

A Feminist Rhetorical Perspective on Informed Choice in Midwifery

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When I was pregnant with my first child, my spouse and I assumed that our baby would be born in hospital. We also took for granted that I would follow the standard routine of blood and ultrasound screening tests. In the end, though, after discussing our options at length with our midwife and after reading a range of materials she made available to us, we chose to plan for a home birth and we chose not to have some of the blood and ultrasound testing that is routine in medical maternity care. In retrospect, I realize that our midwifery care facilitated a valuable process of *informed choice* for us.

Within Ontario's recently regulated profession of midwifery, informed choice functions as a guiding principle for its model of maternity care.¹ In Kenneth Burke's terms, we could characterize informed choice as a motivating "god-term" (Burke, *Rhetoric* 33) for Ontario midwifery. It constitutes an essential feature of the women-centred rhetoric of health-care communication that midwives have consciously sought to enact by contrast with the more hierarchical and paternalistic modes of communication that traditionally occur within biomedical obstetrical contexts.² Informed choice, according to the College of Midwives of Ontario, "is a decision-making process which relies on a full exchange of information in a non-urgent, non-authoritarian, co-operative setting" ("Midwifery" 5). This process is intended to encourage "the

¹ Regulated midwifery began in 1994 in Ontario. Since that time, midwifery has become a regulated health profession in British Columbia, Alberta, Quebec, Manitoba, and the Northwest Territories. Saskatchewan passed a Midwifery Act in 1999, but it has not yet been declared in practice.

² Concerning power asymmetry and paternalism in medical communication generally, see, for example, Richard Gwyn, *Communicating Health and Illness* (61-81), P. Treichler, R. Frankel, C. Kramarae, K. Zoppi, and H. Beckman, "Problem and Problems: Power Relationships in a Medical Encounter," E. Mishler, *The Discourse of Medicine: Dialectics of Medical Interviews*, and D. Silverman, *Communication and Medical Practice: Social Relations in the Clinic*. Concerning the disempowering dimensions of biomedical obstetrical care, see Robbie Davis-Floyd, "The Technocratic Model of Birth," Barbara Duden, *Disembodying Women: Perspectives on Pregnancy and the Unborn*, and Emily Martin, *The Woman in the Body: A Cultural Analysis of Reproduction*, and Ann Oakley, *The Captured Womb: A History of Medical Care of Women*.

woman to actively participate in her care throughout pregnancy, birth, and post-partum period and make choices about the manner in which her care is provided” (5). Informed choice, then, can be understood both as an ideological principle guiding the midwifery model of care and as the rhetorical practice of midwives exchanging information with women in order to facilitate expectant mothers’ decision-making. From my perspective as a rhetorician, informed choice is not simply a desired goal or outcome of midwifery care; it is a rhetorical process of communication that occurs between a woman and her midwife throughout the course of maternity care.

In this paper, I want to interrogate the combined principle-practice of informed choice in Ontario midwifery from a feminist rhetorical perspective. I am interested in exploring the possibilities and the limits of informed choice as a women-centred, feminist mode of health-care communication. My analysis will focus on how informed choice is defined within the College of Midwives of Ontario’s policy document entitled “Informed Choice Standard.” Through its 1991 Midwifery Act, Ontario included midwifery as one of the province’s self-regulated and provincially funded health professions, with the concomitant requirement to establish a College of Midwives of Ontario (CMO) as the governing body for the profession. The CMO is led by a council composed of approximately two-thirds members of the midwifery profession and one-third members of the public. The CMO’s primary duty, according to Ontario’s Health Professions Procedural Code, is to “serve and protect the public interest” by establishing and maintaining “standards of qualification, practice, knowledge, skill, and professional ethics for midwives” (Ontario, “Regulated” sec. 4). To fulfill this mandate, the CMO has produced and continues to produce numerous regulatory documents for governing the emerging profession of midwifery.

These documents form a rich and integral textual site for the definition and negotiation of informed choice as a distinctive feature of the midwifery model of care within the larger landscape of Ontario's medically dominated health-care system. In this paper, I want to consider the extent to which informed choice in the Ontario midwifery context offers a model of women's health-care communication that could be defined as a feminist rhetorical practice. Drawing on a selection of values and criteria for feminist rhetoric that have been articulated in recent research and theory, I will first look at the CMO's "Informed Choice Standard" (the main but by no means only policy document on the subject), focusing in particular on how it defines informed choice as well as the terms that are associated with, or cluster around, this central term.³ In the latter part of my discussion, I will consider how the (potentially) feminist rhetorical practice of informed choice in midwifery is challenged by the dominant medico-scientific and neo-liberal consumerist discourses that shape mainstream health-care and that, inevitably though ambiguously, affect midwifery discourse and values. Through this analysis, I foreground some of the rhetorical and ideological tensions that Ontario midwifery negotiates in its definition of informed choice. These tensions suggest that the discourses of scientific medicine and neo-liberal consumerism constrain the possibility for a feminist rhetorical practice of informed choice in midwifery and may contribute to some problematic assumptions in the CMO's definition of this principle about what counts as a "women-centred" approach to health-care communication. I begin, however, with the good news: namely, how informed choice in Ontario midwifery could be considered a feminist rhetorical practice.

³ Burke refers to this kind of rhetorical study in *Attitudes Toward History* (232-33) and *The Philosophy of Literary Form* (20). For a more developed review of cluster analysis, see Sonja Foss, *Rhetorical Criticism* (69-76).

Informed Choice: A Feminist Rhetorical Practice?

In choosing to look at informed choice in midwifery as a potentially feminist rhetorical practice, I am interested, in the first place, in recognizing this mode of communication as a significant but underexplored domain of women's rhetoric: in its essence, it consists of women (midwives) communicating with women (expectant mothers) about womanly subjects (pregnancy and birth). In this sense, I see myself as participating in the larger project to recuperate and validate women's diverse rhetorical practices and perspectives.⁴ However, rather than focusing on the contributions of individual women rhetors, my study foregrounds the significance of a collective and, to some extent, institutionally structured women's rhetoric.⁵ As Barbara Biesecker argues, in recovering and revalidating women's rhetorics, it is important to avoid the ideology of individualism that informs studies of "the autonomous speaking subject who is both the origin and master of her discourse" ("Negotiating" 238); instead, she encourages researchers to explore the vast array of collective, everyday, heterogeneous rhetorical practices in which women engage and which create (rather than simply reflect) a range of possibilities for discursively structured subjectivity and action ("Negotiating" 238-40). In studying the midwifery rhetoric of informed choice, I am less concerned with how individual women communicate than I am with how the midwifery community defines for itself a practice of communication that occurs among women and about women, and that discursively shapes socio-politically located opportunities for female rhetorical agency and action.

⁴ On the question of recovering women's rhetorics as part of the feminist rhetorical project, see Karen A. Foss, Sonja K. Foss, and Cindy L. Griffin, *Feminist Rhetorical Theories* (17-22) and Patricia Bizzell, "Opportunities for Feminist Research in the History of Rhetoric." A few recent collections that exemplify the diverse and exciting research in this area include Andrea Lundsford's groundbreaking compilation *Reclaiming Rhetorica*, Christine Mason Sutherland and Rebecca Sutcliffe, eds., *The Changing Tradition*, and Molly Wertheimer, ed., *Listening to their Voices*. Joy Ritchie and Kate Ronald's anthology of women's rhetorics likewise offers an important contribution to the recovery of female rhetorical practices and perspectives.

⁵ On this issue, see, for example, Diane Helene Miller, "The Future of Feminist Rhetorical Criticism" (363) and Barbara Biesecker, "Coming to Terms with Recent Attempts to Write Women into the History of Rhetoric" and "Negotiating with Our Tradition."

Although female participation would seem to be a prerequisite for a feminist rhetorical practice, it would be naive to claim that all women's rhetorics or that all research on women's rhetoric is necessarily feminist.⁶ In this case, however, I am exploring whether informed choice in midwifery is a form of women's rhetoric that also could be called feminist. Certainly, for Ontario midwives, the communication principle and practice of informed choice represents one way in which this community of women actively seeks to resist and reconfigure more hierarchical and alienating forms of traditional medical communication. Despite—or perhaps because of—its recent incorporation within the mainstream health-care system, midwifery in Ontario intentionally seeks to articulate alternative ways of providing, and communicating within, maternity care; it employs, to paraphrase Joy Ritchie and Kate Ronald, “different means of persuasion” that may subvert the traditional means and ends of biomedical discourse and, in so doing, contribute to the reinvention of a women-centred rhetoric of maternity care (xvii). Does informed choice, as it is defined in the CMO documents, then, constitute an alternative health-care rhetoric that functions as site of “feminist intervention into biomedical discourse” (Willard 117)? I suggest that there are indeed significant ways in which it does, though, as I discuss in the second half of this paper, the CMO understanding of informed choice likewise has noteworthy limitations.

According to Barbara Willard, informed decision-making is a central feature of the reconfigured relationship between care provider and care receiver⁷ that is at the heart of the

⁶ On this point, see Sutherland (254).

⁷ The terms *caregiver* and *care-receiver* are of course rhetorically inadequate for reinforcing the values of egalitarianism, partnership, and mutuality that Willard proposes, since they imply a kind of sender-receiver relationship. The phrase “participants in the health-care communication situation” might therefore be preferable, but also probably more opaque—and it would not draw our attention to the inadequacies of our common language for identifying the participants in ways that accord with the values that Willard advocates. A similar, more localized problem exists with how to name the participants in the midwifery health-care context: Ontario midwives, in an effort to avoid the connotation of passivity and devaluation that the word “patient” has acquired, have selected the term “client” for referring to women who seek their care. But the use of “client,” which implicitly identifies the

alternative and women's health-care movements: an "egalitarian partnership" based on "mutual respect and understanding," which empowers women to become informed and take control of their own health care (131). These are values that accord with some of the prime features identified by North American feminist rhetorical critics and theorists as alternatives to "traditional ... adversarial, combative, goal-directed, ends-oriented efforts at persuasion" (Foss, Foss, and Griffin 12). For Sonja Foss and Cindy Griffin, feminist rhetoric is "invitational," not coercive or dominating, and is grounded in the principles of equality and self-determination (2); for Patricia Darlington and Becky Mulvaney, a feminist rhetorical practice engenders "reciprocal empowerment," a mode of interaction that simultaneously affirms the "personal authority" or agency of the speaker and seeks to support or empower the "other" (140); for Cheris Kramarae, the study of women's rhetorics provides the grounds for developing a feminist rhetorical theory that values interconnection, trust, mutuality, and equal access to information (Foss, Foss, and Griffin 48).

In what ways, then, does the Ontario model of informed choice in midwifery communication represent a "different" means of women's rhetoric that simultaneously resists and reconfigures traditional or dominant forms of biomedical rhetoric? Can we say that, within the field of health-care communication, it constitutes a rhetorical practice that, at least potentially, enacts the kinds of feminist values suggested by the growing research on women's rhetoric and the re-envisioning of rhetorical theory that is emerging out of this research? In particular, what do the CMO policies on informed choice suggest about how we can reconceptualize the relationship between rhetor and audience in the health-care context and the knowledges generated through this relationship?

midwife as the "professional" in the situation—with all the attendant cultural prestige that this term connotes—is likewise somewhat problematic. My own preference is to refer to the midwife as the "midwife" and to the woman as the "woman" or as the "expectant mother."

The status of “informed choice” as a motivating god-term for Ontario midwifery is apparent both in its “intensity” and its “frequency” (Foss 73) within the CMO documents: not only does the phrase occur frequently in CMO policies other than the “Informed Choice Standard,” but it also possesses significant intensity because of its status as one of the three fundamental principles for the Ontario model of midwifery care (the other two being “continuity of care” and “choice of birthplace”). The sheer repetition of the phrase “informed choice,” combined with its presentation as a central principle of midwifery care give it, as Chaim Perelman and Lucie Olbrechts-Tyteca would say, a definite rhetorical “presence” (174-76) in the CMO’s policies.

Even though the CMO documents never use the terms “feminist” or “rhetorical” in their descriptions of informed choice, the language of at least some of the policies does indeed invoke an alternative, empowering, women-centred approach to maternity care. The midwifery understanding of informed *choice* explicitly contrasts the mainstream medical concept of informed *consent*: the term *choice* suggests the power or opportunity to choose actively among alternatives, whereas the term *consent* implies a more passive compliance with direction provided by a higher authority. According to Farah Shroff, within Canadian midwifery, “[t]he goal of informed choice ensures that midwives provide birthing women with comprehensive information about their care, so that *they* may be the primary decision makers during the course of their midwifery care” (18). This, she argues, “is in direct contrast to informed consent which is, at least in practice, legal protection for physicians” (18). The midwifery view of informed choice goes beyond a mainstream understanding by including explicit support for women’s right to be informed and to control their health care, as well as by valuing a more diverse, less hegemonic approach to the kinds of information and choices explored through the health-care

relationship. It also, in some respects, advocates a more interactive, reciprocal approach to communicating information than is typical in mainstream contexts.⁸

Consonant with the feminist ideals of the women's health-care movement, the CMO's "Informed Choice Standard" begins by asserting women's right to be informed and to be active participants in their health care: "Women have the *right to receive* information and be *involved* in the decision making process throughout their midwifery care" (2; my emphasis). This statement suggests some of the complex set of values and assumptions at work in Ontario midwifery's definition of informed choice: drawing on a discourse of women's rights, it emphasizes the goal of women becoming active agents (i.e., they are "involved").⁹ The value of women as agents in their own health care is further reinforced by the statement that "Midwives encourage and give guidance to clients wishing to seek out resources to assist them in the decision making process" (2). Notably, this second statement suggests that women do not simply receive information from midwives; they are also active, self-motivated seekers of resources. The ultimate purpose of informed choice further supports an ideology of self-determination because it is supposed to help women act as "primary decision-makers" (CMO, "Informed" 1) in their own health care.

The "Informed Choice Standard" continues by explaining that "[i]t is the responsibility of the midwife to facilitate the ongoing exchange of current knowledge in a non-authoritarian and co-operative manner, including sharing what is known and unknown about procedures, tests, and medications" (2). In this passage, terms used to characterize the process of informed choice, such

⁸ We should also note how Shroff's phrase, "midwives provide birthing women with comprehensive information," largely replicates rather than questions a unidirectional model of communication that grants epistemological privilege to the care(information)-provider. The persistence of this model is discussed below.

⁹ The wording of course also asserts the unidirectional view of communication (i.e., women "receive" information), demonstrating the complex problem of negotiating between midwifery's reciprocal and interactive philosophies and the medical establishment's hierarchical mindset. This problem is further developed in the second half of this paper.

as “facilitate,” “exchange,” “non-authoritarian,” “co-operative,” and “sharing,” resonate with feminist values of egalitarian relationships, non-coercive communication, and equal access to information.

Additionally, the explicit guideline that “current knowledge” should include both what is “known and unknown” indicates a subversive rhetorical strategy: midwives are expected not only to communicate what is easily accepted within the standard biomedical frame of reference, but also to share other types of research and evidence that may not fit within this frame, research and evidence that midwives themselves draw on to support their alternative approaches to maternity care—such as, for example, sharing information concerning the risks of hospital birth and the safety of home birth. Likewise, by highlighting what is “unknown” as well as what is “known,” midwives potentially call into question the authoritative certainty of medico-scientific knowledge, encouraging women to think critically about the maternity care information they receive and assumptions they may hold before making decisions about their own situations.

If the kinds of information that midwives give women access to exceeds the medical frame, then so do the choices that they offer to women, as my own experience attests. Most notably, the choice to give birth at home is one that redefines and subverts the dominant medical discourse of hospital-based childbirth—and it is the choice that the medical community has most strenuously resisted in accepting midwifery as a regulated form of health care. But midwives also resist and reconfigure standard medical “options” in subtler ways: for example, by explaining to women the chain of potential physical and ethical consequences that may stem from having a routine blood test in the early stages of pregnancy to assess risk for fetal abnormalities, or by explaining that virtually no research has been conducted on the possible harmful effects of ultrasound, or by offering fathers the opportunity to “catch” their babies as

they are born.

Perhaps most importantly from a rhetorical perspective, the language of the CMO descriptions of informed choice indicates a more reciprocal, egalitarian, two-way process of communication. Terms such as “interactive,” “cooperative,” “non-authoritarian,” “share,” and “exchange” suggest a dynamic, mutually respectful conversation between participants in the health-care context rather than simply a one-way transmission of information from the expert sender to the uninformed receiver. In significant, if not all, ways, the CMO guidelines characterize informed choice as a rhetorical process through which midwives facilitate, encourage, and support women to become more active and knowledgeable participants in the caregiving process. In ideal terms, the process of informed choice both presupposes and supports the rhetorical agency of women as well as midwives in the health-care encounter. At least potentially, then, this model of informed choice suggests the possibility that it can foster a kind of “reciprocal empowerment” (Darlington and Mulvaney) between midwives and childbearing women: an interaction of mutual engagement that simultaneously affirms the “personal authority” or agency of the rhetor and seeks to empower the other to become, likewise, an agent in the rhetorical exchange and the health-care process. In these ways, I think it is fair to say that the CMO definition of informed choice offers an important alternative to mainstream models of communication in health care, models that tend to have a much more consistently limited conception of informed choice as simply the transmission of information from the professional (the informed sender-speaker) to the patient (the uninformed recipient-audience).

However, for all that Ontario midwifery does, in very real and important ways, constitute an alternative, women-centred form of health care, it is also now part of the system that it formerly resisted. The regulatory documents that describe midwifery’s approach to informed

choice are precisely those that play a central role in negotiating midwifery's new status as part of the health-care system. It is no surprise, therefore, to see within the language and rhetorical contexts of these documents tensions and ambiguities, limits as well as possibilities for conceiving informed choice as a feminist rhetorical practice. As Ritchie and Ronald note, "one of the basic *topoi* of women's rhetorics ... might be said to include accommodation and subversion working together" (Introduction xxiv). Within the feminist rhetorical project, exploring this complex, ambiguous *topoi* foregrounds the importance of engaging in the critique of dominant rhetorics alongside the recuperation and revalidation of women's voices. Susan Jarratt reminds us that "[i]f the Western intellectual tradition is not only a product of men, but constituted by masculinity, then transformation comes not only from women finding women authors [rhetors] but also from a gendered rereading of that masculine rhetoric" (2).¹⁰

In the context of this study of women's rhetoric, we should then ask to what extent midwifery's understanding of informed choice, as articulated within the CMO's policy documents, accommodates while also subverting or challenging mainstream/malestream health-care values and ideologies? Specifically, to what extent is the feminist rhetorical practice of informed choice destabilized and potentially undermined by two dominant, interrelated discourses—namely, a medico-scientific discourse and a neo-liberal consumerist discourse—circulating within the broader health-care culture in contemporary Western society? These are large questions that deserve extensive replies; in the remainder of this short paper, I will attempt only to provide a preliminary groundwork as the basis for fuller analysis and discussion.

¹⁰ On the importance of engaging in a critique of the gendered nature of dominant, traditional rhetorical frameworks, see also Miller, and Biesecker, "Coming to Terms" and "Negotiating with Our Tradition."

Challenge I: Medico-Scientific Ideology and Discourse

As feminist philosophers have pointed out, the dominant Western ideal of knowledge-making privileges a rational, disengaged, masculine knower who uses an ostensibly value-free scientific-analytic methodology to produce objective, universal knowledge.¹¹ According to philosopher Lorraine Code, “[i]mplicit in the veneration of objectivity central to *scientific* practice is the conviction that objects of knowledge are separate from knowers and investigators and that they remain separate and unchanged throughout investigative, information-gathering, and knowledge-construction processes” (31-32). This epistemology is problematic because it denies its own situated interests, emotional engagements, and intersubjective nature, and because it marginalizes and invalidates alternative modes of knowledge-making such as embodied, experiential, spiritual, emotional, intuitive, anecdotal, and environmental knowledges.

In the context of a reductive, mainstream conception of informed choice, the problems of this kind of ideology/epistemology appear in the following assumptions: 1. The model assumes that the information that the health-care provider conveys to the patient is scientifically objective and value-free, derived from a biomedical model of what counts as real knowledge or information. 2. It presumes a sender-receiver, transmission model of communication in which the information or knowledge being conveyed exists objectively apart from the people participating in the communicative situation. 3. It assumes that once the patient has received this information, he or she is then adequately prepared to make a rational, autonomous informed choice about his or her course of care.

From a rhetorical perspective—let alone a *feminist* rhetorical perspective—these assumptions are highly problematic. It is possible, as I have just argued, to interpret the CMO

¹¹ See for example the work of feminist philosophers and theorists such as Lorraine Code, Donna Haraway, Alison Jaggar, Genevieve Lloyd, and Margrit Shildrick.

“Informed Choice Standard” as countering or at least calling into question some of these assumptions. At the same time, however, the language of this policy document reveals points of ambiguity, moments of uneasy accommodation between a feminist rhetoric/epistemology of informed choice and a scientific, biomedical one.

This occurs both in how the policy characterizes the nature of the information being communicated and in the action of communicating it. For example, although the CMO guidelines imply that midwives should provide women with “current knowledge” that exceeds (and hence conceivably subverts) the boundaries of mainstream medical knowledge, the specific mention of providing information about “procedures, tests and medications” suggests that these medical subjects nonetheless should form the main focus of the informed choice process—rather than a diverse range of embodied, experiential, spiritual, emotional, intuitive, anecdotal, and environmental knowledges.

Similarly, the communicative actions of “exchange” and “sharing” seem nicely attuned to a feminist perspective on the speaker-audience relationship, suggesting that midwives and women are engaged together in a reciprocal, egalitarian communicative process. However, the statement that “Women have the right to *receive* information” (CMO, “Informed” 1)—while it does, importantly, assert the need for information not to be withheld from women—reinforces the mainstream transmission model of communication: the position of the expectant mother is to receive information from the knowledgeable midwife. If the term “receive” suggests a unidirectional model of communication, then it is also possible to interpret the terms “exchange” and “sharing” from this perspective: that is, midwives are experts who share or exchange the information they possess with women who lack this information. In other words, these apparently feminist rhetorical terms do not necessarily indicate that informed choice is a process

of “reciprocal empowerment,” one that encourages expectant mothers to share or exchange their own different knowledges with their midwives in a mutually engaging and responsive fashion. The coexistence of the term “receive” with words such as “sharing” and “exchange” raises the question of whether the CMO guidelines conceive the midwifery process of informed choice as potentially recreating the knowledges of both expectant mothers and midwives through the cooperative sharing of the situated, diverse knowledges of both participants in the rhetorical exchange, or are more typically and conservatively talking about giving women the information that midwives possess in order that women may then make ostensibly rational, autonomous choices about their courses of care?

The medico-scientific challenge to a feminist rhetorical ideal of informed choice appears even more strongly when considering how other CMO policies indirectly address—and diminish—the midwifery definition of informed choice. Thus, for example, in an important document entitled “Indications for Mandatory Discussion, Consultation and Transfer of Care,” the informed-choice objective of ensuring that the expectant mother acts as the primary decision-maker in her course of care becomes attenuated, displaced by an initial assertion of the midwife’s primary role in the decision-making process: “As primary caregiver, *the midwife* together with the client *is fully responsible* for decision-making” (College, “Indications” 1; my emphasis). In this opening sentence, the midwife functions as the main actor while the client is subordinated to a secondary role: not only is the client positioned after the midwife almost as a kind of parenthetical accompaniment in the subject clause, but the singular verb “is” reinforces the view that it is really the midwife, not the midwife and the client together, who makes the decisions.

In the context of this document, such an assertion of the midwife’s role has important rhetorical functions. The “Indications” policy, which outlines how and when midwives are

required to consult with physicians concerning the women for whom they care, represents a key site of negotiation between the newly regulated profession of midwifery and the established medical profession. As such, midwives must unambiguously demarcate their own status as primary caregivers while simultaneously reassuring the medical profession that they are prepared to work within at least some of its terms.

For midwives, the rhetorical context of regulation within the main, medically dominated health-care system necessarily constrains the degree to which midwifery's alternative, women-centred ideals may operate. As a result, the rhetorical process and caregiving relationship of informed choice articulated elsewhere in the CMO policies is diminished and even undermined by this document. Rather than characterizing the midwife and the expectant mother as active, cooperative participants in the caregiving process, the CMO policy constructs the midwife's job—in traditional nominalized medico-scientific language—as the “detection of an indication for consultation” in her passive female subject (“Indications” 1). Following consultation with medical authority, the midwife is expected to plan with the physician (and without the expectant mother's direct participation) an appropriate course of care for her “client” (“Indications” 2). The “Indications” policy demonstrates how, for midwives and the women for whom they care, the exigencies of an established medical discourse, values, and epistemic framework curtail—but do not wholly obstruct—the available means for recreating a different language and practice of maternity care.

Challenge II: Consumerist Ideology and Discourse

The overt and implied links between informed choice and health-care consumerism further challenge the claim that informed choice in midwifery constitutes a feminist rhetorical practice.

Since the beginning of the lobbying efforts to have midwifery become a regulated health-care profession in Ontario, health-care consumerism and its key value of “choice” have formed an important motivating context. In the 1980s prior to regulation, midwives and self-proclaimed midwifery “consumers” drew heavily on the premise that, as health-care consumers, women have the right to *choose* midwives as their caregivers. For example, the Midwifery Task Force of Ontario—a well-educated, articulate group of midwifery consumers—argued that in selecting midwifery care, they had made “responsible decisions and informed choices” (6), and they warned that should the government *not* regulate midwifery as an autonomous health-care profession, “an underground midwifery system that remains *responsive to consumer needs* would [continue to] develop” (8; my emphasis).

To the extent that the discourse of consumerism emphasizes women’s health-care rights and needs concerning pregnancy and birth, it appears consonant with a feminist approach, in particular the liberal feminist values of self-determination and individual empowerment; and to the extent that informed choice counters the abuses of a paternalistic medical system in which, as Richard Gwyn explains, health-care experts make decisions for their patients based on what they consider to be in the patient’s best interests (79), it certainly represents a significant movement in the direction of granting women greater freedom of choice and control over their reproductive lives. As some feminist and health-care critics point out, however, both “consumer” and “choice” have become problematic terms on which to base an empowering, women-centred model of health care. To the extent that informed choice participates in a mainstream consumerist culture of choice, these criticisms indicate the possible limits of informed choice as a feminist rhetorical practice in midwifery.

One of the problems with engaging in a discourse of “rights,” “choice,” and “control” in

the context of midwifery care is that, as Nadine Pilley Edwards points out, it “leaves little space for negotiation and relational decision-making in which control can be relinquished” (14). We can see this tension between a rights/choice discourse of individual self-determination and a rhetoric of relational, mutually engaging decision-making in the CMO “Informed Choice Standard,” where references to the childbearing woman’s “right to information” and role as “primary decision-maker” occur alongside terms that emphasize the enabling relational dimensions of the informed-choice interaction: “shared responsibility,” “interactive process,” “encourage,” “assist,” “facilitate,” “exchange,” “non-authoritarian,” “co-operative.” A rights-based discourse of choice implies an adversarial environment in which the appeal to “rights” functions as the premise for making a “choice” that conflicts with the recommended course of action. Pilley notes how, among the British women she studied, “while some ... felt that knowing their rights was of some benefit, appealing to these was a far cry from the supportive relationships they felt they needed [with their midwives]” (16).

If not conflict and adversity, a consumerist discourse of informed choice at the very least risks stressing the rhetorical distance and disengagement, rather than proximity and engagement, between caregiver and care-receiver. According to nursing philosopher Sally Gadow, “the hallmark of consumerism is indifference to outcome. In health care this is expressed as professional disappearance from clinical decision making. As moral agents, professionals cease to exist; they function only as adjuncts to patient autonomy. Patients too disappear, to reappear as consumers” (35). In relation to informed choice, this “disappearance” of the caregiver from decision-making is associated with the assumption that the responsibility of the health-care professional is to convey information to the patient who will then be enabled to make an autonomous decision. The duty of the professional is to be non-directive so that the patient’s

choice remains (ostensibly) truly autonomous. This consumerist perspective on patient autonomy and non-interference in decision-making by the health-care provider contrasts—and I think undermines—the midwifery values of partnership, exchange, and shared decision-making that the informed choice policies articulate, as well as the feminist rhetorical values of interconnection, mutuality, and reciprocal empowerment.

The association of informed choice with patient autonomy and self-determination appears based on a mainstream bioethical version of autonomous decision-making that presupposes, according to feminist ethicist Susan Sherwin, “articulate, intelligent patients who are accustomed to making decisions about the courses of their lives and who possess the resources necessary to allow them a range of options to choose among” (24). While this description may apply to many women being cared for by midwives—especially those who worked hard for midwifery to become a self-regulating, autonomous health-care profession—it may not sufficiently address the increasing diversity of women, and in particular of their socio-cultural identities and locations, for whom regulated midwives care. The standard bioethical concept of autonomous decision-making may not adequately account for the complex realities and needs of women living in diverse social, cultural, economic, and political situations. It certainly does not acknowledge that any attempt to facilitate informed choice necessarily engages midwives and expectant mothers as rhetorical agents in a dynamic, intersubjective communicative exchange.

Abby Lippman likewise points out that, although “choice” has functioned as a key principle of the women’s health-care movement, the consumerist discourse in which it is increasingly embedded “encourages and reflects an atomised, individualised view of social life, a society in which private citizens are presumed to act alone and only in their best interests” (283). Framing choice in terms of individual consumers ignores how women’s lives are fabricated

through intricate, interdependent social webs (283). It is noteworthy that the CMO “Midwifery Model of Practice” emphasizes that the principle of informed choice supports decision-making as a “shared responsibility between the woman, her family (as defined by the woman) and her caregivers” (CMO, “Midwifery” 5). At the same time, though, this nod toward the intricate, interdependent social webs of women’s lives exists in tension with commonplace, neo-liberal assumptions about the value of (ostensibly) individual, autonomous decision-making.

Further, Sherwin, Lippman, and Judy Rebeck all critique the rhetoric of individual choice for fostering illusions about the degree of power and control that women really have in a health-care situation and for obfuscating rather than dismantling social inequities (Sherwin 28). In Lippman’s assessment, the kind of individualism fostered by the ideology of consumer choice “hides the social conditions that produce ill health” and it masks “the operations of power that construct choices” (285). Rebeck concurs, noting how “the idea that individual choice is the most important social value is not particularly feminist. In fact, in a society of unequal power, an emphasis on individual choice alone usually gives those with power the only real choices” (88). Although these critiques are not directed at the rhetorical and ideological function of “choice” in midwifery caregiving specifically, they are—at least for Lippman and Rebeck—aimed at re-evaluating the appropriateness of this god-term for the women’s health-care movement, given the term’s increasing currency within mainstream health-care consumerism. They suggest that this currency that may not, in fact, support feminist ideals of caregiving and health-care communication.

For midwives, the views of another Canadian midwife may provide the most compelling argument for engaging in a careful consideration of the potentially problematic as well as positive meanings of informed choice for its alternative, women-centred ideal of caregiving and

communication—an ideal that must be negotiated within and is necessarily affected by dominant health-care discourses. Cautioning that the incorporation of midwifery within mainstream health care threatens its emancipatory agenda because of the dominant consumerist, neo-liberal discourse of choice, Quebec midwife Céline Lemay urges midwives to actively resist this normative discourse by giving voice to “la voix du ‘féminin’ chez les sages-femmes, celle qui n’a pas peur de ne pas être en accord avec l’établissement car le manque de conscience des idéologies en jeu et le manque de courage pourra faire alors du choix un simple instrument du maintien du statu quo” (39). In effect, Lemay is inviting midwives to continue to resist and subvert—rather than uncritically accommodate—the mainstream rhetoric of choice through the self-critical practice of a women-centred and feminist rhetoric that is not afraid to challenge normative discourse and values.

Conclusion

A feminist rhetorical perspective on informed choice in midwifery creates space, I believe, for understanding the midwifery approach as a meaningful alternative to mainstream models of health-care communication. In the context of the growing research on women’s rhetorics and the concomitant development of feminist rhetorical theories, the midwifery communication model of informed choice functions as a significant example of an explicitly women-centred mode of discourse grounded in such feminist values as egalitarian partnership, mutual respect and understanding, invitational rather than coercive communication, reciprocal empowerment, interconnection, trust, and equal access to information. Unlike studies of the rhetorical achievements of individual female rhetors, exploring the midwifery model of informed choice means exploring a rhetorical practice that both emerges from and structures a whole community.

It exemplifies a mode of female rhetoric that does not simply demonstrate the value of women's communication approaches within the existing standards of 'successful' health-care rhetoric, but one that potentially reconfigures health-care rhetoric (and specifically the rhetorical practices of informed choice) at an institutional, systemic level. In this sense, it can be viewed as a form of collective female communication that helps to "reconceptualize and reconstruct rhetorical concepts and theories that contribute to the ideology of domination" (Foss, Foss, and Griffin 28).

At the same time, however, it is important to explore the epistemological and ideological constraints that necessarily structure midwifery's policies on informed choice. These constraints, I suggest, arise both from midwifery's position as a newly regulated profession within the dominant health-care system and its attendant medico-scientific discourse, as well as from the problematic intersection of the (liberal) feminist values of individual "choice" and "autonomy" or "self-determination" with a neo-liberal consumerist rhetoric of health care. Attending to these constraints reveals how the CMO policies function as complex, heterogeneous boundary texts that simultaneously subvert and accommodate dominant discourses and ideologies of health care. Appreciating midwifery's "different means of persuasion" means likewise understanding the terms of the established, masculinist discourses within and against which this alternative, feminist rhetoric must be negotiated.

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