpaid due to the low income of their clients (Benoit 1989, 6). While some of these women had been trained as nurses and midwives, many were self-taught, 'granny midwives' working from their experience and instincts. The main distinction between

the two is that for formally trained midwives, being birth attendants was their profession. Meanwhile, most untrained midwives did not depend on the work for their livelihood and were instead supported by their husbands or other occupations. For those who were paid, in the late 1800s until the 1930s it was often with food or household object like quilts. By the 1940s, midwives were regularly owed a fee of $10 (McNaughton 1989, 29). These women were not only midwives but healers, attending to illnesses and wounds, as well as serving in the place of dentists, housekeepers, veterinarians, undertakers, mothers to their own children, artists, musicians, postmistresses, fishers, farmers and more. Many midwives are rumoured to have provided tansy tea or pills to induce abortion (Crellin 1994, 57–58). In a time when reproductive health care was limited and education and information were not easy to come by, these midwives practiced their own form of reproductive justice, and cared deeply about the families they attended. Jane Waldron (born 1836, died 1925), a midwife in Spaniard's Cove, insisted on naming all of the children whose births she attended, naming many of them 'Jane', after herself (Slaney Brown 2007, 78). Joan Stedman, (worked in Labrador circa 1952-1959), a Grenfell nurse-midwife documented her time in Labrador through photographs such as "Baby and egg" (see Fig. 1). While there are few written records—many untrained midwives could not read or write—many midwives are credited with delivering hundreds if not over a thousand babies during their careers,

Figure 1. Joan Stedman Collection. (ca. 1954). Baby and Egg [Photo]. Them Days, Borning Babies, 47(2).

and many of them are also credited with not losing a single child. While there is no way to confirm these oral histories, it shows the respect and even mysticism that accompanied these midwives' reputations.

In the early 20th century, the creation of The Grenfell Mission—which sent doctors, nurses, and nurse-midwives to rural communities—changed the way midwifery care worked, by providing trained midwives rather than relying on 'granny midwives'. This mission provided needed healthcare workers but was also critical of locals. Historically, Innu and Inuit midwives in Labrador were viewed as ignorant and even accused of witchcraft (Chaulk 2023, 29). So-called 'Livyers', working class fisherman and labourers whose families had lived in Newfoundland and Labrador for generations and were of white, mainly Irish descent, were also viewed as "backward" or "uneducated" (Kealey 2010, 101). Indigenous communities and Livyers were seen as "economically and socially disadvantaged" and "different, inferior, and [requiring] social and moral uplift" (Coombs-Thorne 2010, 213). The British viewed the Irish as ethnically inferior, and violently disposed these lands for generations. This relationship became further complicated in NL as Livyers continued to be racially stereotyped by the British, while also themselves racially stereotyping Indigenous communities. This shifting hierarchy advantaged the Irish over the Innu and Inuit, while ultimately removing traditional midwifery practices for all groups and shifting towards a more medicalized model. British nurse-midwives became more prominent and became more integrated into communities.

In 1920, Newfoundland passed midwifery legislation, providing licenses to practicing midwives and recruiting more nurse-midwives from abroad, mainly the United Kingdom, meaning the role of midwife was now mainly taken up by trained nurses (Connor, Kidd, and Mathews 2015, 117). Before this, there were no laws to govern who could attend birth, no

licenses were issued and no formal training provided (McNaughton 1989, 52). By the 1930s, NL adopted a cottage hospital system, improving the quality of working conditions for midwives and improving care for infants and people giving birth (see Fig. 2).

Cottage hospitals were small, intimate hospitals in remote communities that allowed for more resources to be in one space, while providing client-centred care that was safer than home births at the time. In these hospitals, new midwives were officially trained, integrated into the community, and provided government salaries, which improved their quality of life. The care they provided "kept [caesarean] sections, forceps deliveries and episiotomies at a minimum since they, not physicians, decided whether a laboring client needed additional obstetrical intervention"). At this time, infant and birthing parent mortality rates dropped. While this was partially due to an overall increase in quality of life, many medical professionals said "the care given by cottage hospital midwives also contributed significantly to this improvement", as they had emergency resources and a team of support staff (Benoit 1989, 4). While these working

Figure 2. Forbes Family. (ca. 1947). Bonavista Cottage Hospital [Photo]. Forbes Family Photograph Collection. Memorial University of Newfoundland.

Figure 3. Forbes Family. (ca. 1947). Dr. C.A. Forbes and nurses at the Bonavista Cottage Hospital holding infants [Photo]. Forbes Family Photograph Collection. Memorial University of Newfoundland.

conditions vary greatly from current hospital systems, at this time doctors, nurses, and midwives worked in what can be described as an "ecosystem", meeting the needs of individuals by taking geography and Newfoundland culture into consideration (Connor, Kidd, and Mathews 2015, 124) (see Fig. 3).

Figure 4. Robin McGrath photo. (2008) Elizabeth Penashue [Photo]. Them Days, Borning Babies 47(2).

In Labrador, children were often told that traditional midwives or 'grannies' would find babies in rotten stumps, along trails, or that they would be delivered by birds, encouraging many children to search for babies outdoors (Chaulk 2023, 87). Tshaukuesh Elizabeth Penashue (see Fig. 4) reminisced on her mother and sister following traditional Innu practices by heading into the country to prepare for her sister to give birth saying, "Innu people are very smart, and confident in nutshimit[5]. They didn't say, 'I'm afraid, I'm afraid to go far away in the bush. There's no hospital in there…' Nope. They know there's medicine in there, Innu medicine, in the bush, in the country. All kinds of medicine" (Chaulk 2023, 156). In many circumstances where people were very rural and far away from hospitals, many women ended up catching[6] their

Figure 5. Mary Dumaresque. (n.d.) Mary Dumaresque, L'Anse-au-Clair [Photo]. Them Days, Borning Babies 47(2).

[5] The Innu word Nutshimit' means 'the country'. A study done in Labrador found that "changing the balance back to country-based activities would address both the primary causes of the crisis and improve the health and well-being of the Innu" (Samson and Pretty 2006, 528).

[6] Midwives say they 'catch' babies rather than 'deliver' babies, because the person giving birth does the work of delivering the baby.

own children, or sometimes the children of their family members. Mary Dumaresque (see Fig. 5) remarks on catching her own grandchild:

> That's a different feeling altogether, borning your own grandchild. But after all you're fighting for a life. Lots of people says that they couldn't take it. I don't think anyone took it in them days because they liked it. You had very little to do with. I went ahead and done it because it had to be done. 'Twas a matter of fighting for a life. (Chaulk 2023, 116)

Many settlers noted a high infant-mortality rate in Labrador even when births were attended by trained midwives, saying that one in three children died before their first birthday. Statements like this often came with blame and racist misunderstandings of Inuit and Innu birthing practices, however it is necessary to note that infant-mortality rates were increased by the introduction of disease like the measles and flu which arrived with colonization by Europeans (Chaulk 2023, 163). Some health care professionals rightfully noted the success of Indigenous midwifery practices as well as the benefit of nurse-midwives in Labrador as opposed to a more medicalized western form of maternity care. Grenfell nurse Leslie Diack noted in her 1963 memoir that the maternal deathrate was surprisingly low. Dr. W. A. Paddon discussed the success of Labrador midwifery in his 1986 memoir *Labrador Doctor,* reflecting on his decades of work:

> The record of maternal safety and health was good in Labrador before there were any doctors…Midwives tend to do better natural deliveries than most of my general-practitioner colleagues, having had longer training in obstetrics, and indeed more experience…relatively young doctors tended to take obstetrical cases away from highly trained midwives with perhaps hundreds of deliveries to her credit, just because 'she was only a nurse,' at which point the young doctor invariably got into some sort of difficulty, which I would be called to solve. (Chaulk 2023, 167)

The young doctors who Paddon mentions became more dominant by the 1950's. Despite there being no information to back this claim, some doctors believed that midwives increased the rate of infant mortality, and that birth should therefore be taken over by physicians. In reality, "due to

poor practical training and undue intervention, many general practitioners at the beginning of [the 20th] century posed at least as great a risk to childbearing women as did empirically trained midwives" (McNaughton 1989, 66). Yet the fear of midwives persisted and influenced government control of the profession. The government began forcing people into larger urbanized centres, thus closing cottage hospitals and making male physicians the main birth attendants (Benoit 1989, 13). By removing these small local hospitals and forcing midwives into larger systems, the agency of the general public was removed, leading to the "erosion of the midwife's professionalism" and eventual disappearance of midwifery in Newfoundland and Labrador altogether (Benoit 1989, 19). This removal of agency from midwives happened in both Newfoundland and Labrador. While the cottage midwife system worked well for both midwives and clients, the industrialization of hospitals, and the medicalization of birth led to a loss in midwifery care.

This medicalization of birth made it so pregnant people, specifically women, were viewed as 'sick', which is juxtaposed with midwifery where pregnancy is treated as a normal part of life (Grigg and Kirkland 2016, 336). 'Medicalization' refers to the "biomedical tendency to pathologize otherwise normal bodily processes", causing the medical management of health, and viewing pregnancy and birth as a negative thing (Shaw 2013, 523). During the peak of midwifery care in the early 20th century, women's health, including pregnancy and menopause, were not viewed as an illness by trained and untrained midwives alike. Instead, these women relied on their own experiences of their bodies' 'natural' phases to help guide the wellbeing of those they attended (Benoit 1990, 185). This shift to viewing women as sick causes them to be seen as vulnerable and dependant, with illness making them incapable of making decisions, thus making it necessary for the paternalistic control of physicians (Harding 2000, 73). This gendered

control extended past the pregnant women to the fetus. The increased knowledge of fetal health led to the separation of mother and baby, who were once viewed as one unit, with the mother making decisions for them both. As physicians "appointed themselves as advocates for the fetus", a decision-making dichotomy was created, allowing either for "the safe delivery of the baby or a positive birth experience", with women sometimes unable to request 'both' (Harding 2000, 73). As medical intervention in pregnancy became more familiar to physicians in the mid 20th century, their autonomy over decision-making increased, with many physicians withholding information from women, "believing them incapable of making rational or objective decisions" (Harding 2000, 72).

By the 1960s, applications for midwifery licenses dropped, and it is unclear how many practicing midwives there were in the province, licensed or unlicensed. Women began to accept giving birth in hospital as normal, and fewer and fewer young women wanted to be trained as midwives (McNaughton 1989, 103). In 1986 the midwifery training program through Memorial University's Faculty of Nursing closed due to financial constraints and a lack of students (Herbert 2015). Birth was therefore relegated exclusively to hospitals, however there were still a handful of midwives providing home births, with some parents flying midwives in from other provinces to be able to access their care. Most likely due to the cultural shift back towards midwifery in other parts of the country, in 1999, the provincial government created a Midwifery Implementation Committee, whose job it was to "provide advice on the development of legislation related to midwifery and the implementation of midwifery services in [NL] (Herbert 2015). While a mandate was completed, the provincial government shelved the midwifery implementation process for unclear reasons. Over the next decade, little progress was made towards midwifery legislation, and there were only a handful of unregistered midwives catching

babies outside the healthcare system. Nurses who were also trained in midwifery used to be able to deliver babies in St. Anthony and Happy Valley-Goose Bay, however, as of 2014, this practice was phased out, with the nurse-midwives being told a physician must attend all births (Government of Newfoundland and Labrador 2013, 38).

In 2014, the Government of Newfoundland and Labrador published a report on the implementation of midwifery, which highlighted some of the major benefits of having midwifery care available in the province. NL has the highest rates of caesarean section in the country, both for first time caesareans and repeats of the procedure. While this can be a lifesaving procedure that is necessary in many cases, the increase is concerning as caesarean sections often lead to higher rates of infection, bleeding, blood clots, complications in future pregnancies, respiratory difficulties in babies, and difficulty initiating and maintaining breastfeeding (Government of Newfoundland and Labrador 2013, 26). While midwives approach breastfeeding with an awareness that it is not possible for every patient, and the firm belief that parents and mothers should not be shamed for not breast feeding, they also advocate for it when possible as it can lead to "optimal growth, absorption of nutrients, maturation of the intestinal system, protection against infections, enhanced cognitive development and prevention of sudden infant death" (Government of Newfoundland and Labrador 2013, 27). NL also has the lowest rates of breastfeeding across the country with 59% of parents initiating breastfeeding in NL and 90% of parents in the rest of the country (Statistics Canada 2021). Midwifery care plays an important role here as it is associated with lower rates of caesarean section and higher rates of breastfeeding.

The recent re-emergence of midwifery in North America can be directly traced as a response to the medicalization of birth and the increase of procedures like caesarean sections, as

the "othering of women's bodies as different and therefore dangerous contributed to the professional control of women through medicalization" (Shaw 2013, 529–30). Studies show that this medicalization is not only harmful physically, but also emotionally:

> A national Maternity Experiences Survey (MES) conducted by Statistics Canada [and published in 2009,] reported that 71% of women whose primary caregiver at birth was a midwife rated their labour and birth experiences as 'very positive' compared to 53% of those cared for by obstetrician/gynaecologists, family doctors or nurses and nurse practitioners. In terms of outcomes, the same 2004 evaluation showed that midwives had excellent outcomes, including lower than average intervention and c-section rates, lower than average rates of instrument assisted births, earlier discharges from hospital, and lower than average hospital readmission rates for mothers and babies. (Shaw 2013, 530)

This highlights the importance of midwifery care, and how increased access to care can have a large positive impact on people giving birth. These statistics have influenced and informed my research question: RQ2: why is midwifery care more positive for clients, why does midwifery care lead to fewer medical interventions, and what role does sensitivity play here? However, I do not want to set up a false or harmful dichotomy between midwives and other primary care providers who attend births. Many birthing parents have very positive experiences in hospitals and obstetrics units, and many midwives work in hospitals. As will be shown by participant interviews, many midwifery clients had positive experiences with a wide variety of healthcare providers. It would be false to say that midwifery is the only way to experience sensitivity and empathy in birthing related care, and it would be a large oversimplification to say that midwifery care is always positive. It is clear however that overall, midwifery leads to very positive outcomes both physically and emotionally, and that midwives treat sensitivity as part of their ethics of care, leading to a high quality of care.

The continuity of care that midwives provide allows for more in-depth discussions around "the risks and benefits of practices (such as infant formula feeding or elective repeat

caesarean section)" and these conversations are "critical responsibilities that are best achieved where there is…an ongoing relationship between the provider and the pregnant [person]" (Government of Newfoundland and Labrador 2013, 28). This 2014 report on the implementation of midwifery in NL showed how beneficial midwifery care would be to the province and made a significant step towards midwifery regulation. As will be discussed in the following section, the years of work to achieve midwifery regulation has not been without its struggles but has ultimately brought midwifery services back to the province.

1.4 Current Status of Registered Midwives

Through years of dedicated work done by retired and current midwives, health care workers, advocates, and community groups, midwives have returned to Newfoundland and Labrador through the regulation of their profession in 2016. The first clinic opened in Gander in 2020 in the Central Health Zone[7] and had four practicing midwives. It was intended as a pilot project, with the assumption that the services would grow. However, since then, there has been significant turnover in practicing midwives (Roberts 2022). Further complicating midwifery care, in the fall of 2021, diversions were implemented between the obstetrics units of Central Newfoundland Regional Health Centre (CNRHC) in Grand Falls-Windsor, and James Paton Memorial Regional Health Centre (JPMRHC) in Gander. This means that every other month, one unit was closed while the other remained in operation, forcing people giving birth to travel long distances. This impacted the midwives in Gander as they had been working in JPMRHC. As of January 2022, JPMRHC's unit closed permanently, despite having many obstetrically trained nurses, three pediatricians, and four midwives (CHAG 2024, 1). No official reason was given for

[7] Newfoundland and Labrador is divided into five Health Zones: Central, Eastern-Rural, Eastern-Urban, Labrador-Grenfell, and Western. These zones help to ensure regional representation (NL Health Services 2024). Midwifery care was originally only available in the Central Health Zone.

the closure of JPMRHC's obstetrics unit; however, it was rumoured that obstetrics services were now only going to be offered in one hospital in the Central Zone, and that hospital was in Grand Falls-Windsor. The Citizens Health Action Group (CHAG), a group of local parents, particularly mothers, began advocating for the availability of maternity services in Gander. They held rallies, raised awareness for the unit and for midwifery care, and wrote numerous letters to local officials, calling for the reopening of the obstetrics unit.

The closure of the Gander OB unit meant that CHRHC was receiving twice the number of patients as before. As my client interviews make clear, this sometimes prevented those working in the unit from providing adequate care to their patients due to the overpopulation of the unit. On March 18th, 2024, the obstetrics unit in Gander finally reopened. For the three previous winters, people from eastern Central Zone had to drive to Grand Falls-Windsor to give birth, unsurprisingly causing fear and anger among those affected by the diversion, particularly those who ended up giving birth before they were able to make it to the hospital (CHAG 2024, 3). Thanks to the commitment and passion of those working behind the scenes to ensure maternity services in Central Health, alongside the public advocacy of groups like The Citizens Health Action Group, many parents in Central Health no longer need to travel the extra distance to Grand Falls to have their babies. Not only does this improve access to midwifery care but to much needed maternity care in general.

The government of NL has committed to recruiting more midwifery positions and service sites across the province. In 2024 alone, seven new midwifery positions have been created with multiple being filled, hopefully bringing the total number of midwives to 11 in the coming months. Thanks to the increased availability of midwives, new midwifery teams will open in Carbonear and Happy Valley-Goose Bay in 2024, in addition to the team in Gander (AMNL

2024). By 2027, the Department of Health has committed to providing midwifery services in all Health Zones in the province by increasing the number of midwives to 20. Alongside this recruitment push, the Department of Health and Community Services has "a study underway to determine the feasibility of establishing a midwifery education program to serve the Atlantic provinces[8]" (Mercer 2024). Bringing a training program to Atlantic Canada has the potential to increase midwifery retention. Multiple research participants noted in their interviews with me that Newfoundlanders and Labradorians as well as Atlantic Canadians more broadly often want to stay close to home. Increasing midwifery training programs in the provinces of Newfoundland and Labrador, New Brunswick, Nova Scotia, and Prince Edward Island would allow locals to stay closer to home and could help retain students who travel here to learn. In the following section, the benefits of local training programs is discussed through the implementation of a midwifery program in Labrador, alongside a discussion of the ongoing harms of medicalized and colonized birth practices.

1.4.1 Innu Midwifery Program & the Colonisation of Birth

An example of midwifery training helping locals serve their own communities can be seen through the Innu Midwifery Program in Labrador. The spark for this program began when Thea Penashue, Community Wellness and Systems Navigator and member of the Innu Round Table in her community of Natuashish, decided to give birth in a tent, surrounded by family (Chaulk 2023, 186). The goal of the Innu Round Table was to bring traditional Innu birthing

[8] The current midwifery training programs in Canada are at McMaster University, Toronto Metropolitan University, Mount Royal University, Université du Québec a Trois Rivières, University of British Columbia, and University of Manitoba, as well as the Tsi Non:we lonnakeratstha Ona:grahsta' Aboriginal Midwifery Training Program on the Six Nations of the Grand River Territory in Ontario, and the Inuulitsivik Midwife Training Program in Nunavik, Québec, and a new Innu Midwifery Program in Labrador (CAM 2023).

practices back to communities in Labrador, which is now being accomplished through the creation of the Innu Midwifery Program. In collaboration with registered midwife Gisela Becker and Innu Elders' knowledge of Innu birthing practices, five students have been enrolled in the "culturally-specific, hands-on, individually paced learning" program (Innu Midwifery Program 2023). This program will lead to "Innu children being born on Innu lands, fostering a greater connection to the land and culture, continuation of culturally safe care, and empowering women in the context of pregnancy" (Innu Midwifery Program 2023). Through programs like the Innu Midwifery Program, and the potential for an Atlantic Canadian training program, local midwives who are more experienced with, and sensitive to the local cultures, traditions, and experiences of birthing people could not only improve access to midwifery care, but also improve the quality of care. This can lead to the decolonization of birth and less medicalized birthing processes that value individuals' needs and wants, and respect embodied knowledge.

When discussing bringing birth back to Indigenous communities, a common concern is the safety of Indigenous midwifery and birth that takes place outside health institutions. Many people voice their concerns that giving birth in isolated communities without a nearby hospital could be dangerous for mothers and babies. This concern was addressed by Mi'kmaw midwife and co-lead of the National Council of Indigenous Midwives, Alisha Julien Reid, during a keynote address on Indigenous midwifery in Atlantic Canada. She argues that in reality, giving birth within the Western medical system is unsafe for Indigenous women, and being able to have their babies in their own communities would actually be safer, and could lead to lower levels of postpartum depression for those giving birth, and better health outcomes for babies (Julien Reid 2024). In the current system, infant mortality rates are more than twice as high for Indigenous populations compared to non-Indigenous populations, and "women who travel for birth have

increased rates of induction and unplanned out-of-hospital births along with significantly increased perinatal mortality and morbidity" (Lawford, Giles, and Bourgeault 2018, 481; Sheppard et al. 2017). Having access to Indigenous midwifery in Indigenous communities, particularly rural and isolated communities, would have significant positive impact on parents, babies, and the community as a whole. Through the Innu Round Table's work to bring birth back to Innu communities, we can see evidence of how midwifery care in the province is treating clients' sensitivity and embodied knowledge as a valid epistemological approach to care, and how midwifery is culturally appropriate in NL for Indigenous and settler communities. By respecting the sensitivity of their clients and their own understanding and awareness of their bodies and their cultural needs, the culturally sensitive and culturally aware care that the Innu midwives are being trained in will provide clients with a high level of agency and quality of care. The following section reflects this necessity of personalized midwifery care and addresses how an intersectional approach to care is further evidence of valuing sensitivity and embodied knowledge.

1.5 Intersectional Midwifery

To provide the best care possible, and to demonstrate an appreciation for sensitivity and embodied knowledge, midwives must ensure that they are "culturally aware and culturally competent, [and] that they adopt a non-stigmatising and non-judgemental approach to all families and their care" (Chambers 2005, 97). The Canadian Association of Midwives (CAM) strives to provide intersectional care for clients, and intersectional programs for midwives across the country. Intersectionality is a feminist term coined by Kimberlé Crenshaw in the late 1980s to explore how interlocking and overlapping oppressions impact identity. CAM takes strong stances on issues that directly relate to their ability to provide care to their clients, and to their

clients' overall wellbeing, such as racism, sexism, homophobia, transphobia, language barriers, socioeconomic status, and lack of access in rural areas, demonstrating an intersectional approach to care (CAM 2023). They take into consideration the ways in which overlapping oppressions and issues such as income inequality, class inequality, health conditions, and inequalities in access all have negative impacts on birth and health outcomes (Peckham and Carlson 2005). It is crucial that midwifery focuses on a diverse population of clients, as "maternal and neonatal outcomes are poorer for women from disadvantaged, vulnerable or socially excluded groups, including women with disabilities" (Sandall et al. 2008).

Midwifery is often only available for 'low risk', or 'normal' pregnancies and various identity factors can have an influence on whether a pregnancy is 'normal'. More research needs to be conducted on the impact of maternal identity on midwifery access and birth satisfaction, however, we can see that identity plays an important role here as women in low-income households, women with less than a high school education, and women aged 15-19 were less likely to report that their baby was in excellent health than other women (Public Health Agency of Canada 2009, 213). For many people who are not familiar with midwives, accessing their care is difficult because a "lack of awareness about midwifery limits the approachability of these services, and because information about midwifery care is often not provided by physicians when pregnant people first contact the health system" (Darling et al. 2019). We can see this lack of awareness of midwifery care reflected in the interviews with midwifery clients in NL. Providing this specialized, thorough, and intersectional care to those who are already more advantaged is unlikely to have the desired effect of improving maternal and fetal outcomes. Instead, studies have shown that the opposite is necessary:

> [It] is essential to cater to the most disadvantaged, rather than the most advantaged. Midwifery has the capacity to impact outcomes for women from marginalised and disadvantaged communities. While the temptation is to provide services only for the middle-class populations in our communities who are able to articulate a 'choice' agenda, this is unlikely to improve outcomes and it will be harder to demonstrate cost effectiveness. In contrast, developing models that enable women from vulnerable and socially excluded communities to have access to midwifery continuity of care is more likely to demonstrate cost effectiveness and long-term health gain. (Sandall et al. 2008)

By providing exceptional midwifery care to disadvantaged groups, we would be able to see a larger increase in positive outcomes for clients and their babies. This is not to say that everyone should see midwives rather than obstetricians, as obstetricians are highly specialized in complex pregnancies and are incredibly needed, but rather to say that midwifery care should be available to all clients regardless of their identity. This care should not be reserved for only those who are socially advantaged, and instead focus needs to be given to those who have actively been disadvantaged by the health care system. For example, as a group, Indigenous women have maternity outcomes two to five times worse than non-Indigenous women. These negative outcomes have been "inadequately understood within Canada's health systems…[and] health professionals [have] failed to recognize [that] Indigenous women have interlocking historical, economical, and social circumstances related to colonialism, which negatively impact their ability to access healthcare in an equitable manner they so deserve and need" (Durant et al. 2024, 4). Midwifery care can play an urgent and essential part in decolonizing birth practices and bringing traditional midwifery care back to Indigenous communities.

Midwives have historically played a crucial role in Indigenous communities, however with the medicalization of birth and the removal of midwives in rural areas, many settler and Indigenous people are now evacuated from their communities before birth leading to "the 'breakup of families, the loss of community knowledge about birth, and health problems [for]

women who must sit for weeks in southern cities waiting to go into labour'" (Finestone and Stirbys 2017, 181). The negative impacts of birth evacuation[9] on Indigenous communities has rarely been taken into consideration in policy making (Government of Newfoundland and Labrador 2013, 22; Lawford, Giles, and Bourgeault 2018). The roots of this ongoing colonial genocide dates back to the Residential School System and "the egregious harms inflicted on Indigenous children [that] were justified and based on the white, Christian notion that Indigenous Peoples were fundamentally unfit to be parents" (Durant et al. 2024, 4). This notion has led to the intentional removal of birthing services from Indigenous communities leading to loss of culture and knowledge transfer between generations (Lawford, Giles, and Bourgeault 2018, 480). Birthing alone is often dismissed as acceptable for Indigenous women as they are seen as 'resilient', yet being evacuated for birth is shown to lead to higher rates of "post-partum depression, experiences of racism, and disconnection from family and community" (Lawford, Giles, and Bourgeault 2018, 479). While research is often needed to 'prove' these facts to policy makers, the negative effects of birth evacuations have long been understood by those who have experienced them.

To this day, many single mothers with no support systems are forced to hand over their children to Child and Family Services when they are evacuated for birth, often having a very difficult time getting them back, and having their newborn taken away as well (Cidro, Dolin, and Queskekapow 2017; Finestone and Stirbys 2017). Looking at these issues through the lens of gender, race, socioeconomic status, and geographical location highlights the ways these

[9] In the 1970s, the federal government began evacuating pregnant Indigenous people from isolated communities and sending them to urban centres for birth. This ongoing colonial practice causes the loss of Indigenous knowledge about birth, and health issues for the pregnant people forced to be isolated away from their families for several weeks at a time (Finestone and Stirbys 2017).

oppressions work together to cause physical, emotional, and financial harm to pregnant Indigenous people. Specialists in this area have called for "[increased] access to culturally safe, trauma-informed birthing supports, such as Indigenous midwives and doulas", showing the importance of intersectional approaches to midwifery (Ryan, Shawana, and Ali 2021, 280).

CAM has also made statements surrounding gender identity and being inclusive not only of women but of trans, intersex, and nonbinary people as well, because not all women give birth, and not everyone who gives birth is a woman. Often biomedical health models claim to approach gender neutrally, however, gender sensitivity is necessary in a "holistic health model" and care providers should not ignore gender identity (Celik et al. 2011, 144). These issues impact cisgender women as well as gender diverse people who are pregnant. Midwifery can "play a role in promoting gender equality by educating women about health, and identify and support women who suffer from violence, abuse and socio-economic deprivation" (Peckham and Carlson 2005, 75–76). A study done in the United Kingdom shows that the number of LGBTQ+ people giving birth is increasing, however they are often met with discrimination or lower quality of care due to the ignorance or inexperience of their healthcare providers (Arias et al. 2021, 6). An awareness of gender and sexual diversity, empathy, and sensitivity on the part of midwives and other birth attendants is necessary to provide holistic care for all clients (Arias et al. 2021, 2–3). This focus on diversity in clients and an intersectional approach to care strengthens a sensitive and embodied approach to midwifery. Through personalized care, space is created for parents to express themselves more freely and allows for different aspects of their identities to influence the care they receive through deeper understanding of them as individuals. An intersectional approach to care informed my interview questions and my approach to interviewing, as will be discussed in the following section.

Chapter 2: Theory & Methods- Care, Labour, & Relationships

The theory of care, and the way it is feminized and made invisible, all the while being an essential component of the profession of midwifery, underlies the following chapter and the interviews I conducted with midwifery clients. Through a socialist feminist approach to care, I problematize the dichotomy created between paid and unpaid care, and the domestic and public realm of work, because in this context midwifery and maternity care blur these lines. I then go on to address my research methods and methodology, informed by a theory of care, while discussing how my own sensitive approach to this work is an integral part of my research methodology.

2.1 Feminization of Care

When researching midwifery, reproductive justice, and health care that impacts women and people assigned female at birth, it is crucial to discuss the concept of 'care', the way care is feminized, and the harm this can cause. Midwifery involves paid care work and emotional labour; however, it is also connected to mothering and parenting, which ties in unpaid care work and reproductive labour. Bergeron says that "'caring about' is thought to be its own reward, done out of love and obligation…such work is devalued because it is associated with women in a society that values masculine-coded activities over feminine ones" (Bergeron 2015, 183). With midwifery often being seen as work done 'by women, for women,' midwives are participating in the paid care of parents who are providing unpaid care, thus creating a link between the different forms of care work. Marxist feminists have highlighted that "capitalism exploits unwaged reproductive work as much (indeed, perhaps more) as waged labour—the difference being that the former is naturalised and invisible" (Doonan 2022, 522). Naming unpaid domestic work as 'reproductive labour' shows the necessity of care work done at home for the broader culture, and

not only the individuals being cared for. Paid reproductive labour such as child care and home health care is vulnerable to invisibility alongside unpaid reproductive labour because both are seen as part of women's natural roles, and thus are often dismissed (Duffy 2011, 12).

Traditionally, caring for, and caring about individual's needs has been recognized as 'women's work' and thus relegated to the private or domestic sphere of the household, juxtaposed against the masculine 'public sphere' that is culturally valued as more productive (Cole and Renegar 2023, 179). Unpaid care work is seen as something women do naturally, and therefore is not considered labour. This dichotomy has permeated not only our cultural understandings of gender and work, but also public policy, which generally focuses on the 'public sphere' of the economy, often neglecting caregiving (Cole and Renegar 2023, 180). In this context, I argue that midwifery is often not viewed as labour in the public sphere and is instead relegated to the private sphere as it is done 'by women, for women', despite being paid care work. Because it is associated with intimate physical details of pregnancy, birth, and women's changing bodies, it does not have a place in the public eye and is instead seen as a private matter between women. Simultaneously, a patriarchal and euro-centric medical system has attempted to remove this perceived intimacy by forcing birth into hospitals. Therefore, midwifery is ignored due to the feminisation of care and perception of women's work as private, while it is also medicalized in order to remove authority from women, eliminating the role of emotions and intimacy in care, thus making birth acceptable in a more public sphere.

2.2 Reproductive Labour & Reproductive Justice

A feminist understanding of care and labour through a reproductive justice lens is essential to understanding the connections between gendered perceptions of care and the way health services are often devalued. Reproductive Justice is a term coined in 1994 by Black

women to highlight “the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities” (Sister Song 2024). This term combined reproductive rights with social justice, because the women’s rights movement at the time did not encompass the needs of women of colour, Indigenous women, and trans people. Through reproductive justice and an understanding of reproductive labour, we can see how care models such as midwifery and other feminized forms of health care are devalued and ignored. For example, at the beginning of the Covid-19 pandemic, 70 percent of global healthcare workers were women, making them much more likely to be exposed to illness, with women of colour in particular often working on the front lines (Pietromarchi 2020, 1). This issue of the devaluing of care work can also be tied directly to reproductive justice, especially in relation to emergencies, as reproductive health services are often the first to be cut during outbreaks like Covid. For example:

> Looking at previous outbreaks, such as Ebola, one of the areas where governments tend to cut budgets is from sexual and reproductive health services, including family planning, maternal health services, [and] access to safe abortion…the decrease in availability of sexual and reproductive health services can result in an increased risk of maternal mortality, unintended pregnancies and other adverse sexual and reproductive health outcomes among women and girls. (Pietromarchi 2020, 1)

In Newfoundland and Labrador, the initiation of midwifery services coincided with the beginning of the Covid-19 pandemic, alongside the closure of the Gander obstetrics unit. As will be discussed in Chapter 4, the reinstatement of both access to Gander obstetrics and midwifery services in the town was aided by the unpaid labour of women and mothers who had to fight for their access to care.

In the context of Newfoundland and Labrador, historically, women’s labour was very separate from men’s as the men would often leave for months at a time for work in the 19th and

20th centuries, while women were required to stay in their small communities where their "non-wage labour often meant the difference between minimal comfort and destitution" (Benoit 1990, 175). Midwifery was frequently also seen as a necessary part of women's unpaid labour, particularly in communities with no medical professionals, so groups of women would provide birthing care alongside cleaning, cooking, and childcare for the new mother (Kealey 2010, 85). For decades midwifery has existed at the intersection of both paid and unpaid labour for women. Well known NL nurse-midwife Myra Bennet's story "raises interesting questions about the relationship between paid and unpaid work…A close examination of her work patterns demonstrates a complex round of medical, domestic, accounting, shopkeeping, and community work, thus suggesting that some women's work can be described as occupational pluralism on a somewhat different scale than men's work" (Kealey 2010, 101). The domestic expectations for women were such that many tried to take control of their lives through the termination of pregnancies through stomach salts, jumping from roofs, or the use of scissors. One Newfoundland woman born in 1900 said, "I was fourteen when I started comin' around, you know, when a girl starts changing. I recall my mother saying that the best years of any woman's life were before the change" (Benoit 1990, 178). The gendered expectations of women that still linger in our society today often have actively harmful and violent effects, and negatively impact women's quality of life. The communal and culturally sensitive roles of midwifery can help create a safe space for women. Both midwives and women in the community truly had to work together to combine their efforts to care for each other. Individualism was simply not realistic in these situations as it took shared labour and care to ensure the wellbeing of people giving birth and that of their families. This community approach to care is an early example of reproductive justice, which must "analyze power systems…address intersecting oppressions…center the most

marginalized…[and] join together across issues and identities" (Sister Song 2024). While the contemporary reproductive movement focuses on the marginalized and often ignored experiences of racialized and gender diverse people, early midwifery care in NL served the most marginalized in communities by often providing care, free of charge, while acknowledging the unfair power systems and sexism at play and joining together to provide community care.

2.3 Interdependent Relationships

Another factor essential to care work is relationships and emotions. In work such as midwifery that involves the vulnerability of clients, the midwives must take up the emotional labour needed to create a positive environment in order for their care to be perceived as good (Duffy 2011, 16). Emotional labour means presenting yourself in a way that is appropriate for the situation—for example, smiling and staying positive for the sake of the client even when you are not feeling positive. Putting in this emotional labour allows for a relationship to form, thus enhancing care. Feminist care ethics recognizes the interdependent nature of care as a "universal human experience" that is a "means of enhancing ethical sensitivity" (Buchanan et al. 2022, 2). Many midwives describe relationships as essential, saying that "the relationship built with the client throughout the pregnancy informed the midwives of what was important for that woman, her wishes, her hopes and fears, all of which guided the decision-making process" (Harding 2000, 78). In paid care work such as education and health care, there is often the false narrative of caretaker and cared-for as a one-sided relationship rather than a mutual dependence. However, in the case of midwives, client interviews show that emotional labour allows for a stronger relationship, and thus more client agency. The interdependence formed between caretaker and care receiver ensures a more nuanced and individualised experience for both parties. To help break down social hierarchies, "care should be seen as embedded in relationship rather than as a

one-way dispersal of services to a dependent recipient…unilaterally labelling any individual or group 'dependent' belies the complex web of interdependence in any society, as well as in any individual human relationship" (Duffy 2011, 14). Dependence, or rather interdependence is a reality that is often ignored in Western capitalism; however, it is an unnegotiable part of each of our lives. On power imbalance, disability, and interdependence, Eli Clare says:

> The interdependent relationships between disabled people and the people who provide care for us are often messy and fraught with power imbalances rooted in racism, sexism, homophobia, transphobia, ableism, and capitalism. These imbalances frequently cause abuse and neglect for the person receiving care, low wages and exploited labor for the person providing care, and harassment flying in multiple directions. And yet, interdependence exists whether its laced with easy banter and mutuality or with struggle, hierarchy, and exploitation. (Clare 2017, 136)

In dynamics that involve care there will always be interdependence, whether positive or negative. To help remove the stigmatization of dependence as negative, we must acknowledge the need for relationships and our collective responsibility to look after others (Duffy 2011, 13). In a culture where independence is valued above all else, being cared for can be seen as inherently bad, especially when interdependence is ignored. In midwifery care, as will be shown in client interviews, the focus on interdependence or on relationship between midwife and client helps to break down power imbalances and improves quality of care.

2.4 Care Ethics & Sensitivity in Birth Work

Tied up in the theory of sensitivity is the concept of care, both caring for, and caring about people. However, the history of caring, specifically when done by white women, has a long history in white supremacy. Writer and thinker Hannah McGregor both explores and troubles the concepts of care and sentimentality in relation to femininity and whiteness. She argues that by relegating care to the private realm of women, and simultaneously treating

whiteness as being 'neutral', we make it so "the world [only] changes when white women feel sad about it" (McGregor 2022, 14). She complicates this by addressing the benefits of sentimentality in certain situations, and the dangers of relying exclusively on 'caring about' these issues. McGregor turns to works such as artist Lora Mathis's concept that "radical softness is a weapon," as well as Audre Lorde's concept of self-care as warfare. She says that "Saying that it is good to be soft, to care for ourselves, and to rest is a rejection of the capitalist fetishization of work, the white supremacist reduction of Black bodies for their labour potential, and the patriarchal disdain for feminized qualities such as care and gentleness...Softness, care, and rest can be, counterintuitively, sites of rage, refusal, and ferocity" (McGregor 2022, 40). And yet, she also notes that it is crucial to acknowledge that "softness and self-care can also be a way out, for white people, an excuse not to do the hard work of dismantling white supremacy until we feel like it" (McGregor 2022, 40). Therefore, since white women's sympathy and sentimentality is required to culturally care about an issue, and as white people we are privileged to be able to ignore many social issues related to racism, we can see how sentimentally, and whiteness perpetuates white supremacy. By using self-care as an excuse not to care too deeply, or as a reason not to enact change despite caring, we are shown how "caring is necessary and yet utterly insufficient" (McGregor 2022, xii). Caring only about issues that directly impact ourselves is what led to the exclusion of women of colour and gender diverse people from the women's rights movement on the part of white women, and now must be combated through movements such as intersectionality and reproductive justice.

Simply being sensitive to the experiences of others is not enough to incite change or to do good. Particularly in the context of birth, it is essential to acknowledge the limits of intentions while focusing on what works. While Western healthcare is based on bioethical principals of

non-maleficence, autonomy, justice, and beneficence, many ethicists have said that the system is still "imperialist, inapplicable, inconsistent, rhetorical and inadequate" (Buchanan et al. 2022, 2). Even though many health care workers are well intentioned, the system was built upon power imbalances between physician and patient, so these dynamics inform health care interactions to this day. Despite bioethics being in place, people giving birth around the world report "experiences of disrespect and abuse…obstetric violence, dehumanization and trauma in maternity care…[and] instances of discrimination, both from institutional structures and relationally" (Buchanan et al. 2022, 2). While midwifery care is not flawless, its origins differ from other health care professions, as it began as a collective of women supporting one another and passing down knowledge through generations. Feminist ethicists argue that midwifery takes up care ethics, which helps to separate their care from biomedical models.

> Care ethics recognizes that care is a universal human experience. Care ethics is founded on relationship, based on presence, trust and respect, forged on knowing the person at the center of the care. The practice of care is holistic, is attentive, responsive, responsible and competent. The richness and complexity of the individual socioemotional context is considered, and the caregiver equally values other ways of knowing. Care ethics recognizes the asymmetry of caring relationships and attention to this power imbalance is required. (Buchanan et al. 2022, 10)

All these positive qualities listed help to answer RQ2 and RQ3,[10] addressing the benefits of sensitivity and positive caring attributes often displayed by midwives, highlighting some of the qualities that improve their care and make it so valuable for those giving birth. Many of these qualities were also reflected in my research participants' interview answers.

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[10] RQ2: Can an increased focus on sensitivity on the part of registered midwives improve care and access?; RQ3: Why is midwifery care more positive for clients, why does midwifery care lead to fewer medical interventions, and what role does sensitivity play here?

Practicing care work in this context also requires midwives to take up emotional work by ensuring that their perceivable feelings and emotions are appropriate to the situation. This can take the form of either *surface acting* or *deep acting*. Surface acting happens when someone is making their appearance fit what is appropriate to the situation despite it not representing their actual feelings, while deep acting involves sincere attempts to alter or express emotions authentically (Drach-Zahavy, Buchnic, and Granot 2016, 169). As a midwife or healthcare provider, it is not enough to simply seem like you are emotionally invested, but instead you must sincerely care, as women and birthing parents rate their birth experience as more positive if they perceive their midwife to be deep acting, and their experience is rated more negatively if they perceive the midwife to be surface acting (Drach-Zahavy, Buchnic, and Granot 2016, 176). This displays the necessity of both good intentions on the part of the midwives, and a significant expectation of emotional labour. Theorizing about care is most beneficial when it directly impacts and influences our actions and lived experiences (McGregor 2022, 35). Showing how care and deep acting positively impact midwifery clients shows the importance of care work. This section on theory of sensitivity, care work, and relationships, informed my research methods and methodology. Care theory informed my research questions by contextualizing paid and un-paid care work in the context of midwifery and allowed me to approach my research methods with my own understanding of sensitivity alongside the feminist theories of care work and reproductive justice, as will be explained through the following section.

2.5 ICEHR & Recruitment

Before beginning my research, I applied to the Interdisciplinary Committee on Ethics in Human Research (ICEHR), providing details about my intended research plans, drafts of recruitment letters, my recruitment poster, and interview guideline questions. Initially my

research plan was to interview both midwifery clients and registered midwives in the province. Upon approval from ICEHR (see Appendix A), I emailed the Association of Midwives of Newfoundland and Labrador and reached out to Facebook groups such as La Leche League, and Baby Friendly Newfoundland, requesting that they share my recruitment poster (see Appendix B). Unfortunately, I was unable to interview registered midwives in the province. Given the small number of midwives working in NL, it would have been impossible to ensure anonymity to the midwives if they chose to participate, as they would most likely be recognizable by informed readers even if a pseudonym was used. Understandably, I believe this would have put them in a complicated position had they been able to participate. While sharing about sensitivity in their working lives would have been the focus of the questions asked, conversations around access to their care could have been complicated by contractual obligations and limitations on what can be shared with the public. I believe this is why no registered midwives practicing in NL agreed to participate in an interview. Despite this complication in my recruitment, I was still able to proceed with my research by focusing on my interviews with clients.

Upon having my recruitment poster shared on Facebook, fifteen midwifery clients reached out to me by email requesting to participate. Included on the recruitment poster was that each participant would be given a $10 gift card to Jumping Bean Coffee. This amount was chosen as it is not enough to be a financial incentive to participate, yet it is enough to thank each participant for their time. Each potential participant was then sent a consent form, asked to review the form, and respond with any questions and confirm if they were still interested in participating. Eight interested parties were able to meet with me in-person in Gander, NL, and two asked to meet virtually.

2.6 Semi-Structured Interviews

I conducted interviews with ten midwifery clients, all of whom live in or around the Central region of Newfoundland. I chose to speak with people directly, because as Grigg and Kirkland state, “feminist theories about health emerged in perhaps the most centrally feminist way possible: from richly descriptive and highly politicized accounts by women articulating what it is like to experience one’s body as a site of power struggle” (2016, 332). I am interested in the use of narrative in a health care setting, for as K. M. Saulnier says, there is an “entrenched imbalance in *whose stories are told, whose stories are heard, and whose stories are believed*” (emphasis in original; Saulnier, 2020, 297). Saulnier argues that a consideration of identity and personal narrative are crucial to gain a holistic understanding of a clients’ needs, but that the individual identity of marginalized groups often works against them due to paternalism in the healthcare system. This is a large part of why conducting interviews is important to my research. As the feelings of patients or clients are often overlooked, and I am focusing on sensitivity, I want to create a space where the emotional side of healthcare is the focus. I chose the method of in-depth, in-person interviews because of my feminist commitment to treat participants as equals while taking sensitivity seriously as a form of knowledge production.

It was important to me that these interviews were in-person, when possible, as I feel a discussion surrounding sensitivity should be accompanied by the ability to read body language, and I wanted the people I am interviewing to know I am actively listening to provide an atmosphere of respect. I received funding from the Social Sciences and Humanities Research Council (SSHRC) to support this research, and I used these funds to travel to Gander, NL to speak to eight clients in person. I met with the other two participants over WebEx, which still provided me the ability to display via body language that I was listening intently by video.

While I had specific questions prepared ahead of time (see Appendix C), I was open to the conversation going in directions I did not anticipate, and I welcomed new information that I had not originally considered. Broadly my questions addressed the role of midwifery in Newfoundland and Labrador, sensitivity in midwifery care, sensitivity and access, the role of emotions in health care, bodily autonomy and agency, and intersectionality. The questions I prepared were directly related to RQ1, RQ2, and RQ3.

In a small community such as NL, ensuring participants' anonymity is not always simple, however it was very important to me that I do my best to make participants unidentifiable as they shared vulnerable information with me. I used pseudonyms of their own choosing, and any personally identifiable information shared was removed from my transcripts. I met with participants in the location of their choosing, and interviews lasted from fifteen minutes to an hour. At the beginning of each interview, I reviewed the consent form with each participant, reminding them that they were free to stop the interview at any time. I asked that they only share information they are comfortable discussing and told them that they had up to a month after the interview to request that their information be removed. Once assured that they understood and did not have any questions, I went ahead with the interview. Each conversation was recorded using Rev.com, a secure transcription service that records audio and automatically generates a written transcript.

2.7 Demographics

When planning my research questions, I spent time thinking about demographics. For research to reflect the realities of intersectionality, I believe it is crucial to acknowledge overlapping aspects of identity that impact how we each interact with the world and how we are perceived. However, since I am focusing on each individual's story, I wanted them to tell me

which aspects of their identity they sensed had an impact on their care, rather than inferring that connection for myself. To allow their stories to stand alone and directly reflect their experiences, I decided not to collect demographic information. Through a sensitive approach to research, I felt it would be prying and aggressive to solicit demographic information that participants may not want to share. Directly asking people about their race, sexuality, income, and other private details feels demanding and hierarchical in a way that does not align with my goal of approaching research sensitively. While considering my role as researcher compared to their role as research participant, I wanted their lived experiences to have the power to dictate the narrative. I felt it would be more sensitive to their stories and experiences if I allowed them to share information about their identities that they felt were important to their care. However, upon completing my interviews and beginning my narrative analysis, I have second guessed this decision.

Newfoundland and Labrador is a relatively homogenous population compared to Canada as a whole. According to the 2021 Population of Newfoundland and Labrador census, only 3.4% of the province's population is made up of visible minorities, and over 96% of people speak only English at home. 75% of people own their homes, with 68% of families consisting of married couples, and 40% of couples having children. The average woman made $42,800 in total income while the average man made $53,600. Over 20% of people have a bachelor's degree or higher, and over 28% of people have a non-university diploma. Over 130,000 couples are either married or living common-law. Of all the people who identified themselves as being in a couple, only 970 couples said they were same sex, with there being 460 couples being transgender or non-binary (Statistics Canada 2021). All my research participants identified themselves as women and mothers, and they were all white presenting, meaning they most likely each fit into the

dominant demographic of Newfoundland and Labrador. However, this has left me making assumptions that I specifically wanted to avoid making. While I can infer that my participants are white, cis, and straight based on both provincial demographics and because none of them brought up race, gender, or sexuality when asked broadly if they felt their identity had an influence on the care they received, it is possible they fall outside these categories and either did not feel it influenced their care or did not want to discuss those aspects of their identity. Not taking demographics has also made it more difficult to discuss aspects of identity that could negatively impact care, as I do not want to generalize among my participants and say that they are not minorities and therefore assume that people with different identities would receive different care. I also do not want to generalize and say that all midwifery clients in the province would have similar experiences to the ten I spoke with.

Not taking demographics has led me to focus directly on my participants stories and experiences as I had hoped. However, if I conduct research like this again, I will solicit demographics. I now believe it would not detract from individual stories but would instead help contextualize them. While asking participants to provide me with demographic information feels invasive, I would approach it with sensitivity and respect, and ask that they only provide information they are comfortable sharing. I do not feel that the lack of participant demographics takes away from my current findings as I am focused on individual experiences, and I discuss intersectional care and identity, yet I do feel my research findings could be more precise if I had taken demographics. Given my small sample size, even with demographics, any quantitative results would not have been statistically significant. If I continue with this research and collect a larger sample size, I will branch out to focus on both quantitative and qualitative results. Research can rely on both story and statistics. Like how science and sensitivity do not need to be

polarizing terms in midwifery, perhaps numbers and emotions do not need to be polarizing in research.

As a first-time researcher I have learned a tremendous amount from this experience. I have improved my abilities to actively listen, think critically, and ask thoughtful questions. While interviewing I practiced thinking on my feet, adapting to conversations, and adjusting my thought processes. Throughout the writing process and narrative analysis, I have practiced slowing down, analysing data, and working through issues such as demographics. Because of this error or lack of consideration, I have had to change the way I think and write, and I have grown from the experience. I always want to continue learning and growing, and I feel the experience of interviewing and writing a thesis has helped me take steps towards being a better writer, researcher, listener, and thinker. While I now think that taking demographics would have contextualized my interviews, narrative analysis, as discussed in the following section, allowed the stories of each participant to dictate what was important to their experiences.

2.8 Narrative Analysis

Upon completing my interviews, I turned to narrative analysis to help me identify what was most important to my participants. Feminist narrative analysis creates a narrative from (often semi-structured) interviews by focusing on "plots, characters, roles, themes, structures, props, functions and linguistic turns, and the interplay between the story and the storytelling" (Fraser and MacDougall 2017, 4). Narrative analysis can be described as a "co-construction" of listening, telling, and interpreting, meaning that there are many possible interpretations of each narrative, and there is often more than one possible "truth" in each story (Fraser and MacDougall 2017, 5). To analyse narratives, I grouped participant responses together by common plots or themes, with attention being paid not only to factual information, but also the emotions of

participants, and the way the stories are told. In this context it is important to pay attention not only to words, but also "Silences, breaks, laughter, humor, pauses, false starts, and uncertainties" (Fraser and MacDougall 2017, 6). I recorded each interview with Rev.com, a service that automatically generates a transcript. To ensure the transcripts were accurate, and to begin identifying themes and emotions, I listened to each interview twice while simultaneously reviewing and editing each transcript. I then read through the transcripts, highlighting important anecdotes, commonalities, and emotions. From this highlighted information I was able to condense the most important information down to four main themes: Continuity of care; Agency & Advocacy; Relationships; and Sensitivity and Emotions.

I also want to acknowledge that narrative analysis is not without flaws. While narrations can "make room for voices and styles long denied a public audience or intellectual credibility" (Stone-Mediatore 2015, 934), it can also lead to the dismissal of stories that differ from our own, or a tokenization of marginalized people. By paying close attention to one story, some critics argue that it leads to little concern "for the struggles of differently located people or the broader sociohistorical mechanisms of oppression" (Stone-Mediatore 2015, 935). Stone-Mediatore counters this argument by claiming that hearing other peoples' stories invites individuals to listen to experiences other than their own, and leaves room for "imagination, exploration, and consideration of 'what life is like for others'" (2015, 941). I believe the larger area for danger is the tokenization of the narratives of marginalized groups. I did not want my request for other people's stories to uphold hegemonic hierarchies or lead to voyeuristic interviews. Here I turn to the work of writers like Pam Hall and Farhana Rahman. Both Hall and Rahman use ethnography and place great focus on listening to respectfully convey the stories of those they speak with. Like Hall and Rahman's ethnographic work, through the interviews I conducted, I have placed

the stories of my participants in the larger cultural and historical context of Newfoundland and Labrador and within the context of current day NL and the way identity can impact care. Rahman interviewed Rohingya women, many of whom commented on her willingness to spend time with them, rather than simply listening to the sad parts of their stories and then leaving. Rahman created a more respectful environment, saying, "what became very clear throughout the course of my fieldwork…and which allowed me to build a strong bond of trust and friendships with my interlocutors, was my willingness to listen" (Rahman 2020, 171). Similarly, Hall, who interviewed people from NL, also placed great importance on not rushing those she was listening to. She says, "In many ways, the listening itself remains the central core of this work…In real time and place, this kind of listening includes having tea, admiring household objects, scratching the barking dog's ears, looking at photographs of family, and taking notes of even the uninteresting things because that is how your listening makes itself visible" (Hall 2013, 28). Although my own research was not ethnographic but rather interview-based, I did my best to approach my interviews with a similar level of respect and a willingness to actively listen. As my research specifically addresses sensitivity, I believe I brought this trait to all my discussions and research, by doing my best to empathize with my participants while actively listening.

Participants Christine, Elizabeth, Jacqueline, Jane, Josie, Lisa, Margaret, Marie, Nicole, and Trixie, each shared their pregnancy, birth, and postpartum stories with me. While some had the midwives' care throughout their entire experiences, others gave birth during the diversion to Grand Falls, meaning they only had midwifery care for pre- and postpartum. The vulnerability of participants, and their willingness to discuss their experiences allows for the narrative analysis of their stories to show the importance of valuing sensitivity in health care, while treating both

sensitivity and embodiment as valid forms of knowledge production, and mirrors qualities that have historically been important to midwifery care in NL.

2.9 Archival Research

To situate myself and the interviews I conducted, I used archival research and historical context as a part of my work. Archival research has a large impact on what stories are documented and what stories are told, with some feminist writers arguing that "the archive and other sites of knowledge production…are in fact more generative sites to pose questions on how feminist stories are made and remade" (Frank 2019, 120). Therefore, this work is a practice in telling feminist stories through both archived information and contemporary interviews. I used this research to gain a better understanding of how the reproductive justice movement began, the functions of midwifery, and the history of midwifery care in Newfoundland and Labrador. I turned to the MUNL folklore and language archive, the MUNL Centre for Newfoundland Studies, and The Rooms archive, as each of these archives have information about the history of midwives in NL. This research led me to the works of Cecelia Benoit who extensively researched the history of midwives in NL, as well as books such as H. Gorden Green's *Don't Have Your Baby in the Dory: The Story of Nurse Myra Bennett*, Sonya Foley's *The Women of Fogo Island: Hear Them Speak*, Esther Slaney Brown's *Labours of Love: Midwives of Newfoundland and Labrador*, and Janet McNaughton's thesis *The Role of the Newfoundland Midwife in Traditional Health Care, 1900 to 1970*, which each provide both first hand and historical context of midwives in NL. By conducting this research, I was able to frame the medicalization of birth in the province and the historical de-professionalization of midwives. By putting current midwifery care in historical context, we see that midwifery worked well in the province for generations and was deeply missed by many when it ended. As will be discussed in

participant interviews, there is a continuing need for midwifery care across the province. We have seen that it worked here before, and it could work here again.

In the next chapter, I turn to the overarching threads of sensitivity and quality of care that exist in all four interview themes. I then specifically address the themes of *continuity of care*, and *agency & advocacy*, which help to address RQ1 (to what extent is sensitivity currently a focus of midwifery care in NL), while focusing on what makes midwives' approach to their profession, or their ethics of care, so essential to making their care sensitive.

Chapter 3: The Care Ethics of Midwifery

Inextricably linked to sensitivity is the high quality of care that the midwives provide, which will be discussed throughout the following two chapters, which each address core themes of the interviews. The narrative analysis of interviews I conducted with midwifery clients in Newfoundland and Labrador highlights the significant positive impact of valuing sensitivity and embodiment as methods of knowledge production. Clients' stories show the respect midwives had for their embodied knowledge, their sensitivity towards their clients, and clients' own accounts discuss how their knowledge of their bodies and emotions were given space in their care, increasing their agency and quality of care. This high quality of care and deep acting on the part of midwives can be seen through the interview themes and highlights the need for increased access to midwifery care. While it is possible that the people who wanted to participate in an interview about their care had mostly positive experiences, participants did not sugar coat their birth stories. Many of them had traumatic births, interpersonal difficulties, and many moments of anger, fear, and sadness. Despite this, each one of them credits the midwives with making their pregnancy and birth experience positive overall. Many participants had positive interactions with other health care professionals as well, such as family physicians, obstetricians, geneticists, and

nurses among others, however, as the following section argues, the midwives' uptake of sensitivity as an essential component of their ethics of care, sets their care apart from other practitioners. Through the four recurrent interview themes—continuity of care, agency & advocacy, relationships, and sensitivity & emotions—sensitivity and quality of care emerged repeatedly as core concepts. This gives me insight into RQ1, RQ2, RQ3,[11] and the overall impact of sensitivity in registered midwifery care in Newfoundland and Labrador, which I discuss as I elaborate each theme.

The overarching thread through all ten interviews was that the midwives provided an overall high quality of care, which is fundamentally connected to sensitivity. The interviews portray the midwives as extremely compassionate, dedicated workers who care deeply about their clients—traits which I interpret as elements of sensitivity. Elizabeth addressed how essential this quality of care is, saying: "They reach for the stars for their patients, which is a special kind of connection you're not just getting anywhere…I accredit them to saving my baby's life". For Elizabeth, the overall quality of care not only benefitted her through a personal connection to the midwives, but she also addresses the level of medical care that saved her and her baby. Underlying the four themes which are encompassed by high quality of care, is sensitivity as epistemology. On the part of both midwives and clients, an embodied, emotional knowledge is valued and placed at the forefront of care.

[11] RQ1: To what extent is sensitivity currently a focus of midwifery care in Newfoundland and Labrador (NL)?; RQ2: Can an increased focus on sensitivity on the part of registered midwives improve care and access?; RQ3: Why is midwifery care more positive for clients, why does midwifery care lead to fewer medical interventions, and what role does sensitivity play here?

By ‘sensitivity as epistemology’, I mean that midwives treat sensitivity to client’s emotions and physical wellbeing as valued means of acquiring knowledge, meaning midwives can provide an exceptionally high quality of care. I see this quality of care, which is rooted in sensitivity as epistemology (hereafter “sensitivity” for the sake of brevity) as uniting all the themes that emerged from my interviews. First, the midwives’ ability to be deeply sensitive and to sink into emotions with their clients is enabled by *continuity of care* (theme 1). By respecting their clients’ *agency* (theme 2) to make their own decisions about their own bodies and babies, value is placed on clients’ sensitivity to their own physical and emotional needs, creating space for embodied knowledge. By forming *relationships* (theme 3) with clients and their families, midwives become sensitive to their clients as individuals, breaking down some of the hierarchies often present in healthcare, thereby allowing space for *emotions* (theme 4). Finally, through continuity of care, agency, and relationships, midwives give their clients permission to display their own sensitivity in a safe space, thus creating an overall high quality of care.

Aligned with the exceptional quality of care the midwives provided was the specialized nature of their care. Clients appreciated having a caregiver whose primary task was attending pregnancy and birth as it ensures that they are specialized in this area and can provide their clients with their full attention while reassuring clients and monitoring for complications. For Nicole, the midwives’ focus on pregnancy was reassuring to her as the midwives did not have other types of clients or patients occupying their thoughts or time, making her feel like a priority. She said, “their only role is to help the pregnant women and their babies. Their whole scope is ‘let’s help you.’ There’s nothing else…they have complete compassion and willingness, eagerness to help, which you don’t experience everywhere else”. This focus was also a comfort to Christine, who was reassured by the midwives’ extensive experience with birth, particularly as

she was having her first baby during Covid-19: “to be able to know that I had this connection to a primary care team who was…focused on pregnancy was really important to me…they have the experience of hundreds if not thousands of families depending on the decades under their belts”. Sensitivity, trust of client’s embodied knowledge, and specialized pregnancy experience, which allowed a deep focus on the client, all contributed to the overall high quality of care the midwives provided. Broadly, the throughline of quality of care rooted in sensitivity that runs through all the following themes helps to answer RQ3: Why is midwifery care more positive for clients, why does midwifery care lead to fewer medical interventions, and what role does sensitivity play here? Through extensive knowledge of pregnancy and birth, paired with the sensitivity to each client’s needs, midwives create a positive environment for their clients by allowing them to be the primary decision makers and valuing their sensitivity and embodied knowledge. I turn now to a focused exploration of the first two themes: Continuity of care, and Agency and Advocacy.

In answering RQ1: (to what extend is sensitivity currently a focus of midwifery care in NL), I argue in this chapter that clients perceive the profession of midwifery as taking an approach that is highly focused on sensitivity. The themes I present here, namely continuity of care, and agency & advocacy, reveal that from the client perspective, midwifery’s approach as a profession, or its ethics of care, includes core components that make their care sensitive by my own definition—being attuned to other peoples’ needs, and prioritizing emotions, agency, and empathy— and that reveal what the clients themselves mean when they mention ‘sensitivity.’ As I elaborate in this chapter, these components include such things as: prolonged care, attunement, anti-hierarchical relations, educative intent, and participatory care.

Table 1: Participant Delivery Details			
Name	**Type of Birth**[12]	**Location**	**Midwifery Care**
Christine	Emergency c-section	Gander	Prenatal, birth attendance, and postnatal.
Elizabeth	Emergency c-section	Diverted to Grand Falls which was full. Sent to Clarenville.	Prenatal and postnatal.
Jacqueline	Vaginal delivery	Gander	Prenatal, birth attendance, and postnatal.
Jane	Vaginal delivery	Diverted to Grand Falls	Prenatal, and postnatal.
Josie	1st baby- Emergency c-section 2nd baby- VBAC	1st baby- Gander 2nd baby- Grand Falls	1st baby- prenatal, birth attendance, and postnatal. 2nd baby- prenatal and postnatal.
Lisa	Emergency c-section	Gander	Prenatal, birth attendance, and postnatal.
Margaret	Emergency c-section	Moved to efficiency unit in Gander from Fogo Island.	Prenatal, birth attendance, and postnatal.
Marie	Emergency c-section	Gander	Prenatal, birth attendance, and postnatal.
Nicole	Vaginal delivery	Grand Falls	Prenatal and postnatal.
Trixie	Vaginal deliveries	1st baby- Gander 2nd baby- Grand Falls	1st baby- prenatal, birth attendance, and postnatal. 2nd- prenatal and postnatal.

[12] According to the Canadian Maternity Experiences Survey, in 2006-7, 26% of participants in Canada had a caesarean birth. While these statistics are not broken down by care provider, overall, 69.6% of participants had an obstetrician/gynecologist attend their birth and 4.3% had a midwife (Public Health Agency of Canada 2009, 115). Midwifery care is shown to have lower caesarean births than other providers, for example in Ontario in 2021-22, 34% of all births were via c-section compared to only 21% of midwifery attended births (AOM 2023). The amount of emergency c-sections present in this study was surprising and will be discussed further in section 5.2 on participant delivery.

3.1 Continuity of Care

Perhaps the most raved about aspect of midwifery care by the ten research participants was the continuity of care, particularly in reference to postpartum care. Continuity of care includes individualized antenatal care, labour attendance, and postnatal care by a known midwife (Homer, Brodie, and Leap 2008). Through the time midwives have with their clients as part of continuity of care, they demonstrate sensitivity by slowly attending their clients, making them more attuned to their needs, thus creating an educative and anti-hierarchical care space. As continuity of care is one of the main tenets of midwifery, we can see that it is essential to their ethics of care. Midwives can provide care from the very beginning of pregnancy up to six weeks post-partum, often visiting new parents at home for a few weeks after birth. Research participants had a variety of care from the midwives, with some having care throughout their entire pregnancies, and some clients being affected by the diversion to Grand Falls (see Table 1.). Across the globe, midwifery continuity of care is "associated with positive experiences for women and midwives. It is also associated with a higher rate of normal birth and a lower rate of intervention" (Sandall et al. 2008). Participant Trixie addressed continuity of care saying, "It's not just dealing with your pregnancy and your delivery, it's just the general all around care and comfort they provide you…I had 24/7 access. They were ready to talk to me at any point." For Jane, she felt that the continuity of care made it easier to open up emotionally, saying that discussing anxiety or depression with a known care provider is much easier than in a segregated system where you have seen a family doctor, an OB, and public health nurses, and have not had the chance to get to know any of them on a deeper level.

Many people giving birth across the country are not able to access continuity of care from their providers. For example, First Nations women living on reserves often receive prenatal care

from federally funded nurses, provincial care in hospitals for birth, and postnatally they receive care such as vaccinations from municipal public health nurses. Because of this wide dispersal of their care, "they are often the only point of continuity in their own care" (Lawford, Giles, and Bourgeault 2018, 481). A lack of continuity can lead to negative health outcomes for parents and babies, and cause mothers and birthing parents to rate their experiences negatively. This helps contextualize RQ3, why midwifery care is more positive for clients, leading to fewer medical interventions. Alongside postpartum care having a major positive impact for clients was the midwives' 24/7 emergency line. Any time of night or day, clients and their families can call this line and either speak on the phone, text, or video call with a known midwife. This availability of midwives leads to:

> not only a personal knowledge of each other, but also the ability to be able to work out, investigate, talk about and consider the complex decisions that need to be made together, bearing in mind understandings about the woman's needs and expectations, her social situation, and her current and previous experiences of health and health care. Continuity of care is about developing a partnership to provide mutual support, and a psychological contract that is necessary for the best care of the woman during all the phases of childbirth. (Sandall et al. 2008)

This quotation highlights crucial components of the theme of continuity of care: prolonged care (i.e. slowness), attunement, anti-hierarchical relations, educative intent, and participatory care. By having the time to talk to their clients, midwives can approach care educationally, explaining diverse care possibilities to the clients, thus breaking down the frequent physician/patient hierarchy that exists in healthcare. This slowness and time with their clients also allow midwives to become more attuned to the needs, previous experiences, and opinions of their clients, thus creating an atmosphere where the client is listened to, and her sensitivity and embodiment are valued and trusted. Finally, this time together also allows for participatory care, as the midwives

have the time to create a partnership with the client, thus making decisions together, so both parties are participating in the care. Despite good intentions, if it were not for continuity of care, midwives would not have the time and space to treat sensitivity and embodiment as epistemology, which would have a dramatic impact on the care they provide.

Given that so much of NL is quite rural, homes visits and continuity of care are more challenging than in major city centres, yet the midwives work incredibly hard to provide a high quality of care to each client as is displayed in interview quotations. By making home visits, the midwives can catch medical complications and are able to check in on the mental health of their clients. By getting to know clients from the beginning of pregnancy all the way to birth and beyond, midwives are knowledgeable with respect to the medical and personal context of each individual, allowing them to be attuned to their clients, and therefore notice changes in their emotional and physical wellbeing. In contrast, getting appointments to see family doctors can be incredibly complicated in NL due to a lack of access[13], which does not allow for the same continuity of care and attention to detail provided by midwives, even when family doctors want to provide that level of detailed care. For example, participant Josie went to see her family doctor a month before giving birth, and he did not even remember that she was pregnant as he had not seen her consistently throughout her pregnancy. For Nicole, the constant availability of the midwives and the level of attention in their care contrasted her birth experience during the obstetrics diversion to Grand Falls.

[13] 136,000 people living in NL do not have access to a doctor. This is compounded by the high physician turnover in the province, particularly in rural areas. Between 2018 and 2021, family physician turnover rates were 114% in Labrador-Grenfell, 76% in Eastern, and 71% in the Central Health Zones (Reid 2024). This care crisis echoes care inaccessibility across the country, as one in six Canadians do not have access to a primary care physician (Flood, Thomas, and McGibbon 2023).

> While I was in Grand Falls [because of the diversion], medicine in general was so busy. Everyone there was great, but they just didn't have time to do their job adequately. I was calling my midwife from the hospital and saying, 'this is happening. I'm trying to breastfeed, and this isn't working for me.' And even there in the hospital, they talked me through everything…I love them dearly. When I had my six-week postpartum checkup and she's like, 'we're discharging you now', I was kind of like, 'do you have to?' I prefer if I could stay because it's unmatched care. (Nicole)

Continuity of care through postpartum visits and the 24/7 phone line reassured midwifery clients that all their needs were being met and it provided them with the ability to ask questions, receive reassurance when needed, and ultimately gave many of them the emergency care they needed postpartum. While Nicole's caregivers in Grand Falls were good at their jobs, they were too busy to give her the attention she needed postpartum. The continuity of care provided by being able to call the midwives from the hospital improved her quality of care. Five days postpartum, Nicole tested positive for Covid, and she was very frightened. She called the midwives, and they reassured her saying, "you breastfeed, you keep doing what you're doing. Your breast milk will produce antibodies to help your baby." They called her back two hours later, and again the next day to check on how she was feeling emotionally and physically. Her baby did not get Covid, and the availability and comfort of the midwives helped Nicole with the stress she felt worrying about getting her baby sick. By getting to know their clients well, midwives can pay close attention to them, form strong relationships of trust which help clients to relax, thus creating more positive experiences for clients and midwives, and, due to close monitoring, lowering rates of medical complications. This attention paid to clients help to build a relationship of trust thus exemplifying my definition of sensitivity—being attuned to other peoples' needs, and prioritizing emotions, agency, and empathy. Continuity of care being an integral part of

midwifery's approach to care as a profession integrates this sensitivity into their approach to care.

3.1.1 Postpartum Care & 24/7 availability

From catching postpartum complications, to helping parents get enough sleep, to soothing fears about being a new parent, the midwives provided essential and attentive care. For Jane, the birth attendant you have is less important than the postnatal care with midwives because your hormones are fluctuating, and the follow up with midwives and their attunement to their clients allows them to recognize if anything is wrong and get you the care that you need. By being available by phone, video call, and text, the midwives were able to address many of the worries and questions of the research participants. Many of them even said that the postpartum care was the most important part of their pregnancy and birth experience with the midwives. Christine, who had many complications after birth, still had a positive experience overall due to the midwives' care. After having an emergency c-section, Christine needed to be readmitted to the hospital, however, if it had not been for the midwives' catching complications, she would not have received care as quickly. As it was Christine's first pregnancy, she did not know what to expect during the postpartum period: "I was recovering from a C-section and taking care of an infant. I didn't know what felt normal. I knew I felt terrible. But didn't everybody feel terrible after birth?". As the midwives came to her house for postpartum visits, they noticed the complications and readmitted her to hospital, allowing her to receive care immediately and skip a visit to the emergency department. Before being admitted, her baby was not sleeping through the night, so when Christine was at home, her midwife even came to her house to try to sooth the baby to give Christine and her husband a chance to sleep. By building this relationship of trust,

her midwives were able to provide a level of continuity of care made Christine feel like she was still important to the midwife's caseload, rather than feeling no longer important to the system after birth.

For those who had previous children and for first time parents, postpartum care helped these clients to know what was normal and allowed them to get extra emotional support and medical care when necessary. Jacqueline and Lisa said that checking in on their mental health was a priority for the midwives. Lisa specified, "I was at a high risk for a lot of postpartum depression and things like that. But because I had their support and their care, I think that I dodged that. Whereas if I had been alone at home and relying on just my GP, I think it would've been a bit different." Like Christine, Lisa was also readmitted to the hospital after her husband called the midwives' emergency line when she was throwing up with a fever a few days after birth. Not only did the midwives check on her in hospital, but they visited her husband and baby at home as well. Because her complications after birth were no longer an obstetrics issue, she was switched to a different department, however the midwives continued to visit her, providing her with continuity of care despite seeing different doctors. Lisa had a baby monitor set up so she could see her new baby from the hospital. When the midwives checked on the baby, they would turn the monitor so Lisa could watch the checkup even though she was not there. Not only did the midwives take care of Lisa and the baby's medical needs, but they were attuned to her emotional needs and her connection to her baby as well. Seeing her baby get weighed despite not being there is not a level of care Lisa felt she would have gotten if her husband had had to bring the baby to a clinic to be seen. Postpartum home-visits improved her quality of care.

Elizabeth addresses the comfort of home visits postpartum saying, “You only want to be sat there in your jammies at that stage. And to be able to just do that comfortably and still have that care is nice.” For Elizabeth, midwifery postpartum care with her second child was much more comforting than the care she received after her first pregnancy without the midwives. With her first baby, she felt like she was told “here’s a baby, figure it out”. While she knew more during her second pregnancy because of her previous experience, she says that since each pregnancy and baby is so different, it was comforting to have the outstanding support of the midwives available just a phone call away. Her second baby was born during the obstetrics diversion away from Gander, and she says her care was extra special because her midwife came to visit her in hospital after birth, despite not being her birth attendant. She does not feel like she would have received that level of support if she had not been with the midwives.

Having continuity of care built into midwifery practice improves the working conditions for midwives and the health care conditions for their clients. As participant Nicole said, when hospitals are understaffed and overly busy, those working there are not able to provide the level of care needed by their patients and clients. Since the midwives are provided that extra time through their postpartum visits, they are able to provide that extra quality of care that improves the experience for clients and care providers (Sandall et al. 2008). This addresses RQ3, why midwifery care is more positive for clients, leading to fewer medical interventions. For multiple participants, the midwives’ continuity of care caught complications early on. For others, the midwives helped support their mental health and checked in to watch for postpartum depression. Through being attuned to their clients and displaying sensitivity, midwives were able to notice changes in their physical and mental health, making their care more positive. This attunement allows for the building of trust, and therefore an anti-hierarchical approach to care. Therefore,

midwifery as a profession prioritizes emotions, and empathy, creating space for sensitivity and embodiment to dictate care, and providing clients with high levels of agency as will be discussed in the following section. In an ideal situation, all health care providers would be able to bring that amount of time and attention to their work, but in an overrun healthcare system, that is simply not the case. This highlights the importance of workers who can provide that prolonged care such as midwives.

3.2 Agency & Advocacy

One of the three main tenets of midwifery care, informed choice, has a significant and positive impact on midwifery clients by providing them agency and bodily autonomy, which in turn provides space for sensitivity to embodied knowledge. To provide agency to their clients, midwives must take an evidence-based approach[14], while considering the situation of the parent, the baby, and the family. By taking this evidence-based approach of "involving women in making decisions about their care", midwives can consider short term health outcomes, and long-term outcomes that impact everyone involved, taking an educative and participatory approach to care. It is crucial for them to consider the wants of the parents and how "the form of feeding, emotional well-being and the love between mother, baby and family are of fundamental importance and are likely to affect the individuals involved for a lifetime" (Page and Hutton 2000, 9). Midwives blend an evidence-based approach with a narrative approach which is important because "we cannot rely uniquely on only numbers from trials, but must consider also…narratives which show the complexity and the subjectivity of the world of providers of

[14] Evidence-Based Medicine was introduced in the 1970s to reduce bias in clinical research by standardizing research practices by basing practice from research rather than opinion. This has improved care by "elevating medical science from a paternalistic…approach displayed by the medical community, and, from a historical point of view, it has helped counteract and balance the power of physicians over patients" (Marini 2016, 2).

care and patients and their caregivers" (Marini 2016, 6). By focusing on narrative medicine, which considers the narration of symptoms mainly by those being cared for, but also their loves ones, and their care providers, space is given to describe "feelings, emotions [and] mindset" (Marini 2016, 6). Creating space for emotions and feelings is an essential component of valuing sensitivity and embodiment and allows for an anti-hierarchical care dynamic.

Critical to midwifery and narrative medicine is the dismantling of doctor/patient hierarchies. Chambers discusses the consideration of clients' wants and needs through the term 'concordance', meaning that "decisions are made jointly and in partnership" (2005, 85). Instead of the medical model of 'compliance' where patients must follow through with everything the doctor tells them to do, concordance makes the mother or pregnant person and the midwife a team, allowing them to make decisions together while respecting bodily autonomy. By respecting the significance of childbirth, and recognizing their role as part of a partnership, midwives' approach to maternity care "values women's voices and their power, and has confidence in their abilities to make wise choices that will enable them to give birth to their babies safely" (Harding 2000, 83). Through informed choice, education, a respect for identity, and advocacy, the midwives attempt to give each client a dignified birthing experience. Participant Christine commented on the concept of dignity saying:

> The midwives, they pushed back hard against the idea that birth should be an undignified experience. They actually would not tolerate that language, or I shouldn't say not tolerate, but they really didn't want to hear it said that way. They were like, '[you should feel that] you're being cared for and listened to and that as much as humanly possible that things are going to go how you are hoping they're going to go.' So, they were like, 'it absolutely can be a dignified experience and should be, and we're going to do our best to make it that way for you.' I thought that was lovely. (Christine)

As was discussed by many participants, birth is unpredictable and frequently does not go according to plan. For example, Christine and five of the other ten research participants had emergency c-sections (see Table 1). To accommodate for this, and to ensure dignity, midwives cater their care to each individual person, giving them the tools that they need to advocate for themselves when necessary, and placing a strong focus on education so each client knows what is happening to their own bodies. Like continuity of care, agency provides clients with a more positive pregnancy and birthing experiences, making their emotions and embodied feelings the focus of their care.

3.2.1 Informed Choice

Through a strong focus on education, the midwives do their best to make sure that each client has the tools necessary to prepare for birth, helping them have the birth experience they want, while also preparing them to be adaptable when necessary. By giving clients choice, an environment is created that embraces an epistemological approach of embodied knowledge that relates not only to the physical aspect of care, but also the emotions of each client, their sensitivity, their fears, and their wants. By talking through the options and ensuring each client has all the information, midwives advocate for their clients, and help them to advocate for themselves. By advocating for bodily autonomy and agency we can see the importance of midwives' educative intent and dedication to concordance, therefore improving care as discussed in RQ2. Many of the participants went into midwifery care not knowing how much of their care would be in their control. While they expected a 'compliance' model of care where they are told what to do, they were met with a 'concordance' model where the midwives partnered with them by giving them the information needed to make an informed decision.

For Margaret, an understanding of the importance of informed choice drew her to midwifery care. A sensitivity towards her bodily autonomy and her own embodied knowledge was an important part of her care. She valued the understanding that she knows her own body better than the midwives do, and a trust that she is the expert on her own pregnancy and body. She had carefully considered opinions about what she did and did not want done during her pregnancy and birth, and after having conversations with the midwives about how she came to these conclusions, they respected her choices. For others, the plethora of choices was a surprise. Multiple participants appreciated that they did not have to be weighed at their midwifery appointments, a medical practice that is stressful for many people and often filled with shame and judgment. Participants stressed that they were given a choice in every test and procedure that could be done, particularly during pregnancy and birth, such as blood work, genetic testing, vaccinations, and glucose levels. For Elizabeth, her second pregnancy during which she received midwifery care provided her much more choice than her first pregnancy without midwifery care. After her first delivery, she described the care team "jabbing" her in the leg without her knowing what was happening, whereas under midwifery care, she learned that she was being given an injection to prevent a blood clot. She felt like every decision was her own, whether the midwives agreed or not. They would give her all the pertinent information, sometimes recommending that she receive certain medications or procedures, but ultimately everything was her own choice. Marie also had midwifery care during her second pregnancy but not her first. While during her first she had to give consent for major procedures or interventions, midwifery care empowered her to stop and think about each decision. She points out that "people actually go through pregnancy and delivery and never know that all these [choices] are options for them. It was really eye opening the second time" (Marie). As Trixie describes, during midwifery care, "you

are in control of your entire pregnancy and birth and aftercare. It doesn't feel like you're going in, say for a procedure. It makes it more comforting…they make sure that it's *you* based [and put your wants and needs first]". Midwives generally acknowledge that mothers and birthing parents want what is best for their babies, so if a parents' choice goes against midwifery advice, they make sure the client is aware of all the important information needed to make an informed choice (Harding 2000). While clients will sometimes make decisions that midwives do not agree with, midwifery care places such value on informed choice that each decision is ultimately up to the client, and midwives will support their decisions while doing their best to ensure everyone's safety. By approaching care with the intention to let clients make decisions for themselves, midwives do not uphold a hierarchical care model where they make decisions for the clients, and instead rely on education to provide clients with the information they need to make decisions for themselves based on their own needs and embodied knowledge. Through this educative approach to care, midwives display sensitivity for their clients' embodied knowledge, allowing both parties to take a participatory role in care.

3.2.2 Education

To make sure each client receives the best care possible while making informed decisions, the midwives focus heavily on an educative approach to care and providing clients with the most amount of information possible. This approach to care fits within a care ethics model by being attentive and responsive to clients and recognizing the asymmetry of caring relationships (Buchanan et al. 2022). This asymmetry is dismantled through education and trust of clients embodied knowledge, as giving clients the information they need to make their own decisions creates a partnership where midwife and clients share knowledge: the midwife's knowledge of pregnancy and birth, and the client's knowledge of their own body and their wants

and needs. At the beginning of their first appointment, each client is provided with a form where they can fill out what they want done during their care and what they do not want done. While the unpredictability of birth does not always allow for birth plans to go ahead unchanged, teaching each client about all the possibilities and having them explicitly write down their wants and needs allows for higher levels of respect and agency. By teaching clients about all the options during birth, including potential medical interventions, midwives can take steps like they did with Jacqueline, warning her that she would need an episiotomy if she was not able to deliver soon as her baby's heart rate was irregular. They knew she did not want an episiotomy and told her what she needed to do to avoid one. Jacqueline valued that she was warned about possible intervention ahead of time, instead of being told it needed to happen immediately. She also valued being able to be in whatever position she found the most comfortable, and the choice to deliver medicated or unmedicated. Midwives place a large focus on education not only through conversations with clients but also by loaning books and being available 24/7 to answer questions. Talking to friends and family, Jane finds that people without midwifery care are often missing the educational component that makes midwifery care very valuable. She says she learned a lot because the midwives walked her through all the steps of pregnancy and birth, making her experience very personalized.

The educational aspect of midwifery allows for clients to blend their embodied knowledge with the evidence-based care and information the midwives provide. Nicole knew right away that she wanted an epidural because she has a low pain tolerance. She says the midwives were very attuned to her needs and provided her with all the pros and cons to each option, allowing her to make an educated decision that was right for her. This education had a positive impact on her care which she highlights saying, "with the information they were able to

provide, I did change my mind on a lot of things I felt like was for the better" (Nicole). For Trixie, she was able to pair the midwives' information with her own research, allowing her to create a thorough birth plan. While her birth did not go exactly according to plan, she valued having a stronger idea of what she wanted to have happen to her body. The educational aspect of midwifery allows for their care to rely on concordance rather than compliance, by partnering the midwives' medical knowledge with the client's embodied knowledge. This communal approach to care provides the client with a participatory role, creating space for each client's narrative and allows for high levels of agency.

3.2.3 Identity

For midwifery care and health care in general to be sensitive, each individuals' circumstances and identity need to be taken into consideration. A respect for clients' individuality, and their identity outside their role as client or mother creates a more respectful care environment that relies on a more balanced relationship than the patient-physician model which can be steeped in power imbalance. Multiple clients noted aspects of their identity and personality that impacted their care, while acknowledging a respect for them as individuals on the part of the midwives. Jane is a very independent person and found that the midwives recognized her confidence and understood where she was coming from, creating a nice connection between them, and building trust. Trixie on the other hand, says the midwives will help you along if you are quiet, and that she could voice what she wanted once she opened up. For Christine, she felt respected as an individual because she has a medical education and works in healthcare, meaning that if she brought up concerns about things like blood work, they would give her credit and assuage her worries without being dismissive. She also appreciated that they always referred to her by name rather than calling her 'mama', which can come across as

reducing identity to motherhood. She said, “I’ve traded hats and now I’m a mama…And I’m proud of that, and I’m happy to be that, but I am also me” (Christine). While birth is a major life change, treating birthing parents as more than mothers can provide agency and support individuality. This shows a strong sensitivity for clients as individuals, respecting the significance of becoming a new parent while valuing their agency.

The midwives’ attention to individual identities and their ability to read their clients improved many peoples’ care. However, not everyone was without personality clashes. Margaret says that her identity played a role in receiving midwifery care, as she feels very strongly about trusting her body, and she is often cynical about the current structure of the health care system. Before becoming pregnant, she researched maternity care and went into her midwifery care knowing exactly what she wanted, and she says because of this she was able to “find conflict”. She says she approached her care saying, “this is what I’m doing. This is why I’m here with the midwives, is because you’re going to let me do what I want to do. And if you don’t, then we’re going to have conflict” (Margaret). Because of this, Margaret says she did end up in conflict with one of the midwives providing her care, yet she went on to say that her care was still positive overall. Margaret’s confidence and strong orientation toward decision-making show how a client’s identity can complicate their care, but ultimately helps to ensure they get the care they want. As the midwives’ respected Margaret’s ability to advocate for herself, they created a space for trust, concordance, and participatory care.

3.3 Advocacy

During pregnancy and delivery, the role of advocate is often taken up by both client and midwife. This is the case for Josie, who was advocated for and had to advocate for herself during

her first and second pregnancies. She describes her first labour as having gone very well in the beginning, with the midwives being supportive, and with dim lighting and incense burning, it was everything she hoped for. However, labour was progressing slowly. The midwives were unable to prescribe Pitocin—a medication that causes the uterus to contract, helping with labour—therefore they asked the OB on call for the prescription, but he instead said that Josie needed an emergency c-section, something she begged the doctor not to do. She felt very negatively about what happened, and spoke to the advocacy and support the midwives gave her in this situation:

> They are advocates when you can't be an advocate, because when you're going through something like this, you're just barely getting by. So, you need someone who's telling you, 'No, your feelings are valid. What happened to you wasn't right. And you couldn't advocate for yourself.' Advocating for myself after I had a baby was probably one of the hardest things I have ever had to do because…looking back, I'm sure I had postpartum depression…and then fast forward a few weeks later, a pandemic. So, it was like the worst time to have a baby. (Josie)

Josie had been told that the c-section rates at the Gander hospital where she gave birth were especially high, and she desperately did not want a c-section. Josie's mother had vaginal deliveries with all her children, and it was important to Josie that she have that experience as well. Having a c-section left her feeling bad about herself and like something was stripped from her. Josie wrote a letter to the Minister of Health to help advocate for change, in an effort to prevent negative experiences like her own from happening to others giving birth. Later, with the advocacy and help of the midwives and supportive doctors, Josie was able to have a vaginal birth after caesarean (VBAC), which was very important to her emotional and physical well-being. This support during Josie's second pregnancy not only helped her have the birthing experience

she wanted to have, but also provided her with a strong support system and a sense of community. She describes her second birth which took place during the obstetrics diversion:

> When I had [my second son by VBAC] in Grand Falls, [the midwife] came into the room and she was dancing, and she was so happy. She's like, 'you did it!'…she was really advocating for me when I really felt like I didn't know if I could do it…they're your advocates when you really need someone and when you're going through pregnancy and you don't have any family around, somebody that you can call on. (Josie)

Here we can see how the midwife's deep acting and enthusiasm for Josie's positive outcome helped improve her overall quality of care. The midwives knew how important it was for Josie to have a VBAC, and she says that she is sure one of the reasons she had a successful VBAC is because of their encouragement. They helped her address the trauma of her first birth having gone so wrong, addressing the nuances of how a traumatic birthing experience can impact future births. When Josie was unsure about whether she would be able to deliver vaginally the second time, the midwives were supportive of her choice, but ultimately advocating for her and her VBAC, telling her how in her situation being able to have your baby vaginally can be healing. Josie absolutely agrees with them and says that for her, delivering vaginally made her postpartum experience much more positive than after her first pregnancy, and she believes it helped to prevent postpartum depression. She says she would not have been able to have a VBAC without the midwives, and their advocacy was crucial to her care.

Similarly, midwives advocate for each individual client when it comes to other issues such as breast feeding and vaccinations. While they take an educative approach and provide clients with information to make decisions for themselves, doing that can be very difficult while in such a vulnerable position such as pregnancy, birth, and postpartum. Jacqueline and Lisa were both in situations where breastfeeding was not best for them, however, the 'breast is best'

ideology created feelings of shame around switching to formula. Jacqueline was encouraged to keep trying to breastfeed by her public health nurse and lactation consultant, and if that did not work, they would place her on a pumping regimen. The midwives were supportive if that was what she wanted to do, but they pointed out that "that's breastfeeding and formula feeding at the same time. It's double the work". While Jacqueline felt the other healthcare workers were pushing her to keep breastfeeding, the midwives did not say 'breast is best', but instead told her to do what was best for her and her baby. When Lisa was readmitted to the hospital due to complications, she ended up formula feeding her baby. She remembers that night saying, "the midwife [met] me in emergency, and she said, 'don't let anybody ever convince you that you need to do one thing or the other.' She was very good about it. And she said, 'we'll support you, whatever you need'…they were very big proponents of breastfeeding, and rightfully so, but it wasn't for me at the time" (Lisa). Nicole also felt the midwives advocated for her after she was not asked consent before she and her baby were given vaccinations, most of which she would have consented to, but she was not given the option. The midwife called the hospital, stressing that vaccinations need to be offered and consent needs to be provided. Nicole says the midwife advocated for her, her body, and her baby too.

The advocacy of the midwives was particularly important to clients who felt they had to advocate for themselves alone in previous medical interactions without midwives. This not only displays an aspect of midwifery care that allows for positive client experiences through concordance and participatory care, but also highlights the midwives' sensitivity to their clients' individual situations, addressing both RQ1 and RQ3. During Elizabeth's first pregnancy without midwifery care, she had to advocate for herself to be able to deliver vaginally, as she was being pushed to have a c-section. She says she was narrowly able to avoid a c-section which would not

have been possible if she had a more laid-back personality. After delivery, nurses commended her saying "good for you, for standing up for yourself. Because a lot of people wouldn't", but Elizabeth points out that she should not have had to do that while she was in such a vulnerable situation. For her second delivery, she had midwifery care, and while unfortunately she needed to have a c-section which she did not want, this time the midwives advocated for her, hoping to prevent a c-section. Trixie addressed the importance of having an advocate like a midwife in comparison to advocating for yourself, as she found herself having to demand attention when she was in the hospital. She says, "When you are in that situation, you feel like you don't have much of a voice because you're going through pain, you're going through a world of emotions. So, having someone in advance who has a general idea of what you want, and then they can follow through with that [is very helpful.] Whereas when you're there alone, yes, I had my spouse, but it's just not quite the same" (Trixie). For Trixie, having someone there who knew her birth plan, such as the midwives, would have improved her care and prevented her from having to fight for herself. For Margaret, the midwives' willingness to listen prevented her from having to fight for what she wanted, which was something she was prepared to do. Yet, instead, Margaret was happy to be able to write down her birth plan, and she was able to go into labour after "feeling that really good comfy support the whole time", and having total confidence in herself, rather than preparing to fight to be left alone or have the lights off. The midwives taking on the role of advocate not only provides their clients with care they want and deserve when they possibly would not receive it otherwise, but it also prevents their clients from having to advocate for themselves, which is difficult to do in a vulnerable situation such as labour and delivery. By participating in their own care, clients have their embodied knowledge respected.

3.3.1 Lack of Agency

Overall, clients had glowing reviews of their experience with the midwives, however their stories were not sugar-coated. There were minor interpersonal conflicts and situations where birth experiences did not go according to plan. These conflicts or instances where clients did not feel their agency was fully respected happened not only with midwives but also with doctors and other care providers. Sensitivity can both benefit and complicate situations like these.

Christine reports that for hours, she was 8 or 9 centimeters dilated. Originally, she said she did not want medications unless she asked for it, and after several hours, she did ask. However, the midwives and others in the room decided not to give her an epidural because she was so close to giving birth and they feared that it would slow progress[15]. When asked if she felt her bodily autonomy was respected, she said the following:

> If I ever had another child, I would still trust the person who was with me time and time and time again. They're a competent midwife, they're a competent healthcare provider. They made the best call that they could with the information they had…they also provided every other option they could think of to try to make it better…what they didn't know was [the baby] was really cramped up the wrong way, and he was sunny side up…But I really felt up until that point that any of my wishes or whatnot would've been respected. And I had that body autonomy. And I still think that, but I didn't get [the epidural] and I did ask for it. Do you know what I mean? So, it's a tricky one to answer because I also put my faith in their judgment, which I still would've if I had to do it again. (Christine)

[15] Epidural analgesia provides pain relief during labour and is shown to cause "a significant prolongation in the first and second stages of labor and a significant increase in the frequency of cesarean delivery" particularly for people giving birth for the first time (Thorp et al. 1993, 851).

Lisa was in a similar situation, where her care team was reluctant to give an epidural despite her being in a huge amount of pain. In her vulnerable situation, it required both her and her husband advocating for her in this moment.

> The only thing I found was that when I was in delivery… [the midwife] wasn't really keen on giving me an epidural at the time…After going through so much pain I remember looking at my husband and saying, whatever happens, make sure they give me that epidural. And I had to get him to make [them]. And maybe that's just my perception of it at the time. (Lisa)

Lisa's phrasing, "maybe that's just my perception", is important to note because some thinkers argue that "only the person being cared for can determine what constitutes ethical care" (Buchanan et al. 2022, 10). Her perception of the moment is her embodied reality, and therefore needs to be respected. While this concept is controversial, and 'truth' is highly subjective, there needs to be a balance here between respecting the sensitivity and embodiment of the client, while using an evidence-based approach and medical expertise on the part of the midwife. This is a complicated situation for both client and midwife, as the midwives know how much an epidural can slow birth which they do not want for their clients, yet the clients want to be listened to and do not want to be in pain. When considering conflicts and moments where the client disagrees with the midwife, many midwives say that "people do not usually make unhealthy choices so [there is] a need to evaluate the situation. They felt that it was important to determine whether the client has all the relevant information…and to decide whether she had any misinformation or fears that were influencing her decision" (Harding 2000, 81). There is a balance here between midwives being professionals and knowing more about healthcare than their clients, and the clients knowing more about their own bodies and needs than the midwives.

Because it was unknown that Christine's baby was both stuck and upside-down, the care team did not realize that she needed a c-section, and both the midwife and other care providers had all agreed not to give her the epidural as they thought she was close to giving birth. However, she reflects on her feelings of not being listened to in that moment. Because her baby was stuck, she was in a tremendous amount of pain—more than she should have been for a 'normal' birth.

> So, in the end, [not receiving the epidural] was still the right call all the way around [because I needed a c-section]. But when I say I *suffered.* I remember them walking me through that, the difference between pain and suffering and what that meant. And they said…you do not need to suffer in childbirth. That doesn't have to be something your experience. And there's ways to manage pain. (Christine)

After birth it became clear that the position the baby was in had caused Christine a significant amount of suffering, as distinct from pain. The midwife was very apologetic for not making the call to give Christine pain relief in that moment. The midwife was aware of Christine's request to not have pain medication unless asked, but when asked she did not want to slow the labour progress and therefore did not listen. Despite having her best interests at heart, in that moment, Christine did not feel heard. The Nursing and Midwifery Council in the UK strongly encourages doctors, nurses, and midwives to acknowledge when they have made a mistake or when something goes wrong, and they should "apologise and offer an appropriate remedy or support to put matters right" (Keogh 2014, 13). The Council says this must be accompanied by policies that do not unduly punish workers and instead allow space to learn from mistakes. Because of the midwife's sensitivity to Christine's embodied knowledge of her pain and to her wishes, she did apologize. While this is the ethically correct and sensitive thing to do, this also placed Christine in a complicated position as she then felt the need to provide comfort.

> As women, we're socialized to try to make other people feel better…[The midwife] was devastated that her call was not really correct, and I mean *devastated.* And of course, here I am now in a position when I'm like, 'I don't want you to feel bad about that'. We're all healthy and we're all okay. I just kind of want to get to the next step of things…this person was such a genuine person, she played almost like a friend role as well, so you develop a very different relationship with your midwives, I think, than you do with an average primary care provider. (Christine)

Sensitivity here complicated the situation and disadvantaged Christine. Through McGregor's troubling of sensitivity and sentimentality, we can see here how "softness and self-care can be a way out" (McGregor 2022, 40). This is not to suggest that the midwife was intentionally manipulating her way out of her mistake, but rather that her emotions took up space in this relationship when the focus was supposed to be on Christine and her experience. While the level of care and emotions the midwife was presenting here are a good example of Drach-Zahavy's concept of 'deep acting' as it is clear that the midwife genuinely cared about Christine and her birth outcome, we are shown again that caring about someone is not enough to ensure a good result (2016). As will be discussed later in the section on relationships, while there is interdependence between carer and cared for, there is still a power imbalance in midwife/client relationships, and even when they become friendships, it is still a "professional friendship" (Sandall et al. 2008). Sensitivity and emotions are not without flaws, much like individuals are not without flaws. Midwives, like everyone else, do not get everything right, and as we see in Christine's interview, this negatively impacted her while she was suffering through labour, yet ultimately, she would opt to receive their care again. While in many cases discussed before, sensitivity improves the care that clients receive, we can see here that this is not a black and white issue. The healthcare provider showing that level of emotion in that situation could be unnerving to the person receiving care, who is more vulnerable in that situation. While healthcare workers need space to be sensitive and feel their emotions, there is a balance between

providing sensitive care, and sensitivity negatively impacting social interactions. Just like sensitivity itself exists in the subjective, grey area of emotions, so too does the role of sensitivity in health care.

Margaret also experienced some difficulties leading up to her delivery, but she discusses her midwifery experience very positively overall. Margaret originally lived in St. John's; however, she was so confident in midwifery care that she drove three and a half hours to Gander for appointments, eventually leaving her job and moving to be closer to the midwifery clinic. Like many rural and remote areas in the province, pregnant people are made to leave Margaret's community up to a month before birth, so she and her partner moved into an efficiency unit in Gander. This unit was a small apartment where she was able to stay for free until she went into labour. Throughout all her travelling and her time in the efficiency unit, Margaret felt the midwives were very empathetic to her situation.

In her birth plan, Margaret specified that she did not want any monitoring or induction until 42 weeks, however, her midwife called her to schedule an ultrasound for monitoring at 41 weeks. When she called the midwife back, it was to tell her that she was in labour, but she was not feeling heard:

> She still kept telling me to go for the ultrasound, and I kept saying, 'I'm in labour. Trust me, please trust that I know that I'm going to have this baby in the next 48 hours.' And that was the one moment where I was like, 'you're not trusting my instinct and my bodily autonomy', and I'm saying, 'I'm not doing this. My body's telling me not to do this.' And that's why I was disappointed because you expect midwives to give you that, and they did for pretty much all of it. They always trusted me more than anything. (Margaret)

Not only was Margaret dealing with a loss of autonomy here, but also with unmet expectations. Since the midwives always trusted her decisions and instincts before, the lack of trust in this

moment was jarring and unexpected. After having a very long labour, Margaret was seen by an OB whose care she describes as “dictatorial”. Margaret specifies that this was not because he was an OB, but because he was not a friendly person. Instead of speaking to her, he spoke about her which she found very upsetting, particularly after having been in labour for 40 hours. While Margaret had a conflict with the midwife about receiving an ultrasound, she describes the stark difference in the care she received from the midwife versus the OB: “[The midwife] just stepped back and observed from a dark corner of my room for quite a long time before she intervened. So as much as we had some issues right before, I really, really respected that she was able to be sensitive to where I was at, and I wasn’t there to have a conversation” (Margaret). Despite disagreeing, the midwife continued to take a concordance approach to care, making sure that Margaret was feeling as okay as possible, however the OB took a compliance approach, creating a strong power imbalance.

Power imbalances can be impacted not only by a doctor intent on having complete control, but they can be exacerbated by “structural forces such as standardized guidelines, institutions and policies” meanwhile a care ethics approach here can “[equalize] interpersonal or structural power differentials” (Buchanan et al. 2022, 9). As can be seen in the midwife’s approach to care, despite a conflict between her and Margaret, she continuted to use a care ethics approach. Conflicts are inevitable in all forms of human interaction, and the fact that Margaret was ultimately able to have a positive experience with the midwife and participatory care despite their issues shows professionalism and respect. The midwife’s ability to be sensitive to Margaret’s needs even when they disagreed highlights the importance of sensitivity in quality of care, and in client outcomes. Even when she was unhappy with her care, Margaret still described the midwife as sensitive. After a shift change, Margaret received the care of a midwife she was

very close with. This midwife was able to get the OB to let her into the operating room for Margaret's c-section to be able to provide her with that care and support she needed. She then followed up with Margaret at the Airbnb she was staying in after birth, and she was able to help her initiate breastfeeding.

With Trixie's first pregnancy she was able to have complete midwifery care, however, with her second she had to go to an OB due to the obstetrics diversion to Grand Falls. Unlike with the midwives, Trixie was not given the level of care and attention she wanted while in the hospital. She says her care was not to par and she had to request pain medication and basic hygiene products for aftercare. Jane's experience with midwives versus other care providers was like Trixie's, with midwifery care being overall more positive while her care with a family doctor and OB was more "medical directed". The ten research participants held the midwives to a high ethical, emotional, and professional standard, and they consistently met these expectations. But even when they didn't and mistakes or miscommunications were made, each participant rated their care as positive overall, displaying that the care the midwives provided and their sensitivity to any mistakes allowed for exceptional care.

I argue that the *continuity of care* (theme 1), and *agency & advocacy* (theme 2) that make up a crucial part the approach to midwifery care as a profession allowed for a slow approach to prolonged care, concordance, attunement, anti-hierarchical relations, educative intent, and participatory care. These qualities provide sensitivity towards clients' needs by prioritizing their emotions while being empathetic, thus treating their embodied knowledge as a crucial part of care. I now move away from a more general consideration of the ethics of care of midwifery as a

profession, and into more specific considerations about NL midwives' ability, as practitioners, to forge emotional connections to their clients.

Chapter 4: Relationships and Sensitivity & Emotions

In the previous chapter, I proposed some answers to RQ1. In this chapter, I turn to RQ2 and RQ3. RQ2 asked whether an increased focus on sensitivity on the part of registered midwives can improve care and access. RQ3 asked why midwifery care is more positive for clients and leads to fewer medical interventions, and questions what role (if any) sensitivity plays in these dynamics. In this chapter, I describe the themes of *relationships* (theme 3), and *sensitivity & emotions* (theme 4). In analyzing these themes, I move away from the previous chapter's focus on midwifery's ethics of care as a profession, and towards a consideration of midwives' abilities, as individual practitioners, to make emotional bonds with clients. In elaborating on the themes of *relationships*, and *sensitivity & emotions*, I find interrelated answers to RQ2 and RQ3. An increased focus on sensitivity by registered midwives does indeed improve care and access for clients (RQ2), which makes it more positive (RQ3), by demonstrating genuine interest and compassion for the plight of their clients. Returning to one of my key concepts—that of 'deep acting', I show that registered midwives play an emotional role during a key time in clients' lives, invoking feelings of friendship and family, developing intimate knowledge of their clients, and providing highly personalized care. Through deep acting as well as reassurance, comfort, support, and recognition, midwives are able to show their sensitivity to their clients through the building of relationships and their openness to the display of emotions. I then argue that these qualities are reflected in both present day midwives and midwives from the early 20th century, displaying that midwifery care is culturally appropriate in the context of NL.

4.1 Relationships

Despite good intentions, maternity care can potentially cause harm, therefore strong relationships, sound evidence, and good information are required. A sensitivity to individual clients and their families alongside evidence based, scientific information can create a "relationship [that] is both personal and professional, often being like a friendship, but a friendship with a purpose" (Page and Hutton 2000, 7–8). Ethical care through relationship building has been shown to improve midwifery care. The midwife and the client must acknowledge "that the carer and care receiver are interrelated and interconnected but often unequal in terms of power and resources. Therefore, ethical care must value the importance of relationships, and this is demonstrated through responsiveness, presence, trust, honesty, communication and respect" (Buchanan et al. 2022, 6). A level of interdependence is required to break down hegemonic power imbalances in health care. Breaking down this power imbalance is crucial because "the quality of the relationship between a woman and her midwife…is the single most important factor in being able to look back on birth as a satisfying experience" (Page & Hutton, 2000, ix). This quotation is reflected in interviewee experiences, as even when birth did not go to plan, each participant rated their experience with the midwives as positive. Many research participants talked about these strong relationships with their midwives as both friendship and as family, and they are improved through comfort, support, respect, and reassurance.

4.1.1 Friendship

For many midwifery clients in this and other studies, the type of care they receive is incredibly important, alongside the relationship with the midwifes themselves. A strong relationship is not enough to create a positive care environment without medical skill and

knowledge, but likewise, skill and knowledge are not all it takes to give clients a positive experience. A dynamic of interdependence and respect creates a relationship that “has a professional purpose, which is the provision of safe and effective midwifery care. This has been described as a ‘professional friendship’” (Sandall et al. 2008). Trixie says, “They made me feel as though you were walking into a chat with a friend, so, I felt comfortable to share any information with them, any issues I was having, my insecurities”. Friendship creates a place of trust and requires deep acting and an ethics of care on the part of midwives. Christine questions the line between care provider and friend. She discusses how intimately midwives get to know clients and their families that extends beyond a traditional patient/provider relationship:

> You develop such a close tie to this wonderful group of women and then after a while, that’s it. You have no involvement with them again once your kid is beyond a certain point, which is fine, you don’t need them like you did, but it’s wild to think about how close you were and then that’s it. There’s no more interaction with them. It’s just over…now you almost want to be like, ‘well, how are you, and your partner or your kids.’ Or ‘what’s going on with you guys?’ You know what I mean? Because you feel like friends. (Christine)

While the professional friendship makes care more positive throughout pregnancy, delivery, and the postpartum period, this friendship also complicates care, because as Christine highlighted, it made it harder to leave their care than it would have been without that relationship. It is a reminder of why the relationship is called a ‘professional friendship’ rather than a regular friendship. It is complex that a factor that makes midwifery care so beneficial to clients can also cause negative emotions or a feeling of loss after the fact.

Regardless, this friendship is a beneficial part of care during the fact, and it is made possible in part by scheduling client appointments with each of the midwives on the team. This allows them to get to know everyone who could end up attending their birth, depending on who

is on call. Marie said this provided her comfort during her care. For her first pregnancy without the midwives, she was able to meet with multiple doctors who may attend her delivery, but ultimately it was a resident whom she had never met, which highlighted the benefits of a known care provider. This level of connection does not come without its challenges even during care with the midwives. As Josie discusses, the close relationship that feels less like a working relationship sometimes made her tentative to reach out compared to a more traditional medical relationship:

> When you're a new mom again, and now I have a toddler to deal with, you're swimming. You're just trying to survive the day, and you don't want to bother anyone either. And I know that that's their job, but I didn't want to call anyone and be like, 'you want to check on me?' So that's too bad. Whereas I feel like with a physician, you might not feel that same way, but it's definitely not the same kind of relationship because even my husband used to say, 'every time you have a midwife appointment, you seem so less stressed after. (Josie)

Returning to the complications of sensitivity, here we can see how this close relationship and deep connection with the midwives provided comfort for Josie but also made her feel like she was bothering them. The emotional vulnerability experienced during pregnancy and birth as well as during other health care experiences complicates care. That is why a 'professional friendship' is required, both a dynamic that allows for vulnerability and comfort, while also being professional enough to ensure clients do not feel like a bother. While good health care will create reassuring and comforting relationships, there will still be imbalance as one person is receiving care, and the other is providing this care.

4.1.2 Family

The relationship formed between midwife and client not only becomes one of friendship, but for some, the comfort, support, and reassurance allowed their sensitivity to extend into a

relationship more resembling family. Midwifery extends beyond the care of pregnant individuals and their babies to include partners, previous children, and other family members as well. They take into consideration that a new baby is a huge change for everyone involved, and they allow family members to come to appointment, and partners can call their emergency line when needed. Jacqueline says the midwives did not just have a relationship with her, but also with her partner, and later with her baby. When Nicole and her husband were nervous about driving to Grand Falls during the diversion, the midwives told her husband to call their emergency number and that they would stay on the line the whole drive, which they both found reassuring. Marie's family was so involved in her care that part of their birth plan was to have her older daughter cut the umbilical cord when the baby was born, and she practiced using a pair of scissors and deflated balloon. Because Marie needed a c-section that was not possible, but she says her daughter felt very involved and it helped her transition into being an older sibling and adjust to their new family dynamic.

Midwives not only allow partners and children to attend appointments, but they also get to know extended family during home visits. This family care extends past biological family, with some clients saying the midwives themselves began to feel like family. Jane, Trixie, and Marie all say the midwives became part of their family by providing attentive, client-centered care, talking to other family members, creating a space of comfort, and addressing the way a new baby impacts everyone involved and not just the mother or birthing parent. Through the continuity of care that midwives provide, they, more than many other health care workers, are given the time to get to know their clients and to create these bonds together. During the vulnerable experience of being pregnant and giving birth, as well as being a patient in any context, having a known healthcare provider can lead to a more relaxed environment and

ultimately improve health outcomes. This dynamic of trust, friendship, and family creates space for a higher quality of care and allows space for sensitivity and emotions.

We can see the strong familiar involvement of midwives present in historical midwifery account in NL as well. Nurse midwives like Myra Bennet took up extra house work, spent long periods of time in her client's houses, and even had some expectant mothers move in with her (Kealey 2010). Here we can once again see the blending of care work and reproductive labour. Early midwives in the province would take on feminized caring activities such as cooking, cleaning, and attending other children, while simultaneously attending the labour and delivery of a new baby. They hoped to ease the work of new mothers and recognized that maternity care requires a community approach. In the present day, while midwives are not taking on the same level of domestic tasks, their role of family that develops during home visits mirrors some of the reproductive labour taken up by midwives historically. By providing the role of community member for their clients, midwives can help to ease both the physical and emotional load, allowing space for sensitivity, while addressing the personalized needs of each client. Here I argue that the community based, participative aspects of historical midwifery care in the province are still culturally appropriate today, as the recognition of labour, and the respect and reassurance that midwives provide during their care, shows how sensitivity is key to them as individuals, thus showing their clients that they are 'deep acting', and creating a more positive and participatory care environment based on concordance.

4.2 Sensitivity & Emotions

While sensitivity and emotions were discussed throughout the interviews, for many participants there was a particular focus on the ways the midwives showed their own emotions. Qualities such as "empathy, sensitivity and intuition" are required in midwifery care, and yet

these qualities are often hard to articulate and assess (Brown 2012, 69). While sensitivity, emotions, and what constitutes good care can be very individualized, participants highlighted that it is a focus on this personalized care that allows for sensitivity. Participants defined sensitivity as an "intimate knowledge [or understanding] of who it is that you're working with. So, you're not a case, you're a person" (Christine), also as "being caring and empathetic and making sure that the client is the one that gets to make the decisions and feel like they're in control" (Jacqueline). Jane noted that "giving birth and pregnancy is a really sensitive topic" and for her sensitivity meant "being aware of your values, of your viewpoints" and a level of monitoring to "be able to read a person to see where their level of comfort is" (Jane). Finally, Marie said that sensitivity means "empowering a patient to make their own informed decisions and choices" while keeping in mind what makes them individuals and realizing that everyone has different needs. Marie experienced this sensitivity after discovering that she was going to have to give birth in a hospital where she had a previously negative experience. The midwives were recognized that her situation was impacting her negatively, taking into consideration her previous experience, and putting in the effort to make her current experience more positive. These quotations, which emphasize understanding, empathy, awareness and empowerment, compliment my definition of sensitivity as being attuned to other peoples' needs, and prioritizing emotions, agency, and empathy. These qualities expressed by the midwives show how they are able to convey sensitivity towards their clients while respecting their embodied understanding of themselves, ultimately providing a high quality of care.

Through this sensitivity, the midwives can show their own emotions while they provide care, challenging stereotypical or hegemonic health care models, thus providing comfort to their clients who are given space to share their emotions as well. Foundational to midwifery is "the

sensitivity to respond to women and their families as individuals, to understand the experience and to possess sensitivity to the significance of birth" (Page and Hutton 2000, 4). This level of sensitivity was reflected in many comments made by research participants through a focus on physical comfort and the space to emote freely and safely, valuing embodied experiences as a valid influence on decision making. The midwives were respectful of both the emotional and physical needs of their clients. Their care is very hands-on and personal, and Jacqueline describes them as "very nice, very friendly, [and] very empathetic". The midwives also create a welcoming physical environment in their clinic, showing their sensitivity to their clients' physical comfort during prenatal appointments. Rather than having an unwelcoming environment, they have "a couch for you to sit on because they want you to feel comfortable… [and they have] pictures on the walls that people had painted" alongside soft lighting, so the room does not "feel sterile and clinical…but still felt professional" (Christine). Nicole valued the midwives' ability to display both positive and negative emotions, saying that the excitement they showed when her pregnancy was confirmed was unmatched, and also "the emotion that they couldn't provide the service that they're made to do because they never had enough staff was disheartening to see". Both their excitement and sadness took on the form of deep acting, showing Nicole that they cared deeply about the care they were providing her. Through the experiences of the ten research participants, we can see that the sensitivity they showed their clients had a positive impact on the care they received. Whether it be the sensitivity they received from the midwives, or the emotions they were able to express about the vulnerability and emotionally charged nature of pregnancy and birth. Even when birth did not go according to plan, and even when there were significantly negative aspects of their experiences, the sensitive aspects of the care they received improved their overall quality of care.

Despite complications such as emergency c-sections and hospital readmissions, each participant said their care was positive overall, and the midwives' sensitivity plays a significant role in these outcomes. Lisa said, "I felt like I got the shitty end of the stick. I felt like my experience wasn't anybody else's. I was so sick. It took me a long time to recover…I just felt like what I went through, nobody else was going through it, but I think it was a more positive experience because they were there" (Lisa). For Margaret, sensitivity on the part of care providers allows for the chance to achieve a birth without intervention, if that is what the client chooses. She says having someone who is sensitive to your needs such as leaving you alone, being quiet, and not dictating your care, while understanding that you know your own body better than they do, makes clients more likely to not need medical intervention during birth. Ultimately, for her, "sensitivity and respect is what gets you to a physiological birth if that's what you want" (Margaret). Margaret wanted to have a 'physiological' or vaginal delivery, and the midwives' respect for her decisions and recognition of her emotions helped support her when she discovered she needed a c-section. She says, "I could cry thinking about how sensitive [the midwife] was and how she knew I was losing what I tried so hard to get. And just the way that she spoke to me about it. She was lovely" (Margaret). The midwives' attention to their clients' needs not only helps with birth and delivery but can also help with fear and loss. Their continuity of care allows them to learn each client's back story and previous experiences, which in-turn allows them to cater to each individual and help them work through pain and grief.

By forming a strong relationship with clients, midwives can hold space for their clients to express their emotions in a safe and comfortable environment. Lisa discussed her experience of having two miscarriages before receiving midwifery care, and the way their comfort and reassurance would have made that experience easier for her:

> I was very upset. It felt very lonely. But knowing what I know now, I wish I had been with them right from the first time I got pregnant. They're very, very in tune with what you need and what's important to you. I think the first time I would've been reassured that this is normal and whatever happens, it's going to be fine (Lisa).

While Lisa received what she described as excellent support from her doctors and genetic counselor, she feels the continuity of care provided by midwives would have improved her situation by connecting all her care together, making the sensitivity of care providers more beneficial. With her previous care she felt she had to go looking for information, meanwhile, the midwives did that for her once she was under their care. Nicole also discussed the benefit of continuity of care on her emotional connection to her care provider. She found out two weeks before delivering that her care was being diverted from Gander to Grand Falls because the Gander obstetrics unit was closed. Up until this point, she had been forming a strong relationship with the two midwives working at the time, and they were all emotional about this outcome.

> The birthing part itself was a little stressful…I went this whole pregnancy with the two different midwives that I was very close with. So, it was kind of hard going out and having to leave them to go to an OB that I'd never met. Now the doctor was great. She was incredible, but I had no relationship with her at that point. So that was a little hard. Even when the midwives told me about this, unfortunately it was two weeks before I was due when all this came about, she even sat with me and cried with me in her office over the fact that she had been a midwife for so long. This was the first time she had to hand off a pregnant woman. (Nicole)

Despite having an incredible OB, Nicole points out the importance of relationships and continuity of care. She and her midwife were able to mourn the loss of this care together. With continuity of care being a main tenet of midwifery care, it is unsurprising that not being able to provide this care elicited an emotional reaction from this midwife. In Nicole's case we return to the potential for sensitivity to negatively impact, or complicate care. While Nicole felt her

midwife crying with her was a sign of deep acting and sympathy, for others, this could come across as unprofessional or alarming.

Christine and Josie addressed how professionalism does not have to look only one way, and that health care providers can be emotional and sensitive while still being professional. Addressing her own role as a healthcare worker, Christine said that she is not afraid to show emotions when something good or bad happens to someone she is working with, and she found the midwives to be the same. During her care, multiple midwives shed tears over positive and negative things that happened throughout her pregnancy. She addressed this display of emotions saying:

> I'm not put off by that. Maybe that's just me being a woman. Some people don't want to see emotions demonstrated, but I actually don't find that's the case for the majority. Can't speak for the majority, I guess, but that's my impression anyway, is that we kind of go like, 'yeah, you actually gave a hoot'…Professionalism doesn't have to look one way. It's not one size fits all, and especially depending on the context…You don't have to use the textbook words to describe certain experiences…you can joke, or you can have a laugh in an encounter. It doesn't have to be so serious. (Christine)

This uptake of emotional labour on the part of midwives is tied up in cultural understandings of gender and work which often neglects the caretaker role, treating care and sensitivity as feminine and therefore of lesser value. This negative view of sensitivity contributes to the medicalization of birth, by removing the care and emotions from birth attendance. Josie reiterated Christine's point, as the midwives cried because they were upset about a complication during her delivery. Josie said that some of the nurses laughed when they heard that the midwives cried, implying that their emotional reaction was not professional. She said, "it's like we can't have emotion when this is what you're going through. [Birth is] the most emotional thing that you'll ever feel" (Josie). Vignesh, Jayram, and Belakere argue that demonstrating sensitivity on the part of

physicians when they are delivering bad news may be used to enhance patients' overall satisfaction with their care. However, they counter that the display of caretaker emotions being beneficial is situationally dependent. Vignesh addresses the negative or harmful side of sensitivity saying:

> displaying intense emotions...may not be therapeutic in a situation when a family is already in deep sorrow with heightened levels of sadness requiring someone else to console them. Nevertheless, the physicians remaining numb to every delivery of bad news may be viewed as 'unprofessional.' This may also constitute bad bed side manner. (Vignesh, Jayram, and Belakere 2021, 2)

While having no emotional reaction to a patient or client's bad news can have a negative impact on how this news is received, caretakers being highly emotional when the person being cared for is in a vulnerable situation can negatively take up emotional space. Therefore, the appropriate display of sensitivity is situationally dependent, which involves taking a care ethics approach to recognize that the person being cared for is prioritized. To make sensitivity beneficial for clients, midwives must take on the role of 'deep acting' while also being attuned to each client, helping to read the situation so as not to dominate emotionally, and be ready to provide reassurance, comfort, and support when that is what the client needs. They must take on the emotional labour of showing their emotions appropriately given each individual situation.

By reframing how professionalism looks in healthcare to include appropriate and situational space for sensitivity and emotions on the part of both care providers and care receivers, we will allow for more interdependent relationships, more trust between carer and cared for, and thus better experiences for everyone involved. Space for sensitivity and emotions is crucial because the factors that most significantly raise pain tolerance and lower distress are "Midwives and doctors who are kind, encouraging and interested in the woman as a person; who

are very good at explaining what they are doing; those who treat their patient as an adult; [and] those who can sense the excitement and the feeling of a uniquely important event for this particular mother and father'" (Page and Hutton 2000, 2). Effective pregnancy, delivery, and postpartum care needs sensitivity to best serve clients, their babies, and their families, while valuing the role of sensitivity in care work.

The space for sensitivity and emotions in healthcare is often dependent on having enough time with a care provider. Because of this, even when research participants had sensitive health care workers and birth attendants who were not midwives, they found their experiences with the midwives more positive, whether it was their first pregnancy or second. The continuity of care the midwives provide made it so their sensitivity was more effective and in-depth than the sensitivity provided during short or potentially rushed appointments. While doctors, nurses, and other care providers provide sensitive and empathetic care, the overburden on the health care system frequently does not provide them with the time to consistently connect with their patients on a deeper level, particularly when there is no continuity of care. Because of this, multiple clients felt like their emotions were sidelined when they were receiving care outside of midwifery. Trixie felt like she was looked at as a patient or a number rather than a person, and that emotions came as an afterthought, while with midwifery, emotions were considered as a factor in each decision about her care. Marie also felt like midwifery created the space for her emotions as she was never rushed during appointments, meanwhile, with other care providers she often felt rushed. By focusing both on their physical environment and the social environment they create while providing space to ask questions and voice concerns, midwives can provide comfort to their clients. Their sensitivity to the vulnerability of pregnancy and birth creates an

empathic environment where embodied and emotional knowledge are valued and paired with their evidence-based care, allowing for professionalism that is not unnecessarily sterile or distant.

A focus on deep acting paired with an ability to read the situation have been essential qualities in midwives in NL since the early 1900s. Many early midwives were chosen by their communities rather than volunteering, and it was desired that they paid close attention to cleanliness and were educated when possible. While present day midwives must have these qualities because they have been trained in formal institutions, there are personality aspects that were desired in the 20th century that are reflected in my client interviews as still being important today. For example, it was essential that early midwives had "good nerve", and "sympathy, which included treating a woman gently in childbirth and showing some knowledge of, and compassion for her temperament and circumstances" (McNaughton 1989, 264). A 'good nerve' can be understood in today's midwives by their ability to control their emotions, being sensitive when needed, and being strong and supportive as well. Good nerve "[denotes] physical courage and the ability to remain calm in childbirth", a quality that is still essential today as midwives are the care providers, and therefore must be able to provide reassurance and comfort regardless of how they are feeling (McNaughton 1989, 255). I argue that the quality of 'sympathy' is parallel to interviewees' discussion of comfort and reassurance that represent 'deep acting' present in their midwifery care. This sympathy also includes compassion and a "deep understanding of her clients' personalities and economic circumstances" (McNaughton 1989, 265). This reflects current midwives' focus on intersectionality, and the attention given to their clients as individuals, paying attention to their socioeconomic status, and their personal needs.

Historically, there is also a strong relationship between midwifery and charity, which I connect here to continuity of care and thus high quality of care. Early midwives were rarely paid

for their work and would not only provide their time to their clients by staying with them or caring for them for up to ten days after birth, but they would also provide other domestic services. It is important to note however, that these women were not viewed as domestic servants, “but rather a woman whose affluence and generosity enabled her to extend charity to others. Women who became midwives were respected” (McNaughton 1989, 310–11). Current day midwives being available 24/7 and their commitment to care for the individual and their family are similar to the charity displayed by early midwives. I argue that the similarities in desired qualities in midwifery care between the early 1900s and today and the consistent desire on the part of women and birthing parents to have sympathetic, or comforting and reassuring midwives, who also have ‘good nerve’ and are able to provide support and education, recognizes midwifery as culturally appropriate care in NL. The respect for midwives in the early 1900s is matched for present day midwives, as clients rave about their quality of care and the midwives as individuals. A return to midwifery care provides culturally competent and desired care, that reframes what professionalism looks like by valuing sensitivity and embodied knowledge as crucial to care.

The following section, my conclusion, reiterates the importance of continuity of care, agency & advocacy, relationships, and sensitivity & emotions. In it, I underscore the ways these themes help to argue that midwifery care in NL treats sensitivity and embodied knowledge as a valid approach to care, thus creating a high quality of care for clients. This argument is then contextualized in the province, highlighting how midwifery care has historically worked in NL. I suggest that a return to this practice, and an increase in access to midwifery care, would have a significant positive impact on mothers, birthing parents, families, and babies in Newfoundland and Labrador.

Chapter 5: Conclusion

The trust, passion, and vulnerability present in each of the ten midwifery clients' interviews show the significant and positive impact midwifery care had on each of their lives. By answering questions and telling their stories, these women have shown how prominent sensitivity currently is in midwifery care in Newfoundland and Labrador and the way sensitivity can improve midwifery access and care. Moreover, they highlighted the many overlapping factors that lead to positive client outcomes, such as care that is prolonged, attuned, anti-hierarchical, educative, participatory, reassuring, supportive, and respectful. This work addresses RQ1: (to what extent is sensitivity currently a focus of midwifery care in NL), by arguing that midwifery clients perceive the profession of midwifery and their ethics of care to be highly focused on sensitivity, which is articulated through their *continuity of care* (theme 1), and *agency & advocacy* (theme 2). RQ2 (whether an increased focus on sensitivity can improve care and access) and RQ3 (why midwifery care is more positive for clients and leads to fewer medical interviews, and what role, if any, sensitivity plays here) were both addressed through the formation of *relationships* (theme 3) and *sensitivity & emotions* (theme 4), where I argue that each individual midwife's ability to make emotional bonds with their clients improves care and access for clients, which makes their care more positive. By contextualizing these qualities in the history of midwifery care in the province, we see that midwifery care was culturally appropriate in the 20th century and continues to be culturally appropriate today. Through the themes of continuity of care, agency & advocacy, relationships, and sensitivity & emotions, this work argues that midwifery care in NL treats sensitivity and embodied knowledge as a valid epistemological approach to care. By respecting the sensitivity of clients and their own

understanding and awareness of their bodies, clients are provided with a high level of agency and quality of care.

Through these interviews we can see that "the integration of science and sensitivity in practice is the crux of the new midwifery" (Page and Hutton 2000, 4). By combining medical, scientific knowledge with emotional ways of knowing, midwifery care places value on sensitivity as epistemology. By respecting different ways of knowing, care ethics through midwifery care "allows for the acknowledgment of tacit, embodied, and experiential knowledge, as important and integral to ethical care. Accordingly, good care is individualized, holistic and receptive to context, partnering with the person at the center of the care to determine what is ethical" (Buchanan et al. 2022, 8). Science and sensitivity are not a dichotomy in midwifery care, instead, they are both necessary to provide parents with client-centered continuity of care, informed choice, and choice of birthplace. By partnering evidence-based knowledge with embodied knowledge, patients and clients can be provided with sensitive, autonomous care.

5.1. Access

My argument that midwifery care in NL treats sensitive and embodied knowledge as a valid epistemological approach to care, partnered with the interviews from clients, highlights the necessity of *access* to this care in the province. Therefore, it is important to offer some concluding observations about access. The insights of clients show the complex politics and emotions present in expanding midwifery care. By highlighting the issues present in their care and in the health system, participants have shown what needs to change to improve midwifery care in the province. Simultaneously, they have shown why access to this care is so important by sharing what works, and why it works so well.

When asked how midwifery services could be improved in Newfoundland and Labrador, the immediate first response from each of the ten participants was 'access.' Through continuity of care, agency & advocacy, relationships, and sensitivity & emotions, the registered midwives in NL take a sensitive approach to midwifery as a practice, and as individuals they create space for their clients to express their embodied knowledge. Five of the ten participants gave birth during the diversion to Grand Falls meaning they had to travel at least an hour and a half to give birth despite having access to midwifery care in Gander (see Table 1). While they were still able to receive pre- and post-natal care, the diversion prevented them from having the midwives attend their births. The overwhelming response about access to midwifery care not only shows how important their care is, but also highlights how it is not enough to simply focus on the quality of care. If the care is not accessible, its quality becomes a secondary consideration. While it is clear that "the relationship between women and their midwives is fundamental to more sensitive, personal and effective care, this relationship is not sufficient in itself since the context of care is also important" (Sandall et al. 2008). The availability of attentive, non-hierarchical, educative, and participatory high-quality continuity of care is very clearly wanted and needed by parents in Newfoundland and Labrador. Accessing this care should not be a concern, because as Josie said, "growing families, that's a human right. You shouldn't have to think, 'oh, well, I shouldn't have a baby here because I don't have access to care'". Josie went on to say that midwifery care is "the best care that you can get, and although here it's not without its problems, the problems are that there's not enough of them". Jacquelyn pointed out that we not only need midwifery care available in other communities outside of Gander, but that retention of midwives has been difficult. The midwife that delivered her baby left shortly after, and the midwife who attended her postnatally ended up leaving as well.

Not only does NL need improved access to midwives, but participants shared that knowledge of midwifery care was also needed. Many participants did not know midwifery care existed until they were pregnant, and they often found out about via word-or-mouth. This too, is an access issue. As strong advocates of midwifery, many participants try to raise awareness of their program, such as Trixie, who said "I've spoken to a few women who are expecting and ask if they've considered midwifery, and they knew nothing about it". Marie argued that word-of-mouth is great, but more needs to be done to educate people about the possibility of midwifery care. Raising awareness of this possibility could dramatically improve access to care, because if people do not know midwifery care exists in the province, "[how would they know] to fight for it or ask for it?" (Christine). We see the power in community members fighting for health services through the Citizens Health Action Group, and the tremendous amount of work they put in to fight for the successful reopening of the Gander obstetrics unit. The power of community voices could also benefit widespread access to midwifery care; however, widespread knowledge of what midwives do and the type of care they can provide is essential to motivate the fight for access.

Access to midwifery care not only benefits the clients who are able to receive their care, but also the health system, as the midwives can take over the caseload of all the 'low risk' or 'normal' pregnancies allowing all care providers to have more time with each patient or client. For many participants, the care they received from various health care workers outside of midwifery care was insufficient, not because the workers did not care, but because the system was so busy that they were not able to provide the care needed. Jane addresses how many healthcare workers are burnt out due to the strain on the system which causes them to overwork. She says it is a "horrible, vicious cycle" where so many people need care that the care providers

are overworked, problems get missed, and then patients and clients need more care. The night that Nicole gave birth in Grand Falls, six other babies were born as well, with only one case room available. While she was there, she had to request to be discharged because there was no breastfeeding help available in the hospital, and despite wanting to help, there was not enough time for the workers to address her breastfeeding needs. Because she had a fairly easy delivery, she was not a priority. Having a designated space for the midwives to work alongside resources and support from obstetricians and nurses would help to improve both the care they provide and would help the healthcare system as a whole (Lisa).

Jane is a strong advocate for midwifery access, pointing out the work being done by the government already to increase access, and demanding more respect for the work that midwives do. She says, "Our government is doing a good job trying to get midwives here. Now we need to get the heath agencies on board and the current obstetricians that are here." She points to not only the physical inaccessibility of midwifery and maternity care for many people in the province, but also the financial inaccessibility, and how vulnerable people who are in a tough financial situation are further disadvantaged by the lack of access to midwifery care, because "If you're up in St. Anthony or if you're over in Port aux Basques or you're down in Burgeo…you're driving a long ways away to get to a doctor. You're spending a lot of money to get to all your OB appointments. So, if you have midwives central in some of the bigger rural areas, then people can have babies there" (Jane). Lack of access to care for disadvantaged populations increases the risk of poor maternal and neonatal outcomes, and providing these people with adequate care benefits them individually and benefits the health care system financially (Sandall et al. 2008). Since midwifery care leads to fewer medical interventions, providing midwifery care to people at higher risk of complications can help to prevent the need

for medical procedures, thus saving the system money, and benefitting the person giving birth. Jane advocates for midwifery availability because people of lower socioeconomic status, particularly those who live rurally, cannot afford to drive long distances to get to health appointments, and they cannot afford to stay in hotels to wait to have their babies. She highlighted the frequency with which people are turned away from the hospital when they are in labour, but they are not far enough along to be admitted. For those who have driven a long distance, even if they have the money to stay in a nearby hotel, she said this is an "inconvenience" and a "disrespect". Midwifery care can prevent this situation from happening because when labour begins, clients can call the midwife who will come check on them or tell them when to go to the hospital. This saves time and energy for both the clients and healthcare workers.

Strong advocates like Jane are needed to show both the benefits of midwifery care, and the risks of not having access to their care. She says we need to "do it the old way that we had in Newfoundland", providing small communities more access to care in centralized regions like the cottage hospital system, and increasing access to midwifery care. Jane and many other midwifery clients take on the role of the killjoy by stating explicitly what is not working in our current health system, and in the case of midwifery in NL, highlighting the dangers of the lack of access and the diversion to Grand Falls. When Jane was driving an hour and half to the hospital to deliver her baby, her husband was driving fast, and they were grateful it was a nice night. In the winter, travelling in NL to give birth becomes increasingly dangerous due to storms, darkness, moose on the highway, and a lack of cell service. She says, "it's a very scary experience if you go into labour and you can't make it to the hospital on time" (Jane). Josie echoes this statement regarding the need for increased access to maternity care by saying, "These babies are coming

regardless. They’re not waiting for no doctor…Something needs to happen with regards to care. And I think that the midwives really filled a gap for that in such a good way.” Interview participants highlighted the vulnerability of labour and delivery present even when getting to the hospital is not an issue, and this vulnerability is exacerbated by needing to travel long distances.

5.2 Delivery

Six of the ten participants ended up having unplanned—and unwanted—caesarean sections (see Table 1). This is particularly important to note because midwifery care is shown to lead to lower than average c-section rates and fewer medical interventions (Shaw 2013, 530). Therefore, it was surprising to see that over half of the participants had c-sections. Despite the small sample size, 60 is a large percentage. Throughout the interviews, multiple participants said that they knew that the obstetrics unit in Grand Falls had a higher-than-average caesarean section rate. While this information is not readily available to the public, it is information that is clearly in the public consciousness of the Central Health Zone. Whether it a rumour or fact, caesarean sections are strongly impacting people giving birth in the Central zone and across the province. In 2012, 31% of births in NL were by caesarean compared to 27% in the rest of Canada. 91.5% of people in the province who have had a previous caesarean had the procedure for their next pregnancy, compared to 82.5% of the rest of the country (Government of Newfoundland and Labrador 2013). The reasons for this high c-section rate are not entirely known but could be happening due to “older age at first birth, higher prevalence of obesity/overweight as well as from changes to obstetric surgical practice that have made caesareans safer than in the past. Variations in medical practice contribute to higher rates also” (Government of Newfoundland and Labrador 2013, 25). Despite being a safe and necessary option, there are many complications to c-sections, and importantly, each of the six participants who had c-sections did not want to

have one. More research needs to be done to understand the high c-section rates in NL, but in the meantime, the dedication of midwives to achieve full client autonomy has the potential to help lower c-section rates. Even when that is not possible, the deep acting done by midwives and their genuine sensitivity towards the wants of their clients improves quality of care even when c-sections are necessary.

Christine, Josie, Lisa, Margaret, and Marie all had c-sections and valued having the midwives with them. Christine said that the midwife being there for her c-section helped to hold up both her and her husband. For Josie, having a midwife at her c-section helped her to remember some of the details afterwards that she could not remember on her own. On her baby's first birthday, the midwife called her to celebrate, acknowledging both the trauma of the experience and the joy of a first birthday. This phone call shows the importance of being remembered by healthcare providers and remembering your own care. The recognition of both the fear and celebration that were present during Josie's birth allowed her more dignity and respect than if either of those emotions were overlooked. Lisa found that having midwifery care allowed for continuity of care from the beginning of her pregnancy, during delivery, and then during the postpartum period, despite complications and needing to see multiple health care providers, the midwives were a constant in her care. Having a midwife attend her c-section was a relief for Margaret, and she appreciated their sensitivity towards the fact that she was losing the ability to have a vaginal birth which she strongly wanted. When she found out her baby was breach, the midwives helped Marie decide between a c-section or a breach delivery. She knew that no matter what happened, a known midwife would be there. All these situations display the deep acting of midwives, showing their clients that they genuinely care about their experiences and outcomes, therefore displaying sensitivity on the part of the midwives, and allowing room

for sensitivity on the part of clients. This reiterates the need for access to midwifery care in order to provide a sensitive and embodied epistemology to maternity care.

5.3 Sensitivity & Access

When considering the role of sensitivity in access to midwifery care, initially I was curious but unsure if there would be any connections between the two. Perhaps it was naïve to ask RQ2: Can an increased focus on sensitivity on the part of registered midwives improve care and access? Emotions alone cannot change the government and health authority policies that closed the Gander obstetrics unit and allowed the midwifery team to go understaffed for years. Like McGregor's argument that caring about an issue is not enough to incite change (McGregor 2022), being sensitive to the needs of pregnant people in the province is not enough to improve access to midwifery care. As has been made clear from the interviews, sensitivity is essential to providing good care, but it is not enough on its own. Yet, throughout my research, I have become increasingly optimistic that sensitivity can play a role in access.

Sensitivity to the needs of pregnant women and people across the province can be seen in midwives, clients, community organizations, doulas, and other healthcare workers. For example, The Citizens Health Action Group- North East Central Newfoundland advocated for years to encourage the ultimately successful reopening of the James Paton Memorial Regional Health Centre and raised awareness of midwifery and access to maternity care in the province (CHAG 2024). The passionate work and advocacy of these groups of people has had a significant impact on the availability of midwifery care. Across the country, we can see countless groups working to improve access to midwifery services. These advocates are not fueled by greed or financial gain, but instead they are compassionate and sensitive to the needs of the broader population. Similarly, it is clear from participant's discussion of the deep acting displayed by midwives that

they are sensitive to their clients' needs, going out of their way to provide care, thus showing that their sensitivity to clients increases pregnant and birthing peoples' access to midwifery. While care and sensitivity are not enough to enact change, they are both necessary to incite change.

5.4 Future Pregnancies

Midwifery care had such a significant impact on research participants that for many of them, access to midwifery care—or a lack thereof—is impacting their decision to have more children. Having to leave the care of the midwives during the diversion was so negative for multiple people, that it made them question whether they would have more kids at all, unless they could be guaranteed a nearby place to give birth. Alternatively, some participants had such a positive experience with the midwives that it makes them want to have another child to experience that level of care again.

Waiting to give birth, Nicole worried that she would have to drive in a snowstorm to be able to deliver in Grand Falls. It was so nerve wracking that her husband asked her, "are we going to have another kid? Are we going to be able to go to Grand Falls again?" (Nicole). Jane has talked to many people who are afraid to get pregnant because they do not know what is happening in healthcare and they worry about having a frightening and bad experience. This is reflected in Margaret's statement, because now that she has had a caesarean, she wants to try to have a VBAC, and while she thinks she could do that with a midwife, their lack of availability makes her "terrified to do this again". While she could have a doula, she acknowledges that that ability is a privilege. Elizabeth wants to get pregnant again, and despite having a family doctor now, she is certain that she will return to the midwives because she values their care so highly, as does Marie who said, "I can't say enough good about the whole experience. I laugh and joke to my husband that the experience was so positive, it makes me want to have a third child just so

that we can experience midwifery care again, because they're so empowering." Access to care that treats sensitivity and embodiment as epistemology has such a strong impact on research participants that it influences their life course, impacting their decisions to have more children or not. To restate Josie's earlier statement, having children is a human right, and an essential part of reproductive justice. Reproductive justice is the "human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities" (Sister Song 2024). Sister Song highlights how reproductive justice is not simply about reproductive choice but is also about access. For example, abortion being legal is necessary, however even when it is legal, many people, particularly marginalized groups like women of colour, cannot afford it or travel long distances to receive an abortion. We see this reflected in midwifery care in NL, as "there is no choice where there is no access" (Sister Song 2024). Therefore, access to midwifery care is inextricably tied to the sensitivity that is an essential part of their ethics of care, and to their individual approaches to their clients.

Through prolonged, attuned, anti-hierarchical, educative, participatory, comforting, and respectful care, the midwives in Gander, NL were able to provide these ten women with ultimately positive birth experiences. Jane drives home all these points:

> I think publicly, new moms love them, and everybody that I talk to values them so, so much. And we need to advocate more for these women because in any system, they can't advocate for themselves. When you're hard on, you can't advocate for yourself because you're bound into contracts, and you can't speak out of your contract without being reprimanded. Everybody's afraid of that…So, I think awareness needs to be key, and there needs to be more understanding, and there needs to be more education to the general public. And more people need to speak out who have experienced midwifery care and explain our viewpoints and our experiences and how we think. We need to be the driving force… And the more people talk about it, the more people will be aware and want to try the midwife approach, and then hopefully it becomes the norm. (Jane)

Advocating for increased access to midwifery care and more support for midwives is essential for parents and babies in the province, because, as Elizabeth said, " They are the change to women's healthcare. And I can say that with all honesty. They advocate for women's health more than anyone else does, that's for sure. And they let you be vulnerable to have your emotions, and that's okay." Their care is emotionally and physically supportive.

By challenging a hegemonic healthcare system, the midwives in Newfoundland and Labrador can provide empowering, sensitive, and exceptionally high-quality care to their clients. Through this research I hope to have shared the significance of midwifery clients' stories and demonstrated that their embodied knowledge of their experiences with the midwives are essential to gain a wholistic understanding of what is working and what needs to change in our health care system. We need midwives. We need continuity of care. We need to listen to the people who are the most negatively impacted and overlooked by hegemonic healthcare practices. We need to respect everyone's sensitive and embodied knowledge. Through my research participants and research done on midwifery care around the world we can see that clients are "explicit that they [want] midwives to have more power and authority, a high public profile and higher status; to have outlets for stress and support in dealing with stress; to be better paid, and for [health authorities] to employ them in greater numbers" (Page and Hutton 2000, 2). Through the history of midwifery in Newfoundland and Labrador we can see that this care worked for generations, and that the removal of regulated midwives and midwife training programs in Atlantic Canada negatively impacted both Indigenous and settler parents and babies. Parents are worried about availability of this type of care, and want to articulate how important it is, because midwifery services have only been established in NL for a short period of time, but it is "an established

practice in other parts of the country, and frankly, and established part of [NL] history" (Christine).

Improving availability of midwifery care not only benefits individuals, but also health authorities, as midwifery continuity of care is shown to cost less than standard or traditional models of care. They are able to meet care demands as needed, midwives are often able to provide care to more individual clients than other care practitioners, and the reduction of medical intervention and long hospital stays can all greatly reduce health care costs (Sandall et al. 2008). Over decades of research on midwifery care, it is clear that there is "a consistent and persistent desire on the part of women to have sufficient time with familiar, sensitive, well-informed and skilled midwives who are able to provide the necessary level of information and support to meet the needs of the individual woman" (Page and Hutton 2000, 3). Through sensitivity and a respect for embodied knowledge, midwives in Newfoundland and Labrador have historically and contemporarily provided essential care to new parents and their babies. This care is not only needed currently, but parents also want this care for the future. Marie raved about the care she received when she said:

> Having two daughters and myself, you always think about, well, 'maybe someday they're going to decide to become mothers.' And I remember saying to [the midwives], 'as a parent, the only thing that I can hope for is that if they decide to have children, that they are able to receive the quality of care that we received from the midwives.' It was phenomenal and such a positive experience, and I just can't say enough good about it. I'll scream it from the rooftop to anybody who will listen! It was so positive. Right from day one, from our very first appointment. It was just a great experience…I wish that all women could experience that kind of care during their pregnancy and postpartum. (Marie)

Increased access to midwifery care would significantly improve the wellbeing of mothers and parents, providing them with personalized, specialized, and attentive care that treats sensitivity

and embodied knowledge as a valid epistemological approach to care. This care shows how sensitivity is inextricably linked to midwives' ethics of care (RQ1), how this sensitivity can improve medical outcomes (RQ3) and have a significantly positive impact on client's emotional perception of their care, as well as increase their access to care (RQ2), which has positive impacts prenatally, during birth, and postnatally as well.

5.5 Limitations & Next Steps

Further research is required on midwifery care and maternity care in Atlantic Canada. To create a broader understanding of the role of sensitivity in midwifery care, interviews should be conducted with registered midwives, as well as unregistered birth attendants, OBs and family doctors, and the family members of midwifery clients. More interviews with midwifery clients could also benefit the fight for increased access to midwifery care, as the voices of clients are needed to change government funding and policy. By interviewing registered and unregistered medical professionals, a better understanding of unattended birth and the gaps in care accessibility could be understood. Conducting interviews with people who chose to have completely unattended births, or births with unregistered midwives and doulas could similarly show where access and care are insufficient, ideally allowing space for further trust building between midwives and potential clients by addressing the concerns of people who do not want to give birth within the health care system.

Further research is also needed in areas of greater diversity. Hearing perspectives from 2SLGBTQIA+, BIPOC, disabled, immigrant, and other marginalized parents would expand the parameters of research on midwifery, and further explore the role of intersectionality in their care. This is a limitation in the current study because of the homogeneity in central NL, and the small number of participants.

Through interviews with the partners, other children, and extended family of midwifery clients, as well as the diverse experiences of midwifery clients, an understanding of family-oriented continuity of care could be gained, modelling how family-based care can improve experiences for clients and patients with diverse health care needs. Midwifery care is a prime example of how continuity of care and family-oriented care can positively impact individuals and their families. Further research on this model of care would also provide insight into how continuity of care impacts not only individuals, but also health care providers.

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Appendix A: ICEHR Approval

**Interdisciplinary Committee on
Ethics in Human Research (ICEHR)**

St. John's, NL Canada A1C 5S7
Tel: 709 864-2561 icehr@mun.ca
www.mun.ca/research/ethics/humans/icehr

ICEHR Number:	**20240459-AR**
Approval Period:	August 23, 2023 – August 31, 2024
Funding Source:	
Responsible Faculty:	Dr. Christina Doonan Department of Political Science
Title of Project:	*Sensitivity as Epistemology: The Role of Sensitivity in Midwifery Care in Newfoundland and Labrador*

August 23, 2023

Maureen Margaret Smith Levangie
Department of Gender Studies
Faculty of Humanities and Social Sciences
Memorial University

Dear Maureen Margaret Smith Levangie:

Thank you for your correspondence addressing the issues raised by the Interdisciplinary Committee on Ethics in Human Research (ICEHR) for the above-named research project. ICEHR has re-examined the proposal with the clarifications and revisions submitted, and is satisfied that the concerns raised by the Committee have been adequately addressed. In accordance with the *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (TCPS2)*, the project has been granted *full ethics clearance* for **one year**. ICEHR approval applies to the ethical acceptability of the research, as per Article 6.3 of the *TCPS2*. Researchers are responsible for adherence to any other relevant University policies and/or funded or non-funded agreements that may be associated with the project. If funding is obtained subsequent to ethics approval, you must submit a Funding and/or Partner Change Request to ICEHR so that this ethics clearance can be linked to your award.

The *TCPS2* **requires** that you **strictly adhere to the protocol and documents as last reviewed** by ICEHR. If you need to make additions and/or modifications, you must submit an Amendment Request with a description of these changes, for the Committee's review of potential ethical concerns, before they may be implemented. Submit a Personnel Change Form to add or remove project team members and/or research staff. Also, to inform ICEHR of any unanticipated occurrences, an Adverse Event Report must be submitted with an indication of how the unexpected event may affect the continuation of the project.

The *TCPS2* **requires** that you submit an Annual Update to ICEHR before **August 31, 2024**. If you plan to continue the project, you need to request renewal of your ethics clearance and include a brief summary on the progress of your research. When the project no longer involves contact with human participants, is completed and/or terminated, you are required to provide an annual update with a brief final summary and your file will be closed. All post-approval ICEHR event forms noted above must be submitted by selecting the ***Applications: Post-Review*** link on your Researcher Portal homepage. We wish you success with your research.

Yours sincerely,

James Drover, Ph.D.
Vice-Chair, Interdisciplinary Committee on
Ethics in Human Research

JD/bc

cc: Supervisor – Dr. Christina Doonan, Department of Political Science

Appendix BA: Recruitment Poster

SEEKING PARTICIPANTS

MIDWIFERY CARE & SENSITIVITY

Have you been a midwifery client in Gander? Are you willing to be interviewed about your experience?

I am Maureen Levangie, a Master of Gender Studies student at Memorial University. The purpose of this study is to explore the role of sensitivity in midwifery care in Newfoundland and Labrador, and to gain a better understanding of why midwifery care is reported to be more positive for clients, leading to fewer medical interventions.

I am seeking volunteers who are willing to discuss their experience of receiving midwifery care in Newfoundland and Labrador in the past 3 years.

Interviews will be in-person, one-on-one, and last 45-90 minutes (90 minutes max).

They will be in a location of your choosing, and will be scheduled at your convenience. Depending on your preference, the interview may or may not be audio-recorded, and they may take place over Webex.

Participants of diverse backgrounds and identities are welcome.

Each interview participant will be given one $10 Jumping Bean Coffee gift card as a token of appreciation.

To participate or inquire, please email me at mmslevangie@mun.ca

Participation is not a requirement of any organization that may post and/or distribute this recruitment flyer on my behalf.

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research, such as your rights as a participant, you may contact the Chairperson of the ICEHR at icehr.chair@mun.ca or by telephone at 709-864-2861.

Appendix B: Interview Questions

- Can you tell me about what kind of midwifery care you received (e.g. prenatal care? Birth attendance? Postnatal care? Etc.) and what the experience was like for you?
- What does sensitivity mean to you?
- Does sensitivity play a role in midwifery care? How so, or why not?
- Do you feel that you experienced sensitivity in the care you received? Please tell me about it.
- What is the most important aspect of midwifery care to you?
- How do you feel your own identity plays a role in midwifery care?
- What are the roles of bodily autonomy and agency in midwifery care?
- What is the role of emotions in health care?
- How could midwifery services be improved in Newfoundland and Labrador?
    - -Sensitivity in relation to care?
    - -Sensitivity in relation to access?
- Are there any questions / issues that I did not ask that you think I should ask about? Please tell me about it.