RECALLING OUR SOCIAL MOVEMENT ORIGINS: DIVERSITY AND THE SHIFTING PRACTICE OF CONTEMPORARY MIDWIFERY IN B.C.

-AND-

REPRESENTING GARDASIL: A CLOSE TEXTUAL ANALYSIS OF PRINT ADVERTISEMENTS FOR THE VACCINE GARDASIL

by

Lisa Michelle Weeks
Bachelor of Arts, University of Victoria, 2005

EXTENDED ESSAYS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

In the
Faculty of Arts & Social Sciences
Department of Women's Studies

© Lisa Michelle Weeks 2008

SIMON FRASER UNIVERSITY

Summer 2008

All rights reserved. This work may not be reproduced in whole or in part, by photocopy or other means, without permission of the author.
APPROVAL

Name: Lisa Michelle Weeks
Degree: Master of Arts
Title of Extended Essays: Recalling Our Social Movement Origins: Diversity and the Shifting Practice of Contemporary Midwifery in B.C. and Representing Gardasil: A Close Textual Analysis of Print Advertisements for the Vaccine Gardasil

Examining Committee:
Chair: Dr. Marilyn MacDonald
Assistant Professor, Department of Women’s Studies

Dr. Cynthia Patton
Senior Supervisor
Professor, Sociology/Anthropology and Women’s Studies

Dr. Brian Burtch
Supervisor
Professor, School of Criminology

Dr. Lara Campbell
Internal Examiner
Assistant Professor, Department of Women’s Studies

Date Defended/Approved: June 17, 2008
Declaration of Partial Copyright Licence

The author, whose copyright is declared on the title page of this work, has granted to Simon Fraser University the right to lend this thesis, project or extended essay to users of the Simon Fraser University Library, and to make partial or single copies only for such users or in response to a request from the library of any other university, or other educational institution, on its own behalf or for one of its users.

The author has further granted permission to Simon Fraser University to keep or make a digital copy for use in its circulating collection (currently available to the public at the “Institutional Repository” link of the SFU Library website <www.lib.sfu.ca> at: <http://ir.lib.sfu.ca/handle/1892/112>) and, without changing the content, to translate the thesis/project or extended essays, if technically possible, to any medium or format for the purpose of preservation of the digital work.

The author has further agreed that permission for multiple copying of this work for scholarly purposes may be granted by either the author or the Dean of Graduate Studies.

It is understood that copying or publication of this work for financial gain shall not be allowed without the author’s written permission.

Permission for public performance, or limited permission for private scholarly use, of any multimedia materials forming part of this work, may have been granted by the author. This information may be found on the separately catalogued multimedia material and in the signed Partial Copyright Licence.

While licensing SFU to permit the above uses, the author retains copyright in the thesis, project or extended essays, including the right to change the work for subsequent purposes, including editing and publishing the work in whole or in part, and licensing other parties, as the author may desire.

The original Partial Copyright Licence attesting to these terms, and signed by this author, may be found in the original bound copy of this work, retained in the Simon Fraser University Archive.

Simon Fraser University Library
Burnaby, BC, Canada

Revised: Fall 2007
ABSTRACT

Paying particular attention to the context of British Columbia I outline some transformations in midwifery practice in recent decades and highlight emerging challenges as midwifery shifts from a grassroots lay practice to a mainstream profession. With a focus on the social movement context of the origins of contemporary midwifery practice, I argue that the present midwifery system does not adequately contend with the diversity of birthing women’s interests.

A close textual analysis of Gardasil print advertisements, found in North American medical association journals and fashion magazines, serves as an entry point for understanding some of the social values and assumptions at play in the representation of the vaccine Gardasil as a “cure for cancer.” I pay particular attention to how visual imagery, semantic relations, and hyponymy work to produce distinct representations of the world that simultaneously emerge out of and are immersed within discourses of health, disease, morality, and protection.
ACKNOWLEDGEMENTS

I am grateful to Dr. Cindy Patton and Dr. Brian Burtch for their assistance and thoughtful attention throughout the process of my degree and to Dr. Lara Campbell for her insightful contributions to my defence. I also thank Helèn Kang for her encouragement, Brian Richter for his diligent moral and technical support, and my parents for always being proud of me.
# TABLE OF CONTENTS

Approval ........................................................................................................................................... ii  
Abstract .......................................................................................................................................... iii  
Acknowledgements ....................................................................................................................... iv  
Table of Contents ........................................................................................................................... v

## 1: Recalling our social movement origins: Diversity and the shifting practice
   of Contemporary midwifery in B.C. ......................................................................................... 1
   Introduction ............................................................................................................................... 2  
   A Social Movement Context .................................................................................................... 5  
   Situating Contemporary Practices of Midwifery in B.C. ..................................................... 12  
   The Challenge of Incorporating Diversity .......................................................................... 19  
   Unintended Consequences and Future Considerations ..................................................... 32  
   Bibliography ............................................................................................................................ 36

## 2: Representing Gardasil: A Close Textual Analysis of Print
   Advertisements for the Vaccine Gardasil ........................................................................... 40
   Introduction ............................................................................................................................... 41  
   A Framework for Contextualizing Gardasil ......................................................................... 43  
   What is Gardasil and Where Did it Come From? ................................................................. 45  
   Gardasil: It’s About Cancer, not a Sexually Transmitted Infection .................................. 50  
   The Rhetoric of “Protection” ................................................................................................. 53  
   What About the Science? ....................................................................................................... 56  
   Concluding Concerns ............................................................................................................ 61  
   Bibliography ............................................................................................................................ 63
1: RECALLING OUR SOCIAL MOVEMENT ORIGINS: DIVERSITY AND THE SHIFTING PRACTICE OF CONTEMPORARY MIDWIFERY IN B.C.
Introduction
The origins of social change are often hard to locate. We may be tempted to link sequences of events together, neatly, as if they unfolded purposefully, one into the other, until we reach the present. This propensity for narration masks the sense in which it always might have been otherwise. When we connect stories from the past with present circumstances we often draw on a sense of certainty about the flow of events that diminishes the complex intermingling of factors that coalesce in the multifarious processes of social change.

The following quote marks a beginning in the context of midwifery practice and midwifery politics in British Columbia (B.C.): specifically, the origin of one woman’s career as a midwife, told at the watershed 1980 Midwifery is a Labour of Love Conference in Vancouver, years before many midwives in her community imagined themselves to have professional careers.

And people came to me and they said, ‘Luba, we’re going to have our baby at home alone, but we were wondering since you’ve had a baby at home, if you would come, just to be there because you know more than we do, even having been at one. And so I said, ‘Sure, great, wonderful, I’d love to come to another birth.’ And that’s how it began. (Lyons 1981, 3)

At the time, Luba Lyons was a lay midwife articulating her experiences of practicing midwifery in the context of advocating for midwifery legislation in B.C. By lay midwife I mean that Lyons was an apprentice-trained midwife who received her midwifery training outside of formal institutions and who practiced without accreditation. In her impassioned account of the terrain of lay midwifery in the province, she recounts her own experiences of birthing, and details her struggle to learn how to access the information in
texts like *William's Obstetrics* and *Myles' Textbook for Midwives*. She also traces her community's approach to learning midwifery through collective prenatal clinics, initiating classes led by experienced midwives from other communities, and sharing stories over time.

In the 28 years since this inspirational account was presented to a crowd of midwives, mothers, politicians, and midwifery supporters, Luba Lyons Richardson has carved out a very successful career for herself as a professional midwife. Richardson is now a licensed midwife registered in both Washington state and B.C., president of the College of Midwives of BC since its inception in 1995, and Head of the Midwifery Department in Victoria (Victoria Midwifery Group 2008). My point in borrowing from Luba Lyons Richardson's story to introduce the subject of midwifery practice in B.C. is twofold: first, it illustrates nicely the trajectories of contemporary midwifery practice; and second, it draws our attention to challenges that arise when the practice of midwifery shifts from a marginalized, lay status to an established health care profession.

Complex issues emerge when one begins to investigate the evolution of the practice of midwifery within B.C. There are inevitably positive and negative aspects to any regulated sphere of activity, and for many midwifery supporters, it becomes increasingly difficult to unequivocally favour or oppose the development of a regulated form of midwifery. For example, some midwifery supporters embrace the sense of safety gained from the notion of accountability that comes with regulated parameters of care whereby standards establish what is 'normal' based on data drawn from populations of birthing women, guidelines outline how a given situation ought to be responded to, and practitioners are held accountable by professional and regulatory bodies. The detriment,
it seems, is to the possibility of approaching each pregnancy, especially those just slightly outside the bounds of “normal”, as a unique event where flexible parameters of care can be drawn based on a guided attentiveness to the particularities of each individual pregnancy. This is just one instance of the sorts of balances that midwives, birthing women and midwifery supporters weigh as the practice of midwifery shifts within contemporary society.

Given the dynamic status of midwifery practice in recent decades it is important to continually evaluate whether the things we thought were crucial remain benign and progressive once implemented. Equally important, is the need to examine whether midwifery’s transformations engender new sites of concern to contend with as part of a committed intention to realize the best possible situation for birthing women in the province. In the following pages I outline some transformations in midwifery practice in recent decades, and highlight emerging challenges as midwifery shifts from a grassroots lay practice to a mainstream profession. I argue that the present midwifery system does not adequately contend with the diversity of birthing women’s interests, and has the unintended consequence of jeopardizing our collective ability to confront and challenge a seemingly continuous “cascade” of medical “interventions” into childbirth (Kitzinger 1992).
A Social Movement Context

Present forms of legislated midwifery in North America find their roots in the social movement context of the late 1960’s and early 1970’s. The shifting status of midwifery practice is generally characterized as evolving out of a social movement narrative along a fairly linear trajectory from a marginal, even illegal or alegal (i.e. where its legal status is uncertain and not clearly criminal) status, toward a professionalized end where midwives practice openly and often within the medical infrastructure. The impetus for midwifery legislation is often connected to the wider alternative birth movement (ABM) that coalesced with other phenomena like the civil rights movement, women’s movement, environmentalism, and anti-war movements as just one of the many threads weaving together to create the social fabric of the time.

In her influential book *Justice and the Politics of Difference*, political philosopher, Iris Marion Young attends to the distance between claims about social justice being made by new social movement groups of the late 1960’s and 1970’s and claims about justice available from contemporary political and philosophical theories. Specifically, Young rejects the abstracted positivist stance of established theories of justice and embraces the normative ideals of critical theory to critique the material focus of the distributive justice paradigm and argue for a concept of justice based in notions of oppression and domination. For Young, the starting point for theories of justice ought to be the socially situated instances of oppression or domination that compel a desire to realize new possibilities, and not “a position outside social life that rests on reason” (1990, 4). Tending to issues of injustice like “power” or “opportunity” in a paradigm conceived with relations proper to material goods in mind “obsures” crucial sites of
oppression and domination that are better attended to with more “process-oriented” or
“relational” frameworks (Young 1990, 8). Young’s analysis calls for theories of justice
that move beyond a distributive paradigm to incorporate everyday practices like:
“decision-making procedures, the social division of labour, and culture” (1990, 9).

Young borrows from post-modern thinkers to unsettle the “denial of difference”
embedded in Western reason and articulate a “politics that attends to rather than represses
difference” (1990, 7). Young posits this “denial of difference” as an important factor in
the oppression of social groups, and articulates a concept of the social group that
disembarks from prior ontological assumptions of atomistic individuals to conceive of the
social group as “socially prior to the individual” (Young 1990, 9). The identities of
individuals are thus partially constituted by their affinity with members of social groups.
Even as social groups are fluid and shifting, they are always distinguished by their
differences. Young also outlines a concept of oppression and conveys the way social
movement activists of the 1960s and 1970s understood oppression as marking a shift
from traditional notions of a coercive or “tyrannical power” emanating from the few, to
include also the structural and cultural assumptions and norms that instruct people’s
actions in everyday, ordinary life in “well-intentioned liberal society” (Young 1990, 41).
Not all social groups are oppressed, and Young employs these concepts to show how
political theory and practice work to “universalize dominant group perspectives” and
perpetuate what she calls “cultural imperialism” (Young 1990, 165).

Young argues for a “heterogeneous public that acknowledges and affirms groups
of difference” as a means of circumventing universalizing tendencies, averting cultural
imperialism and realizing social justice (1990, 10). The “ideal of impartiality”, adhered
to by most theorists of morality and justice, is one example of how cultural imperialism is perpetuated. By asserting a “standpoint” from which “all moral situations should be treated by the same rules” the difference between subject positions is denied and the experience of the privileged social group is universalized (Young 1990, 10). Advocates of this universalized perspective insist all subjects be interpreted and understood in the terms of the dominant group. This position is reinforced by the universalizing tendency of participatory democratic theory to value “commonness and sameness” over “specificity and difference” (1990, 3) and to thus silence voices that are deemed unworthy or irrelevant. Young articulates how the concept of a “universal and unified polity” has historically worked to “exclude” particular groups from citizenship: notably, those individuals “identified with the body and feeling” (1990, 10). Young also notes the important contribution of contemporary social movements through a sustained effort to “politicize vast areas of institutional, social, and cultural life” that were being “depoliticized” by the “rising tide of welfare state liberalism” (1990, 10). This is an admittedly limited representation of Young’s work, but it does add nuance to our understanding of the context of the social movements of the 1960’s and 1970’s, and draws our attention to some broad cultural assumptions embedded in the structures, institutions, and practices of contemporary society that engendered these new social movements.

Betty-Anne Daviss draws on 25 years of personal experience as a midwife and activist to study the shifting status of midwifery as a central component of the alternative birth movement (ABM). Daviss borrows from classical “strain” theory where the rise of a social movement is explained as a response to a breakdown in society to suggest that
the ABM arose in response to a variety of social, economic, and cultural factors: most notably, as resistance to the medical profession's established cultural and legal authority over childbirth and in protest to increased technological interventions into maternity care (2001). In this context, midwives come to represent the healthcare provider most likely to meet women's desires for woman-centred models of care based in holistic understandings of pregnancy and childbirth, and the attainment of midwifery legislation becomes an expression of the success of these goals as articulated by the ABM (Daviss 2001; Beckett and Hoffman 2005). This point of departure for understanding the complicated interactions that transpire between individuals, groups, and institutions along the way to legislated midwifery serves to contextualize the narrative structure of the shifting status of midwifery, and at the same time to locate a sense of the broad distinctions between medical and midwifery models of care.\footnote{This is not to suggest that in practice midwifery and medical models of care are distinct or mutually exclusive models or that women seek a homogenous notion of midwifery care. Certainly, we could find medically-minded midwives or holistically-inclined medical doctors. There are also a number of studies that illustrate the diverse ways women and midwives navigate and incorporate the domain of medical knowledge into the practice of midwifery (see for example, Margaret MacDonald (2001); Davis-Floyd and Davis (1996); and Klassen (2001)).}

In a later piece, Daviss relates both professionalization theories and social movement theories to the particular circumstances of the ABM as a means of challenging the primacy of professionalization literature in explaining shifts in contemporary midwifery practice (2006). Daviss argues that we might better understand the experiences of North American midwives as an example of how it is that social movement actors gain legitimacy and become institutionalized over time rather than an example of how it is that a professional group comes to gain legitimacy and authority over a particular area of knowledge (2006). In her argument, Daviss links specific
aspects of the ABM to four theories of social movements: classic strain model theory (mentioned above), resource mobilization theory, political process theory and new social movement theories.

Daviss explains that in contrast to classic strain model theory, resource mobilization theorists posit that there are always “breakdowns” within a society, and focus not so much on the circumstances and impetus surrounding a given “breakdown”, but rather the processes and organizations that emerge to foster and facilitate social change (2006, 421). Other authors describe the trajectory of resource mobilization theory as marking a shift away from focusing on the social psychology of collective behaviour toward an emphasis on the political and sociological aspects of understanding social movement actors and organizations (McCarthy and Zald 1977). Similarly, Taylor and Rupp, in their study of the American women’s rights movement, draw on resource mobilization theory as a tool that directs our attention to consider both the “internal dynamics” of how a social movement manages its “human and material resources”, as well as the “outside factors” that work to either “support or constrain” the social movement (1991, 124). Taylor and Rupp describe this as an “open-systems” approach to studying social movements in contrast to more traditional “closed system” approaches whereby social movements are understood to pass through an “evolutionary life cycle” of growth and decline (1991, 124). The authors use resource mobilization theory to argue for the continuity of the women’s rights movement throughout the post-1945 period. Specifically, Taylor and Rupp suggest, that in part, it was the androcentric and “managerial” biases underlying traditional approaches to social movements that led scholars to assume an absence of a women’s rights movement where a resource
mobilization perspective, coupled with feminist sensibilities encourages us to notice a sustained, though small and elite-driven, women’s rights movement across this period (Taylor and Rupp 1990, 122).

In her analysis of the relevance of different aspects of social movement theories to the ABM, Daviss also draws on the work of political process theorists who explain social movements in relation to shifts in opportunities within the political system of a given society. Specifically, social movements are understood as the processes through which broad reaching populations of “previously unmobilized” groups gain access to the political process (2006, 428). Here, Daviss makes a distinction between Canadian and American experiences, and notes the tendency of Canadian feminists of the 1970’s and 1980’s to be more “pro-state” and “politically proactive” in comparison to their American counterparts who relied less on traditional political processes and more on “individual transformations” like “consciousness-raising” groups (2006, 428).

Finally, Daviss draws on the work of Melucci and Touraine to suggest that we might best locate the American ABM within the context of new social movement theory. Here, social movements are understood to arise out of, and organize around “new identities” and “new communities”, and these new sites harbour the potential to transform social relations and move us toward a new “more egalitarian postindustrial society” (Daviss 2006, 434). Steven Buechler, a sociologist who analyses the usefulness of new social movement theories for explaining collective action in contemporary society, summarizes a number of characteristics of new social movement theories and outlines major contributions of new social movement theorists. Buechler stresses that the work that emerged to challenge the then-dominant paradigm of resource mobilization theory
was not a cohesive body of theory, but rather, "many variations on a general approach to something called new social movements" (1995, 442). Some themes that connect social movement theorists beyond their focus on "collective identities" include: an attentiveness to the significance of the "cultural sphere" and "symbolic action"; an emphasis on "postmaterialist values"; attention to processes related to "autonomy" and "self-determination"; acknowledgement of "submerged, latent, and temporary networks" that often play a critical role in the mobilization process; and a recognition of the "social construction" at play in notions of "grievance and ideology" that cannot be explained by a given group's "structural location" alone (Buechler 1995, 442). Buechler outlines major debates and sites of contention in new social movement theory and concludes that the most beneficial contribution of new social movement theory might be achieved when combined with other theoretical frameworks, for "different theories speak most effectively to different levels of analysis" (1995, 460).

In Daviss' account of the relationship between new social movement theory and the ABM she links the role of midwives and midwifery with the work of other social activists and imagines the possibility of "large-scale cultural change" (2006, 435). Daviss' contention is meant to both preserve, and inspire anew, the spirit, ideals, and values of the ABM, and thus challenge the conforming influences that bureaucratic structures and institutions place on the present-day practice of professional midwifery. I introduce Daviss' work because it illustrates nicely how various theories used to explain and understand social movements can be applied to different aspects of the North American ABM. Daviss reminds us that there is almost always more than one way to interpret a social phenomenon and the framework we use will generally only direct our
attention to certain aspects while obscuring others. My intention in drawing on Daviss’ work is not to choose a particular theory and apply it to the phenomenon of legislating midwifery in B.C. as a means of highlighting a particular aspect of that process. Rather, I draw on Daviss’ work for the broader map it sketches of the debates in contemporary studies of midwifery practice between professionalization literature and social movement theories. Like Daviss, I place more emphasis on the social movement context, and less on understanding the particular strategies that professional groups use to articulate their interests. In doing so, I direct my attention toward particular aspects of midwifery practice in B.C. that quite intentionally slant me toward specific kinds of conclusions because, like Daviss, my motivation, in part, is to extend the diversity of interests articulated by the ABM.

**Situating Contemporary Practices of Midwifery in B.C.**

As a means of finding our way toward considering some of the challenges that the shifting practice of midwifery poses for midwives, policy makers, and birthing women it is perhaps useful to create a brief sketch, however inadequate, of some of the historical developments influencing present-day Canadian midwifery practice. The politics of contemporary midwifery are inevitably tied to broad historical shifts in cultural and legal approaches to managing pregnancy and childbirth. These shifts are almost always influenced by broader questions of knowledge, expertise, and legitimacy that are linked to intricate systems of power that often ignite jurisdictional disputes over who has the authority to manage birthing bodies. A detailed analysis of the technological and sociological developments that transformed approaches to managing pregnancy and childbirth throughout centuries is not possible within the page limits of this essay. While
the birth process exists as a biological certainty across time and social space, there are a
two number of distinctions in the cultural, legal, and professional parameters that define
cchildbirth practices, even within a North American context, that make it very difficult to
relate a tidy and generalizable tale about the origins of contemporary midwifery practice.

Midwifery’s position in society is often defined in relationship to an evolving
medical system. As Marland and Rafferty describe it, the history of midwifery often
reads like “a moral fable in which midwives struggle towards, or from, the teleological
goals of the increasing use of technology, the hospital and the professionalization of
childbirth” (1997, 3). In Canada, midwifery’s history is often told as the demise of
midwifery practice facilitated by 19th century developments like the establishment of the
Canada Medical Act, the origins of the present day hospital system, and the technological
inventions that combine to hasten the field of medical expertise and secure the medical
profession’s position as the legal and cultural authority over childbirth (Benoit and
Carroll 2005). The marginal position of midwifery within Canadian society is further
marked by the “dubious distinction” that Canada holds as the last of the “industrialized
nations” to incorporate a place for midwives as legitimate actors within its evolving
health care system (Bourgeault et al 2004, 3). In contrast to the maternity care systems of
nations like England, France, and Sweden, it was not until the 1990’s that Canadian
midwives began to garner legal recognition and professional status as healthcare
practitioners. Today, the majority of Canadian jurisdictions have some form of
midwifery legislation in place\(^2\) and while the particular form and scope of practice varies from province to province, the Canadian experience is often related as a general success story for the integration of the autonomous profession of midwifery into an already existing system of healthcare professionals (Bourgeault et al 2004; Davis-Floyd and Johnson 2006).

Finally, this brief outline of Canadian midwifery practice would be incomplete without a mention of lay midwives and private birth attendants who continue to practice in various communities either without or against legislation, as well as the small, but relevant, number of women who choose to birth unassisted\(^3\). The tendency to treat some midwives as outcasts in the face of the shifting status of midwifery is interpreted by Daviss as a strategy used by professionalizing midwives to distance themselves from those “rabble-rousing, anti-establishment, irreverent midwives of questionable integrity and training” (2006, 422). Similarly, Robbie Davis-Floyd, a cultural anthropologist, uses the term “renegade midwife” to distinguish “plain midwives”, who reject any form of licensure in favour of remaining outside the system to optimize their autonomy and allow the women they serve to dictate their own terms of care, from professionalizing midwives, who operate within the system where regulations guide parameters of practice and ensure systems of accountability (2006, 455). For Davis-Floyd, all midwives, to some extent, are “renegades” in the sense that wherever they practice, midwives present a

---

\(^2\) The first legislated, publicly-funded Canadian midwifery practice began in Ontario on January 1, 1994. Other provinces, like British Columbia in 1998, have followed the model set out in Ontario to establish the bureaucratic structures necessary to support a publicly funded, legislated midwifery practice within the provincial healthcare system. As of August 2007, Ontario, British Columbia, Manitoba, Alberta, Quebec, and the Northwest Territories all have some form of regulated midwifery in place. Jurisdictions like Saskatchewan, New Brunswick, Nova Scotia, and Nunavut have instigated legislation but it is yet to be implemented. Areas where no formal regulation is in place include Prince Edward Island, Newfoundland Labrador, and the Yukon Territory (CMRC 2007).

\(^3\) See Adrienne Tanner’s article “Unassisted birth: No midwife, no hospital . . . no safety net?” for a characterization of the unassisted birth community in BC.
dramatic alternative to the dominant obstetrical model of maternity care present in the vast majority of North American women's birth experiences. Davis-Floyd describes the variability within midwifery practice as a "spectrum of renegadeness" where those midwives at the most radical end of the spectrum threaten the often tenuous level of "cultural acceptance" achieved by professional midwives (2006, 463). In the face of this alleged threat, professional midwives tend to emphasize "accountability, protocols and regulation" as a way to distance themselves from their renegade allies and assert a more sophisticated and qualified knowledge about childbirth (Davis-Floyd 2006, 455).

My attention to the diversity of historical and present day representations of Canadian midwifery practice is inspired, in part, by Lesley Biggs. Biggs, a pioneer in the history of Canadian midwifery, rejects an interpretation of midwifery's past as a universal "demise" at the hands of an encroaching male-dominated medical profession, and argues instead that midwifery's demise varied across time and place in conjunction with unique social, economic and political circumstances (2004, 29). Biggs thus dismisses the concept of a singular history of midwifery in Canada, and draws on studies that investigate the exclusionary practices of midwifery in Ontario, as well as the sexist and objectifying features of medical discourse to suggest that the problem with the dominant stories of childbirth is that they centre around a unifying image of "woman" that cannot possibly represent the diversity and multiplicity of women's lived experiences (2004). Biggs "retells" the history of Canadian midwifery with a dedicated commitment to exploring and exposing diversity, and in the process reveals the complex relationship between competing narratives surrounding midwifery. Specifically, Biggs suggests that contemporary midwives have relied on a particular image of the "neighbour midwife" as
a “benevolent” narrative to be perpetuated and aligned in opposition to the dominant narrative of allopathic medicine as a means of establishing and legitimizing their own professional interest. Biggs’ contention is significant because it reveals the extent to which professional interests may diverge from lay interests, and calls into question the implications of professional strategies for representing women’s diverse interests and experiences within midwifery practice. The relevance of Biggs’ perspective will be explored in more detail below, but first, let us continue the task of situating current midwifery practices in B.C.

The development of legislated midwifery practice finds its legal expression in the 1995 proclamation of the Midwives Regulations under the Health Professions Act. This proclamation created a legitimate realm of authority called the College of Midwives of British Columbia (CMBC) to define and regulate the newly-declared profession of midwifery with a mandate to protect the public interest (CMBC 2006). The first registered midwives began to practice on January 1, 1998, but the genesis of the CMBC was made public on May 10, 1993, when Elizabeth Cull, the then Minister of Health for the province of British Columbia, announced the government’s intention to recognize midwives as “legitimate health professionals” to a crowd of some 2,000 midwives gathered at the 23rd International Congress of Midwives meeting in Vancouver (Toronto Star 1993). Many midwives and midwifery supporters mark this moment as the culmination of years of meetings, organizing, and negotiating; other less invested observers recognize this moment as part of a broader shift in the tides governing social and health care policies in Canada.
Alison Rice provides a detailed account of the various actors and events that inspire and facilitate the transformation of midwifery practice by using a social movement trajectory to describe the historical shifts of midwifery in B.C. Rice characterizes the 1980 “Midwifery is a Labour of Love” conference held in Vancouver as a “pivotal event” in the development of regulated midwifery, in part, because it led to the establishment of the Midwives Association of BC (MABC) and the Midwifery Task Force (MTF). According to Rice, the genesis of these two organizations is significant because the MABC came to represent the professional interests of midwives in the province while the MTF functioned as an expression of the consumer voice of lay people, and together, the two organizations played an integral role in promoting and pursuing a professionalized form of midwifery.

This narrative of collaboration between midwifery consumers, represented by the MTF, and professional interests, represented by the MABC, arguably, overshadows the extent to which multiple voices within and between these groups, as well as other groups, converged, dispersed, and re-emerged over the years. For example, the Community of BC Midwives (COBCM), a group of midwives, community members and midwifery supporters apprehensive about legalized midwifery, developed out of a concern for the consequences that the system of midwifery being proposed by the MTF and the MABC might have on the existing practice of lay midwifery. One of the founding members of this relatively short-lived organization describes its genesis as a moment in July 1993, at an information night hosted by the MTF and the MABC, when a community member’s question “Is this the end of lay midwifery?” was met with the response, from a MABC

4 The precursor organization to the Midwifery Task Force was the Maternal Health Society, Campaign for the Legalization of Midwifery that was established in the 1970's (Kornelsen 2000).
organizer, of “well, yes” (COBCM 1994). From here, members of the COBCM began to articulate a position that imagined lay midwifery coexisting with professional midwifery, and they sought to provide an alternative voice to the position carved out by the combined efforts of the MTF and the MABC.

Part of my intention is to interrupt the seemingly cozy narrative of collaboration that Rice constructs between the MABC and the MTF by introducing an alternative, albeit minority, perspective. Second, my intention is to rekindle the argument held in this historical moment, and imagine anew the possibility that the introduction of professional midwifery need not be “the end” of lay midwifery, and suggest the possibility that different categories of midwifery might co-exist harmoniously. But first, let us consider some of the broader influences that shaped the shifting status of midwifery practice in the province.

While it seems clear that consumer interests, professional aspirations, and the various organizations that emerged to represent them, definitely had an impact on the establishment of regulated midwifery, Kornelsen and Carty caution us against overestimating the degree to which regulation was accomplished by consumer and professional demands alone (2004). Specifically, they remind us that the movement toward regulated midwifery coincided with broader trends like government fiscal constraints and the shifting of healthcare services out of institutional settings (Kornelsen and Carty 2004). In a similar caution, Pat Armstrong reminds us that by focusing too much on the details of regulation we run the risk of being “blinded to the many larger social and political forces currently rocking the Canadian health care system” (quoted in Van Wagner 2004, 87). Rice adds to these perspectives, suggesting that factors such as:
the proclamation of the Health Professions Act, the Royal Commission on Health Care and Costs, changes to the government in BC, as well as shifts in policy approaches within the broader context of the Canadian health care system all led to transformations in the political climate and organizational structures of government that contributed to an environment favourable to the development of regulated midwifery. The point here is not to provide a complete explication of the particularities that surround midwifery’s professionalization process, but rather to highlight key events surrounding the development of midwifery legislation as a useful foundation for considering some of the challenges and obstacles that a regulated form of midwifery encounters and overcomes.

**The Challenge of Incorporating Diversity**

Incorporating diversity is perhaps one of the most difficult challenges that materialize when a professionalized form of midwifery emerges out of the context of a social movement narrative. This challenge stems, in part, from the generally agreed upon characterization of social movements as heterogeneous “networks” of multiple, diverse and “autonomous organizations” that are united by a “shared ideology around a common goal”, and social movements often experience “fragmentation” as a result of the contradictions and competing agendas that exist within the diversity of the overall movement (Daviss 2001, 74). In contrast, the professional entity that emerges out of the social movement context is created by a precise articulation of state-defined parameters that create a legally recognized authority over a delineated sphere of knowledge, and the profession of midwifery becomes motivated, in part, by the combined goals of securing a monopoly over a particular market and acquiring social status (Macdonald 1995). The interests of a profession are, by definition, specific, and the standardized requirements of
professional members are, arguably, inimical to the fluid structures, and diversity of interests and organizations that the social movement came to represent over time.

The tension between lay and professional interests, highlighted by a social movement theory approach to the study of North American midwifery, is presented by Cecilia Benoit as a debate within Canadian midwifery between those in favour of midwifery professionalization and those opposed (Benoit 1997). Benoit characterizes the debate by putting forward two "ideal-type" models of midwife: the lay attendant who is outside the state and finds her theoretical roots in radical feminist theory versus the autonomous professional who is regulated by the state and finds her theoretical roots in liberal feminist theory. We can hear echoes of Benoit's theoretical model resonate in the words of Carol Odell, a B.C. midwife, spoken months before professional midwives began practicing in B.C.:

I recently had a conversation with a MABC midwife who I like and respect very much. She talked about her concern regarding the factions in midwifery. I agreed that there is a tremendous waste of energy when midwives attack other midwives. Unfortunately, under the current conditions, many of us do not feel able to entrust our futures and our livelihoods to the MABC. We are not against the MABC; we support them to have a school. They are great midwives and we would love them to keep practicing with the women who choose them. If they want a category of midwives who have Bachelor's degrees and hospital privileges, we will support that too. But we will not give up our right to train as we know is right for us and practice as we and our clients agree. If we are diverse and plentiful, then we will be strong. We have much to learn from each other, but this learning is blocked because some midwives are trying to control others. If midwives are supported, cared for and called on by sister midwives to
be responsible to clients, then women will be well supported and able to reclaim the power and strength to birth. A little grain of sand will be added to the great sand dune of healing that needs to happen in this province and on this planet.”

(COBCM 1994)

When I talk about diversity within midwifery practice I am talking about two different things simultaneously constituted: the diversity of lay, professional, and aspiring midwifery practitioners on the one hand, and the diversity of the clientele of women who seek different kinds of midwifery services that might, or might not be, available in their communities, on the other hand. The nature of midwifery practice makes it hard to separate practitioners from “clients” (Lay 2000), and the changing status of midwifery practice also creates a situation in which an individual might inhabit all of these positions at different points in time, sometimes simultaneously.

Admittedly, there is much to be gleaned from the language of the above quote. I insert it as a way of, first, highlighting some of the antagonisms that exist between BC midwives; second, to illustrate that the professional aspirations of some midwives are inimical to the values, beliefs and sensibilities of other midwives; and finally, to foreshadow my eventual suggestion that we might do well to imagine a system that incorporates a more flexible, multi-levelled interpretation of midwifery practice to meet the diverse interests of B.C.’s childbearing women.

Antagonisms between lay and professional midwives highlighted in the above quote still persist in the B.C. midwifery community. The College of Midwives of BC (CMBC) has invested substantial resources to protect the public from the practice of lay midwives. One such example is the case of Gloria Lemay, a Vancouver-based midwife turned private birth attendant after the CMBC appropriated the term “midwife” for its
members only as a protected status similar to other professional designations. Lemay has received considerable attention and public condemnation for continuing to attend births without CMBC accreditation. On separate occasions, the CMBC has hired private investigators to infiltrate midwifery courses facilitated by Lemay and acquire evidence to support a charge of contempt of court for disobeying an injunction against her. The outcome, after a series of lost appeals, was five months served in a minimum-security prison for Lemay, and an assertion of the CMBC’s legal authority over the realm of midwifery practice in the province (CMBC 2002).

This is only one example of the sorts of tensions that develop between maternity care providers as midwifery integrates into the already existing health care system. Other health care professionals, most notably doctors and nurses, had similarly antagonistic responses to the new profession of midwifery. In a 2004 study that compares “pre-registration concerns” with “post-registration realities”, Kornelsen and Carty point out that doctors and nurses were “overwhelmingly” opposed to midwifery integration. They argue that the process of integration has not gone smoothly in B.C., and they characterize the current maternity care environment as one in which “competition overrides cooperation” (Kornelsen and Carty 2004, 122). The authors also illustrate the extent to which midwifery integration is complicated and contested by other professional groups, and at the same time expose the central role that professional interests play in crafting and delineating midwifery’s place within the healthcare system (Kornelsen and Carty 2004). These tensions and antagonisms continue to reverberate and inform relationships between maternity care service providers, in a way, I would argue, that has negative consequences for birthing women.
Tensions between lay and professional midwives and the conflicts that arise between different professional groups unfold within an environment inevitably influenced by other systemic and policy-related factors. Specifically, problems of racism, colonialism and regionalization remain when the practice of midwifery incorporates into an already existing health care system. For example, Sheryl Nestle, in her recently published book *Obstructed Labour: Race and Gender in the Re-Emergence of Midwifery*, presents a thoughtful exploration of the racism inherent in the structures and organizations that defined and implemented a system of regulated midwifery in Ontario.\(^5\)

Specifically, Nestle articulates some of the “voices” of immigrant women of colour who were excluded from the processes of midwifery regulation, and through her work reveals the inevitability of racist exclusion based on the strategies and ideologies that the midwifery movement used to achieve its goals. Nestel explains that,

> ... the assumption that guided Ontario midwifery was that women were oppressed in similar ways and that race, class, and sexuality only complicated a fundamental gender oppression. Such a stance does not require that relations of domination between women be taken into account, and thus a path is cleared for racial domination to be re-enacted within a feminist context. (2006, 5)

The re-enactment of racial domination, according to Nestle, is perpetuated, in part, through the movement’s representation of a “universal woman” who acts as the “protagonist of its ‘heroic tale,’ in which autonomous subjects, constrained only by gender inequity, pursue and win their goal through dedication and courage” (Nestle 5).

Nestle’s contention, like many other critics of second wave feminist movements, is that

---

\(^5\) For an alternate account that uses midwifery integration in Ontario as a sociological case study to explore the gender relationships between the professions, their “clientele”, and the state see Bourgeault’s *Push!: The Struggle for Midwifery in Ontario* (2006).
the "universal woman" is not so universal after all, and embodies instead primarily the values and sensibilities of the most privileged women in society.

The introduction to Nestle's book is titled "A New Profession to the White Population of Canada", which foregrounds her argument that many immigrant women of colour were excluded from the new profession of midwifery in Ontario. Accordingly, the economic and social benefits of regulation went, for the most part, to white women. Nestle furthers this argument by illustrating the colonialism, and present day systems of domination, that mark the Ontario midwifery experience. Specifically, Nestle describes how global relationships are constructed such that immigrant women of colour, on the one hand, despite their training and education acquired in other locations, are excluded from the burgeoning midwifery profession in Ontario. On the other hand, Canadian women foster their own professional development by travelling to birthing centres where they gain access to the births of "Third World women" as a means of meeting requirements for the minimum number of births attended as set out by the standards of the newly established profession.

The insights that Nestle provides are relevant to our exploration of the issue of diversity in the practice of midwifery in B.C. for a couple of key reasons. First, Ontario was the first province to regulate midwifery, and consequently the Ontario case acted as a blueprint for other provinces, and a number of the women who were instrumental in establishing the Ontario system participated in the establishment of the B.C. system. Second, while there are definitely distinctions between the two provinces, for example different population sizes and different economic resource bases, which make for unique instances of establishing midwifery systems, the ideological positions staked, and the
social contexts, are sufficiently similar to imagine that comparable situations of racism and colonialism impacted the experience in B.C. The comparability of the two situations is supported by an ethnographic study investigating the experiences of the first group of women who applied for registration in B.C. The authors note that for women who “practiced in non-English speaking countries” the requirement of “documenting their practice (above and beyond providing certification of formal education) was not only an onerous task, but also one that excluded most of them from going further in the process” (Kornelsen and Carty 2001, 16).

Other consequences of colonialism for contemporary practices of midwifery are evidenced by the almost complete absence of attention paid to distinct forms of Aboriginal midwifery. Biggs argues that the story of Aboriginal midwifery in Canada is a narrative untold, and she emphasizes the extent to which specific Anglo-European historical and geographical contexts have been universalized at the expense of recognizing diverse cultural understandings of the practice of midwifery throughout history. Carroll and Benoit acknowledge a similar paucity of available information on Aboriginal midwifery in Canada and rely on data drawn from two focus groups held with Aboriginal elders and community health representatives in Kamloops and Vancouver, as well as consultations with Aboriginal and non-Aboriginal midwives across the country as a means of “unravelling the threads” of the untold story of Aboriginal midwifery in Canada (2004, 265).

Carroll and Benoit stress the role that colonialism played in disrupting and destroying significant social, economic, political, and cultural processes within

---

6 Of all the participants, 22% received their training in Canada, 42% in the U.K., 14% in the U.S.A., and 22% in “Other” countries (14 Kornelsen and Carty 2001).
Aboriginal communities to the detriment of Aboriginal midwifery practices. Specifically, Carroll and Benoit point to disease, paternalistic government policies, religious indoctrination, residential schools, and the gender inequality inherent in colonial processes as key factors that interrupted the transmission of cultural knowledge and challenged the survival of Aboriginal midwifery. The authors relate historical and political changes since the late 1980’s to suggest that a gradual shift happened in Canada that placed control over maternity care services back in the hands of Aboriginal communities. Carroll and Benoit distinguish between mainstream midwifery motivations for professionalization and the unique motivations of Aboriginal midwifery to retrieve and maintain a “worldview” that preserves a legitimate place for midwives within Aboriginal communities and links the work of Aboriginal midwives to the larger work of cultural restoration and invigoration. If the situation is as promising as Carol and Benoit suggest, perhaps we can learn something from these examples about how to achieve flexible, community-based approaches to maternity care services that meet the unique needs of birthing women in different communities.

The distinction between the kinds of maternity care services available in different communities throughout B.C. is another factor that highlights crucial challenges that a contemporary practice of midwifery faces. Often, policy decisions have disparate implications based on location, and the process of regionalization is an example of how policy decisions can exacerbate already existing distinctions between urban and non-urban locations. In a 2002 study, “But Is It Good for Non-Urban Women's Health? Regionalizing Maternity Care Services in British Columbia”, Benoit et al. investigate the perceptions of the impact of the process of regionalization on maternity care services in
B.C. The authors define regionalization as a general shift in policy processes that sees “service delivery moved from the centre out to the periphery with an emphasis on local control and decision-making” (Benoit et al 2002, 373). The intention of the study is to focus on the “actual benefits” of regionalization experienced by non-urban women despite the generally accepted notion that the regionalization of health care services, for the most part, serves the interests of rural communities (Benoit et al 2002, 376).

One area of concern that the study highlights is a lack of access to, and choice of, maternity care providers. The authors posit that issues such as the large geographic size of regions, budgetary constraints, and an absence of concern by the “powers that be” might be factors that contribute to a lack of access and choice for women (Benoit et al 2002, 383). The study also reveals that none of the participants identified midwifery as a maternity care option in their community. The lack of midwifery availability is not surprising since at the time of the study statistics showed that approximately 70% of registered midwives practiced in the urban centres of either Victoria or Vancouver, and the remaining registered midwives practiced in different towns “sprinkled” across the southern region of the province (Benoit et al 2002, 384). A second area of concern is the lack of continuous care across the birthing cycle; most specifically, the fact that many non-urban women do not have the option to give birth in their own communities. Inadequate quality of maternity care is a third concern among respondents, and the authors relate these concerns to understaffed and over-worked resources, as well as the general shift in care away from public institutions toward “informal networks” of friends and family (Benoit et al 2002, 386). A fourth and final concern is the lack of opportunity that women have to participate in local health care planning processes. The authors
conclude that while regionalization “promised” to bring more control to local levels the result has been increased control and accountability to an “appointed managerial elite” and not communities themselves (Benoit et al 2002, 388).

Another related finding is the problematic tension that exists in B.C. between the over-uses of medical technology on the one hand, and a lack of reasonable access to obstetrical care services for some women on the other hand (Benoit et al 2002). Arguably, the movement for professionalized midwifery care services grew, in part, out of this very tension, and the representation of midwifery as the expression of women’s desire for non-medicalized, woman-centred models of maternity care service was posited as a significant contribution to solving this problematic tension. However, the present situation seems to suggest that, at least for the non-urban women represented in the study, the introduction of regulated midwifery care has done very little to ameliorate the availability of non-medical forms of maternity care service, and the process of regionalization has further exacerbated the problem of reasonable access to life-saving forms of obstetrical medical technology.

The apparent failure of the “promises” of regionalization for the benefits of non-urban women’s access to maternity care services in B.C. reveals the extent to which broader social and political factors influence and affect women’s pregnancy and childbirth experiences. The study also reveals the real disparities that exist between urban and non-urban women’s access to midwifery care services in B.C., and seems to suggest that when we talk about professionalized midwifery in B.C. we are really talking about a service that is presently only available to a particular population of women;
specifically, those women who live within urban centres where registered midwifery care is readily available.

Kornelsen and Carty, in an ethnographic study that pays particular attention to the experiences of the first group of midwives who registered to practice in BC, also note discrepancies between urban and rural locations. “Location”, according to the authors is an important term because it refers “not only to geographical/physical location but also to political standing”, and in some situations these “meanings converge” (Kornelsen and Carty 2001, 24). The convergence of the meanings of “location” might also help to explain, in part, the distribution of the majority of the provinces’ midwives in urban centres, as noted above. Specifically, the authors state that many respondents felt that women “outside the Lower Mainland and Victoria were at a definite disadvantage: ‘It seems that there was inside information circulating in the circle of midwives in the city.’”

The authors quote another study participant who explained:

Registrants who came from rural areas were very poorly prepared because they had no idea what to expect. Those who did know did not seem willing to share their information and the end results were that the vast majority of “successful” applicants were clustered in the big cities. Small communities lost really experienced but poorly exam-prepared midwives. (Quoted in Kornelsen and Carty 2001, 24)

A politics of “location” and the loss of experienced midwives in rural communities is another example of the serious challenges that issues of geographical diversity present for the new profession of midwifery.

Admittedly, the term diversity is rather nebulous, and I have employed it quite liberally to bring together a variety of materials related to midwifery practice in B.C. and
consider some of the challenges that arise when a profession of midwifery develops out of a social movement context. Some challenges outlined above include: racial or ethnocultural exclusion, legacies of colonialism, regional disparities, political disadvantages, interprofessional conflicts, and antagonisms between lay and professional midwives. A final consideration that might broaden our understanding of the depth of differences that the new profession of midwifery sought to contend with is offered by Farah Shroff's chapter "All Petals of the Flower: Celebrating the Diversity of Ontario's Birthing Women within the First-Year Midwifery Curriculum." Shroff outlines "third-wave feminist theory", which she defines as a body of theory integrating an analysis of the intersections of race, class, and gender, and draws on this work to construct part of the curriculum for Ontario's professional midwives.

The first-year midwifery text and course that Shroff designed uses this body of "race class gender theory" to incorporate social analysis into midwifery education, teach midwives how to recognize and be attentive to diversity and power relations within their own practice, and through a process of "self-reflexivity" and "anti-oppression work" provide "appropriate" midwifery care for "marginalized women" (Shroff 1997, 263). The bulk of Shroff's chapter draws on information acquired through public consultations organized by the Equity Committee of the Interim Regulatory Council on Midwifery to understand different identity-based groups in Ontario. The text is organized into sections titled: Aboriginal Women; Recently Arrived Immigrant and Refugee Women; Ontario Mennonite Families; Francophone Women; Lesbian Mothers; Teen Mothers; Women with Disabilities; and Women in Prison. Through descriptions of these communities, statistical references, and quotes from individual women representing experiences
particular to each group, the aspiring midwife is presented with diverse perspectives of pregnancy and learns things like: How do lesbians get pregnant? What are some of the cultural biases in prenatal clinics that immigrant women might have differing reactions to? How are teens disrespected and alienated from participating in the decision-making process around their own prenatal care?

By celebrating diversity in this thorough analysis, Shroff illustrates how complex women's identities can be, and how challenging it is to construct a publicly-funded and regulated form of midwifery that successfully meets the needs of all these differently and multiply defined women. Nonetheless, Shroff is optimistic about the ability of Ontario midwifery to overcome the exclusionary consequences of second-wave feminism, incorporate the insights of third-wave feminists, and create a midwifery service that meets the diverse needs of birthing women. Nestel's work, on the other hand, invites us to consider just how effective an "anti-oppression framework" based on "anti-racist feminist principles" might be within a system that according to Nestel, is itself, inherently oppressive and racist. Similarly, the value of a model of education that celebrates diversity and incorporates social analysis to meet the diverse needs of birthing women is only realizable for those women who actually have access to midwives in their communities. A recognition of the challenge of incorporating diversity into the professional structures of midwifery practice is not an argument against legislated midwifery; rather, it is an acknowledgement that the form of professional midwifery that emerges is a particular form of midwifery that only meets the needs of specific groups of women.
**Unintended Consequences and Future Considerations**

The social movement origins of contemporary midwifery practice, though less pronounced, are still evident in present-day discussions surrounding the place of midwifery in society. These discussions, which largely ignore the practices of lay midwives and private birth-attendants, focus much less on the safety, legitimacy, or validity of a professional practice of midwifery, and centre instead on the “restorative” contributions that a profession of midwifery has to offer within the current context of a “maternity care crisis” (Kornelsen and Saxell 2004, 3). B.C.’s “maternity care crisis” is characterized, in part, by a decrease in the number of physicians attending births. A report produced by the Maternity Care Enhancement Project (MCEP), a collaborative effort of the BC Medical Association and the BC Ministry of Health, provides a detailed account of the factors that create this “crisis” environment, and also seems to suggest that the integration of midwifery into the health care system has minimally impacted the number of available maternity care providers in the province (2004). Some of the factors that contribute to this minimal impact include: the limited number of available midwives, the maximum of 40 births per year that professional midwives can attend as primary attendant, the limited capacity of the UBC educational system to produce a supply of midwives, and the inadequate availability of resources to do Prior Learning Assessments for foreign trained midwives (MCEP 2004, 14). Nevertheless, midwives, midwifery supporters, professional organizations, and policy makers remain optimistic about the ameliorative impact that midwifery might have on the existing “crisis” situation, and continue to explore ways of increasing midwifery’s contribution to the

---

7 At the time the report was published there were 108 practicing professional midwives in the province who were attending less than five percent of the population of pregnant women (MCEP 2004, 14).
maternity care system. For example, a report produced by the BC Centre of Excellence for Women's Health (BCCEWH) recommends, among other things, an increased scope of practice for midwives, including: second-assisting caesarean sections, performing vacuum extractions, and carrying out pharmacological induction of labour (2003). The report also recommends an inter-professional collaborative curriculum that would "take advantage of the common skill set among midwives and other maternity care professionals" (BCCEWH 2003).

The recommendations of the BCCEWH report are particularly relevant for people concerned with reasonable, legal, and sustainable access to non-medical maternity care options. Similarly, the MCEP report highlights an increase in the use of "technological and pharmacological interventions" into childbirth that has occurred over the past ten years (MCEP 2004, 10). The authors list "epidural anesthesia, fetal monitoring, ultrasound and caesarean section" as examples of "technological and pharmacological interventions" that have increased over the past decade, and they predict that the rates for these procedures will continue to rise in the coming years (MCEP 2004, 11). The prevalence of caesarean section surgery is another phenomenon that has created much concern among childbirth activists, academic researchers, and the medical and midwifery communities more broadly. Presently, B.C. boasts the highest caesarean section rate in the country with 29.9% of babies born through caesarean section surgery in 2005, a dramatic increase over the 19.8% caesarean section surgery rate in 1995 (B.C. Ministry of Health Vital Statistics 2008). Despite the general belief that the introduction of midwives into the health care system would decrease the reliance on medical technology

---

8 An often-cited statistic used to provide context for a given area's caesarean section rate is the World Health Organization's recommendation that caesarean section surgery rates of 10%-15% in developed countries reflect an appropriate use of medical technology (WHO 1985).
in childbirth, statistics indicate that the caesarean section rate in B.C. has risen steadily each year since midwifery integration (B.C. Ministry of Health Vital Statistics 2008). The rising prevalence of technological interventions in childbirth, coupled with the possibilities of increased inter-professional collaboration in the area of both practice and education, is cause for concern among individuals worried about reasonable access to non-medical maternity care options.

The present flux in maternity care services in B.C. creates an ideal environment in which to evaluate and reconsider the present system of midwifery care. My contention is that a narrowly-defined form of regulated midwifery cannot accurately reflect the diversity of perspectives and interests expressed by the social movement that engendered the profession of midwifery. The risk is that the presence of midwifery within the health care system, construed as the authentic expression of a non-medical childbirth choice for women, masks the substantial challenges that midwifery integration faces. One unintended consequence of midwifery integration is that it precludes the possibility of connected groups of concerned women organizing to oppose the continued dominance of medical technology in childbirth. Again, this is not an argument against a regulated form of midwifery, but rather a suggestion that we pay particular attention to the ways in which we construct our understandings of midwifery practice lest we lose our critical ability to confront and challenge a seemingly continuous “cascade of medical interventions” into childbirth (Kitzinger 1997).

We can look to the state of Oregon as one example of a model of midwifery licensure that incorporates different forms of midwifery practice in a way that ensures access to legal non-medical, non-interventionist maternity care options. Admittedly, the
situation in Oregon develops out of a particular sociopolitical landscape that facilitates a particular system of midwifery practice. In Oregon, midwifery has always been legal, and in the 1970's when nurses challenged midwifery, the Attorney General held that midwives did not need a license to attend births outside of hospitals provided they were not administering drugs, using surgical equipment or medical procedures (Parker 2008). Today, the existence of this system, where different categories of midwives practice simultaneously with varying scopes of practice, provides an example of how we might incorporate a more inclusive and flexible system of midwifery practice toward a goal of meeting the diverse needs of both birthing women and practicing midwives⁹. Now seems a pertinent time to reflect on the possibility that midwifery legislation is not the end of a struggle, but rather another step along the continuous path of protecting and preserving women’s authority and power in childbirth.

⁹ Direct entry midwives (DEMs) practice without regulations in Oregon. There are also licensed direct entry midwives (LDMs) who obtain voluntarily licensure as a means of providing their clients with access to reimbursement through the Oregon Medical Assistance program (OMAP) (Citizens for Midwifery 2008). Certified Midwives (CMs) and Certified Nurse Midwives (CNMs) are professional midwives with hospital-based practices, Master's levels of education, and accreditation from the American College of Nurse Midwives (Oregon Midwives 2008).
Bibliography

http://www.bccewh.bc.ca/publications-resources/documents/solvingmaternitycarecrisis.pdf


College of Midwives of British Columbia (CMBC). “Supreme Court Judge Sentences Illegal Practitioner Gloria Lemay to Five Months in Jail”. News Release. Aug 2,


Kornelsen, J. and Lee Saxell. Regulated Midwifery in British Columbia: Practice
Conditions in the First Four Years. Vancouver: British Columbia Centre of Excellence for Women’s Health (BCCEWH), 2004.


Shroff, Farah M. “All Petals of the Flower: Celebrating the Diversity of Ontario’s Birthing Women within First-Year Midwifery Curriculum.” In Farah M. Shroff, ed. The New Midwifery: Reflections on Renaissance and Regulation. Toronto:


2: REPRESENTING GARDASIL: A CLOSE TEXTUAL ANALYSIS OF PRINT ADVERTISEMENTS FOR THE VACCINE GARDASIL
Introduction
The Canadian federal government’s announcement in March 2007 of its 300 million dollar investment in provincial programs to inoculate school age girls with the vaccine Gardasil has sparked considerable public debate and media attention. Canadian print media hail Gardasil as “a milestone in health care” (National Post April 16, 2007); “the most revolutionary advancement in the area of women’s sexual health since the pill” (Globe & Mail March 2007); and in the words of one Vancouver-based gynecological oncologist this is “the first time in our history that we have the ability to actually truly prevent cancer” (Vancouver Sun May 2, 2007). The representation of the vaccine as a “revolutionary” substance that “actually truly” prevents cancer stems from a scientific explanation of the link between cervical cancer and some strains of the over 100 varieties of the human papillomavirus (HPV). A complex intermingling of social, economic, and political factors coalesce to articulate particular understandings about the relationship between HPV, cervical cancer and female bodies. A close textual analysis of Gardasil print media advertisements serves as one entry point for understanding some of the social values, norms and assumptions at play in the representation of Gardasil as a “cure for cancer.”

The complicated cast of characters present in the news media, editorial pages and public discussions that surround Gardasil is evidence of the complex relations that surround the creation and promotion of the new vaccine. Here we find drug company representatives, lobbyists, politicians at various levels of governments, women’s health groups, public health officials, scientists, researchers, professors, doctors in the specialized fields of oncology, gynecology, epidemiology, and pediatrics, parents,
fathers, mothers, and any number of metonyms for female ranging from little girls, to daughters, to pre-adolescents, to sexually active women; all the subjects of much discussion. Debates oscillate between questions of desirability and necessity with scientists, government officials, and the medical community in general viewing the vaccine as a favourable advancement in the interests of women’s health; while women’s health advocates, researchers and concerned parents look warily at the rapidity with which Gardasil is being introduced, questioning whether the vaccine is studied enough, safe enough, and what the rush is; a sentiment expressed in the MacLean’s magazine cover story “Our Girls Are Not Guinea Pigs!” (August 2007). A third position within these broadly sketched debates is represented by conservative voices, like Moira McQueen of the Canadian Catholic Bioethics Institute, who worry about increased promiscuity among youth and argue that the vaccine gives a “clear message” that “sexual activity is okay at any age and they will be protected” (quoted in Comeau 2007).

Another critical element that underlies much of the public discussion is a skepticism on the part of many women’s health advocates, commentators, and opponents of vaccines who question the weight of influence that the financial interests of pharmaceutical companies, marketing agencies, and lobbyists have on the speedy acceptance of the vaccine Gardasil.

In the following pages I explore the intricate relationships between scientific “facts”, biomedical certainties and social processes by investigating the ways that marketers draw on and reinforce discourses of health, security, and morality to construct particular meanings about Gardasil. Through a close reading of Gardasil ads directed at both consumers and physicians I pay particular attention to how visual imagery, semantic
relations, and hyponymy work to produce distinct representations of the world and how these representations simultaneously emerge out of and are immersed within discourses of health, disease, morality, and protection. I suggest that marketers navigate available discourse to represent Gardasil in a way that emphasizes the link between HPV and cervical cancer and de-emphasizes HPV as a sexually transmitted infection, and in doing so find a publicly palatable way to promote a socially contentious product.

A Framework for Contextualizing Gardasil

The debates that surround the introduction of the vaccine Gardasil, along with the federal government’s funding of school-based inoculation programs, are secured by a biomedical world-view that normalizes certain kinds of knowledge as authoritative. The theoretical contributions of feminist investigations into the phenomena of medicalization and biomedicalization provide a useful framework for contextualizing my analysis of representations of Gardasil in a North American context. Katherine Pauly Morgan, a philosopher and bioethicist with an interest in the epistemic politics of the global Women’s Health Movement, highlights the depth and pervasiveness of the rational, authoritative, scientific kinds of knowledge that attend the phenomenon of medicalization and sheds light on just how ingrained the medicalized world view is in Western cultural processes (1998). For Morgan, the term medicalization refers to the “intentional and unintentional expansion of the domain of medical jurisdiction”, and she conceives of medicalization as a “protean, dialectically shifting, social and political dynamic” that creates a situation in which “individuals, groups, and cultural institutions” come to perceive of a particular domain, be it a “problem, condition, choice, or life circumstance”, in medical terms (85, 1998).
Morgan draws on theorists like Foucault and Habermas to illustrate a number of dialectically related components that converge and interact to construct a situation in which virtually all aspects of life are construed through a lens of biomedical knowledge. Morgan identified the components of a multi-levelled process that has led to medicalization: the conceptualization of medical knowledge as authoritative knowledge through the construction of theories and paradigms, the monopolization and dominance of expert knowledge through “institutional interactions at a macro-level” in the form of social, economic, political and symbolic processes, the “institutionalization of medicalized knowledge” through “micro-interactions” like doctor-patient relationships, as well as through the lived and “subjective experiences of self-management”, and finally through the extension of medicalized processes into the “ordinary lifeworlds” of everyday living (87-89, 1998). These extensive and complex processes of medicalization constitute the web through which knowledge about HPV, Gardasil and cervical cancer is formed, dispersed, and interpreted.

A related framework is offered by Clarke et al. who locate the origin of medicalization in post World War II American medical institutions and argue that biomedicalization is a related, but distinct, phenomenon characterized by an historical shift, underway since the mid-1980’s, involving transformations in biomedical processes that go beyond medicalization’s established control. The authors explain the distinction between medicalization and biomedicalization in terms of “a shift from enhanced control over external nature (i.e. the world around us) to the harnessing and transformation of internal nature (i.e. biological processes of human and non-human life forms)” (2003, 164). The authors provide a framework of biomedicalization that includes five major
themes: an explanation of the economic and political transformations of the biomedical industry; an increased focus on “health, risk, and surveillance”; the “technoscientization of biomedicine” described as the “increasingly technoscientific nature of the practice of biomedicine”; the transformations of information and the production and distribution of knowledges; and finally, the “transformation of bodies”, as well as collective and individual identities (2003, 183).

According to Clarke et al. we are “awash in a sea of biomedicalizing discourses” whose ubiquity makes “technoscientific” conceptions of the self, and biomedical understandings of health, cultural certainties, and culminate in a perception of the world where it is “virtually impossible not to be ‘at risk’”(2003, 184, 172). The certainty of biomedicalization discourses constructs specific understandings of the world that make certain representations possible while negating others, and the contributions of feminist scholars outlined above reveal the intricate and complex relations through which representations of Gardasil appear and public debates about vaccines, viruses, and cancers are constituted.

What is Gardasil and Where Did it Come From?
Given the complex nature of the relations that constitute Gardasil it is useful to briefly outline some of the developments that lead to the appearance of the vaccine on the market and on the public agenda. In this way, we can also locate the specific print ads analyzed below within the broader context of the multi-phased, multi-level advertising campaign orchestrated by the pharmaceutical company Merck Frosst.

The vaccine Gardasil, created by Dr. Albert Bennett Jenson and Shin-je Ghim at the University of Louisville’s James Graham Brown Cancer Centre in 2006, is designed
to prevent infection with four strains of the human papillomavirus (HPV). Gardasil is now available for sale in over 50 countries including the U.S., Canada, the European Union, Brazil, Mexico, and New Zealand. The four types of HPV that the vaccine works on are strains 16 and 18 that cause about 70% of cervical cancers, and strains 6 and 11 that cause about 90% of genital warts. While approximately 75% of sexually active Canadians will have at least 1 HPV infection in their lifetime, most of these will be cleared spontaneously by a regularly functioning immune system (CMAJ 2007). The human papillomavirus, and the diseases it purports to protect against, are not new phenomena. Interested scientists, researchers, and epidemiologists have been meeting to consider advances and developments in the papillomavirus since the mid-1970's, and in 1982 the first annual Papillomavirus Conference was held to consider the now over hundreds of variants of the papillomavirus that affect humans and non-humans alike.

Presently, Gardasil is the only vaccine of its kind available on the market\textsuperscript{10}, and is distinguished by many journalists and commentators as the "most expensive vaccine on the planet" (CBC). Approved by the Food and Drug Administration (FDA) in the U.S. in June of 2006, and given a Notice of Compliance by Health Canada in July of the same year, Gardasil became available in Canada in August 2006 at a price of approximately $400 dollars for a course of three shots. The Canadian federal government’s March 2007 budget allocation of $300 million to support provinces and territories in making the vaccine available free of cost through school-based vaccination programs is a measure of

\textsuperscript{10} Glaxo Smith Kline's comparable product Cervarix is approved in all countries of the European Union and Australia, but has not yet been approved in North America.
financial support only and provincial and territorial governments have responded differently in terms of whether they provide inoculation programs and at what age.¹¹

The various stages of development and government approval that Gardasil passed through coincided with a very large, very successful award-winning educational, informational, and advertising campaign developed by Merck. In 2007, Beverly Lybrand, Merck’s vice president of the HPV franchise, was named marketer of the year by Brandweek magazine. In the same year, Gardasil took Gold at the DTC Perspectives annual conference for the category of best branded TV ad, and Merck and the ad agency DDB New York also received Gold and Silver accolades for best non-branded television and print campaigns for their promotion of both cervical cancer and HPV.

Merck marketers began creating the advertising and informational campaigns linking HPV and cervical cancer in the lead up to the introduction of the product Gardasil in 2004. The public phase of the pharmaceutical giant’s advertising efforts was initiated in 2005 with the “Make the Connection” campaign, an informational program developed to promote consumer awareness about the link between HPV and cervical cancer. The central component of the “Make the Connection” campaign was the distribution of make-your-own beaded bracelet kits. Designed and promoted by noticeable figures in the fashion industry, the bracelets were a vehicle for connecting concepts like HPV and cervical cancer in the minds of consumers, but also a means of connecting the individual bracelet wearers to each other. In 2007, the “Make the Connection” campaign was transformed into the “Make the Commitment” campaign encouraging women to talk to

¹¹ As of December 2007, four provinces - Ontario, Nova Scotia, Prince Edward Island, and Newfoundland - had implemented school-based vaccination programs with the remaining provinces still in the decision-making process. In a May 2008 press release titled “New Vaccine Program to Protect Girls Against Cancer” the B.C. provincial government announced its intention to implement a school-based inoculation program for girls entering grade 6 and 9 (B.C. Ministry of Health 2008).
their doctors about cervical cancer prevention. Merck’s informational campaign also included the “Tell Someone” print and TV ads that began in May 2006 and encouraged viewers to “tell someone” about the link between HPV and cervical cancer.

Finally, a few months after the June 2006 approval of Gardasil by the American FDA, the campaign for the product Gardasil was launched. The Gardasil campaign includes the now popularly referred to “One Less” television ads. These ads present images of sporty, healthy girls and young women engaged in activities like equestrian riding, baseball, skateboarding, drumming, and gymnastics, to name a few, interspersed with close up shots of the same actors making empowered declarations about being “one less cervical cancer statistic”. The characters in the ads embody the spirit of taking charge of their own health and futures as they assert, “I want to be one less cervical cancer statistic” (Gardasil 2008).

The Gardasil campaign also includes print ads directed at both physicians and consumers, and in the following pages I focus my attention on a close textual analysis of these particular ads. While I look at the ads on their own, and in close detail I acknowledge that they do not exist outside of or apart from the context, production, and relations of a whole bunch of other material forces that constitute notions of health, disease, cancer, and HPV in contemporary society. In this way, I understand the ads as one piece of a larger whole, greater than the sum of its parts, and I approach the ads with the general belief that texts produce “social, political, cognitive, moral and material effects” (Fairclough 2004, 14). I understand discourses as “internally variable” (124) “heterogeneous entities” (126) that operate at varying “levels of abstraction” (124) and
“constitute nodal points in the dialectic relationship between language and other elements of the social” (Fairclough 2004, 126).

I also borrow from Leiss et al.’s historical study of advertising as a form of social communication to inform my analysis. The authors of this pivotal text understand advertising as “an integral part of modern culture” that can act as “a useful interpretive key for tracing aspects of our consumer culture” (Leiss et al 2005, 5). The authors explore the intersection of economics and culture to articulate a view of advertising where, in their own words,

As an industry, advertising mediates between commodity production and cultural production; as a message form, it adopts, revises, and shapes other cultural message systems; most importantly, through research it appropriates the social structure and cultural dynamics of market society, and recycles them as strategies targeted toward segments of the population – making the marketplace into an oscillating feedback loop. (Leiss et al 16)

In this sense, I approach the ads as both productive and representative of cultural understandings as they work to both shape and reflect meaning.

The specific print ads that I refer to are found in copies of the Canadian Medical Association Journal (CMAJ) and the Journal of the American Medical Association (JAMA) published between January 2007 and March 2008. These ads are directed at broad groups of North American physicians, and while Merck’s marketing efforts also included inserts directed at specific medical specialties and demographics, for example, pediatricians or gynecologists, these inserts are unfortunately not available in the editions of the journals archived in local library collections. The direct-to-consumer ads that I mention as contrast to the direct-to-physician ads are found in publications like Vogue,
Cosmopolitan, and InStyle magazines printed during the same time period. The following analysis takes these texts as the starting point for considering some of the social values and cultural assumptions at play in the representation of Gardasil as a “cure for cancer” in a world where biomedicalization discourses construct, among many things, risk as an ever-present certainty.

Gardasil: It’s About Cancer, not a Sexually Transmitted Infection

Ironically, while feminist critiques of consumer culture have often objected to the sexual commodification of girls and women as a means of selling consumer products, in this case, where the product actually has something to do with sex, references and visual representations of sex are, for the most part, absent. Despite the direct relationship between engaging in sex acts and contracting the four viruses that Gardasil is designed to protect against, there is a stark absence of representations of sex or sexuality in the ads used to promote the product. The absence of sex is most noticeable in the direct to consumer print ads that appear in magazines like Vogue, Cosmopolitan, and InStyle. The only visual image in these full-page ads is the Gardasil symbol that is about the size of a quarter and appears at the bottom of the page. Aside from that, marketers rely on different sized brown text, with a few select words emphasized in red, against a stark white background to convey meaning about Gardasil. Viewed in isolation, there is nothing striking about the ads, but viewed in their context, amongst the richly glamorous, extravagant, often intense images of expertly poised fashion models and elaborate commodities, the visual simplicity of the ads is noticeable.

Positioned within the pages of excessive, sexualized images of women and products, the sort typically associated with print advertising and for which the advertising
industry has received extensive critiques (Jhally), the rhetorical style of the ads work to distinguish the product Gardasil from the others. The crisp clarity of the white background asserts an element of truth or severity about the advertisers claims in contrast to the visual images on the pages that surround it. Bold, capitalized, large font, brown letters at the top of the page state, “CALLING GARDASIL A CERVICAL CANCER VACCINE IS ONLY THE BEGINNING OF THE STORY” or “CERVICAL CANCER IS NOT NEW NEWS. BUT THE VACCINE THAT COULD HELP PREVENT IT IS.” The size, style and positioning of the font also contrasts to the more subtle advertising messages throughout the rest of the magazine, and in doing so works to capture the attention of the reader and import a sense of urgency about this particular message.

The red lettering in the above quote highlights the connection between cervical cancer, the vaccine, and prevention. Even though Gardasil is a prophylactic vaccine that does not target cancer directly but the viruses that lead to cancer, specifically variants of the human papillomavirus: and even though the smaller text below the bold, capitalized font tells us that Gardasil “is a vaccine that may help protect you from 4 types of human papillomavirus – the types that may cause 70% of cervical cancer and 90% of genital warts” it is cervical cancer that takes center stage in the ads and not the human papillomavirus or genital warts. By emphasizing the link to cervical cancer and de-emphasizing the connection to sexually transmitted infections marketers avoid the moralizing discourses that surround sex and highlight the more socially benign disease of cervical cancer. The threat of cervical cancer is also a much weightier claim to stake to your product than the consequences of genital warts, and in doing so marketers both reflect and reinforce the ubiquity of risk in a medicalized world. Another compelling
reason for Merck to emphasize cervical cancer as Gardasil’s target disease is built into the licensing processes of the U.S. Food and Drug Administration (FDA). Specifically, the FDA includes an option to fast-track licensing approval, and in this case hasten the application process by up to six months, but only if the product targets "a serious or life-threatening disease and addresses an unmet medical need" (CQ Researcher 2007).

The absence of images of sexuality in the ads found in fashion magazines, or any images for that matter, is circumvented, in part, by the phrase "you could become one less life affected by cervical cancer." Here, the words "one less" insert a kind of intertextuality that connects the audience of the print ads to the widely circulating "one less" television ads where again the focus is on becoming "one less" cervical cancer statistic and not the human papillomavirus or sexually transmitted infections. Visual images of diversely ordinary, healthy, empowered girls and young women asserting their desire to be "one less" cervical cancer statistic convey meaning about Gardasil while avoiding the culturally contentious terrain of sex. Despite the direct association between sex acts and the four types of human papillomavirus that Gardasil was designed to prevent infection with, sex remains tellingly unspoken.

There is a similar absence of direct images or references to sex or sexuality in the print ads targeted at physicians. Only under the red seal of approval of the National Advisory Committee on Immunization (NACI) does sex become mentionable. The asterisk in the image of a red seal, the sort you might see on an official document, directs the reader to the tiniest print at the bottom of the page where the very small words state "NACI recommends GARDASIL for females 9 to 13 years of age, as this is generally before the onset of sexual intercourse and females 14 to 26 years of age even if they are
already sexually active.” These ads are the only ads where direct references to sex or sexual activity appear which suggests that only under the authority of recognized experts is it socially safe for marketers to speak about sex.

The centrality of images and references to girls and young women in the Gardasil ads, as well as public discussions, debates, and editorial commentaries more generally, is by now perhaps obvious. Nonetheless, it is worth highlighting the curious absence of men in images and representations related to Gardasil. By emphasizing the disease and not the agent of infection Gardasil manufacturers gain distance from claims that Gardasil will contribute to promiscuity and a false sense of security, and in doing so render invisible the vectors, notably boys and men, of the viruses that lead to the diseases. The invisibility of boys and young men dissuades us from asking important questions about the sensibleness of vaccinating girls, but not boys, against a virus they are both susceptible to. Presently, Gardasil is licensed for males in all the countries of the European Union as well as Australia (CQ Researcher 2007), but in both the U.S. and Canada licensing authorities state that there is insufficient testing to recommend the product for use on male subjects.

The Rhetoric of “Protection”

The delicate position marketers negotiate on the slippery slope of sexual morality is also noticeable in the public debates surrounding Gardasil where discourses of protection and morality circulate around the perceived risk that the vaccine will encourage promiscuity and unprotected sexual activity on the one hand, and conversely, the perceived benefit that the vaccine will offer protection for girls and young women against the threat of cervical cancer on the other hand. Associations between risk, sexuality and youth have
been studied at length by scholars and activists in the area of sex education, and both theorist and researchers have articulated and critiqued the dominant view that sees adolescents “positioned precariously between the innocence of childhood and the danger of adulthood”; and thus “socially constructed” as “deficient, dangerous, in need of protection or caught in time” (Gilbert 2007, 51). Gilbert locates the conflation of risk and youth sexuality in the 1983 publication of *A Nation at Risk*, and describes that this U.S. report “served to wed youth with ‘risk’ and culminating with the educational response to the AIDS pandemic, the concept of risk has hovered around adolescents and their perceived proximity to danger” (2007, 51). Gilbert draws on the work of psychoanalytical theorists to examine developmental theory in relation to sex education and argues for a theory of adolescent sexuality that imagines adolescents as “sexual subjects” with a unique sexuality both similar to and different from adult sexuality, but not simply a just-not-yet adult sexuality (2007, 47).

The sense of vulnerability or need of protection articulated by scholars and activists is visually noticeable and eerily present in the ads directed at physicians. Biomedicalization discourses converge with modern conceptions of adolescence to convey Gardasil as the “just in time” protector of the ever-present threat of disease. We see girls and young women flying kites, roller-blading, running, chatting, none of which appear to be immediately dangerous or risky behaviours. However, there is an eerie sense of susceptibility to an unknown that is created by the absence of eyes. None of the girls or young women in the ads has eyes. This looks particularly strange on the image of the young woman who sits on a bench reading and wears glasses to see out of the eyes that she does not have. A sense of vulnerability is also conveyed by positioning the
representations of girls and young women in open space, outside of and beyond the bounds of background images representing either neighbourhoods or cityscapes. This positioning emphasizes girls and young women as a central focus of the ads, but it also imports a kind unguarded isolation against which the product Gardasil offers protection. Despite their rather innocuous activities the girls and young women in the ads appear exposed and unprotected with a permanent physical inability to see what surrounds them. Danger is imminent and everywhere.

The representations of girls and young women in the ads also work to disrupt settled ways of thinking about women’s health issues by redrawing the established lines between girls and women’s health. The images in the ads, and the product Gardasil itself, asks health care practitioners, parents, and the public in general to think in new ways about health issues that up until now have only been associated with adult female bodies. How to include pre-adolescent girls and sexually active women in the same context without sexualizing the innocence generally associated with youth? More pragmatically, how to articulate a product to health care professionals across specialties in a way that connects young girls with young adult females? As the executive director of Merck’s vaccine and infectious diseases unit describes it “we had to tailor our education efforts to different provider groups and integrate them so they could talk to one another ... a gynecologist can tell a pediatrician how bad HPV is for women, but the pediatrician has to explain how to get children into a vaccination program” (quoted in Applebaum 2007).

Consistent with the “One Less” TV ads mentioned above, the visual images in the print ads depict strong, healthy, girls and young women engaged in various sports and activities. We see colour illustrations depicting images of girls roller-blading, flying
kites, bike riding, jogging, to name a few, and we also see images of studious or professional looking young women either reading alone on a park bench, or walking together in pairs, one with a brief case the other wearing a backpack. The images connect the different kinds of individuals, notably girls, adolescent females, and young women together in the mind of the viewer. At the same time, the words cervical cancer, cervical dysplasia, genital warts, and in some ads vulvar/vaginal cancers appear as some of the largest text on the page, in bold, capitalized font further highlighted by either red lettering or yellow bullets. The words work to connect the different kinds of individuals to the particular diseases. Phrases like: “Now is the time to vaccinate girls and young women age 9 to 26” and “GARDASIL - help protect a generation of girls and young women” reinforce the connections established by the visual images, and at the same time contribute to a sense of urgency about the immediate need to rectify their vulnerable position. In this way, rhetorical strategies work to overcome established ways of thinking and imagine new relationships between girls, women, specific diseases and the vaccine Gardasil. What remains to be considered is to whose benefit these new relationships accrue.

What About the Science?

The claims marketers make about the safety, efficacy and desirability of the product Gardasil rest solidly on scientific evidence bolstered by the approval of governing bodies like Health Canada and the U.S. FDA in the form of licenses granted to sell the product. Interestingly, both proponents and opponents of the product Gardasil, and school-based vaccination programs more specifically, draw on the same science to support their arguments either for or against the vaccine. The scientific evidence that provides the
basis for the claims about Gardasil presented in the ads is the same scientific evidence
that health advocates, researchers and scholars like Abby Lippman point to as very shaky
ground on which to stake claims about the health of a generation of girls and young
women (CMAJ 2007).

A close reading of the print ads directed at both physicians and consumers reveal
some of the rhetorical strategies marketers use to reinforce both the safety of the product
and the solidity of the science that supports it. Agency shifts within the ads depending
on the context or the audience to whom the ad is directed: specifically, who is encouraged
to act and how changes slightly between different ads. For example, in ads directed at
physicians highlighted phrases like “now is the time to vaccinate”, “Today, you can do
more”, “Vaccinate today” and “help protect a generation of girls and young women”
combine the rhetoric of protection with the perceived benevolence of the medical
profession to persuade doctors to use the vaccine Gardasil. In print ads directed at
consumers phrases like “may help protect you” and “only your doctor can decide if
Gardasil is right for you, so ask about getting vaccinated” appear as regular sized font on
the page. In the same sentence, women are persuaded to ask about vaccination, but only
after being informed that their doctor is the only one who can decide if Gardasil is right
for them. Consistent with the ads directed at physicians and indicative of the ubiquity of
biomedical discourses the authority to act rests with the expertise of the doctor, firmly
grounded in medical knowledge.

12 Who is encouraged to act and how is in some cases influenced by laws regulating direct-to-consumer
advertising (DTCA). In Canada, DTCA is prohibited with two exceptions: first, “reminder ads” that
include the brand name but no references to what the product is used for, and second, “disease oriented”
or “help seeking ads” that include information about a disease or condition with a suggestion to consult a
doctor but no information about a specific brand associated with the condition or disease (Mintzes 2006).
Arguably, Canadians’ access to and consumption of American cultural products make DTCA regulations
irrelevant for certain products.
A related similarity between the two sets of ads is the way that marketers draw on the rhetoric of science and safety to move people toward action by creating a sense of authority and certainty about the product. In both the ads directed at consumers and the ads directed at physicians the positioning of text on the page and the use of colour to emphasize text works to reinforce the safety of the product and the science that supports it. For example, in the advertisements placed in fashion magazines where meaning about Gardasil is conveyed through brown text on a stark white background, the colour red is used to emphasize certain words or elements. Apart from the red, bold, capitalized words “cervical cancer”, “vaccine”, “prevent it”, “only” and “beginning” that appear as the largest text at the top of the page, the only other red lettering is used to highlight the capitalized words “select safety information” that appear in the centre of the page in the second largest font size. In this way, safety information is emphasized as one of the most important elements of the ad, and by relationship the product.

Another way that rhetorical strategies work to convey a sense of solidity about the product and the certainty of the scientific data that supports it is noticeable in the ads directed at physicians where references to “select safety information” appear in bold text in either brown or red colouring. In other ads, a sense of support is conveyed visually by the way that representations and claims about Gardasil are positioned above, resting on top of, the smaller, dense looking text that covers the bottom half of the page and presents information about safety, proper usage, adverse reactions and in some cases references to clinical trials. The distribution of information on the page conveys visually the sense in which claims and information about Gardasil are held up or supported by expertise,
science, and in the process imply a committed concern for the safety of the girls and young women represented in the ads.

A similar strategy is noticeable in one of the ads found in the Canadian Medical Association Journal (CMAJ). The phrase, "GARDASIL was 100% effective in helping protect young women from HPV types 16- or 18- related CIN 2/3 or AIS (cervical cancer) and VIN 2/3 or VaIN 2/3 (vulvar/vaginal cancer) in combined worldwide analysis of 20,541 patients****" appears in a brown text box against a blue background underneath visual representations of girls and young women along with bulleted and coloured text that convey information about Gardasil. The lettering of the text of the above quote is all white except for the words "100% effective" which appear in a larger bold-cased, yellow coloured font. The accentuated words "100% effective" are the most pronounced on the page, and the information that supports this statement is found as the smallest text located by following the asterisk in the above quote to the bottom of the page. In this way, the efficacy of the vaccine is highlighted and the science that supports the claim is inserted to reinforce the sense that this is a well-studied product for which the benefits far outweigh the risks.

The science that marketers rely on to imprint a sense of safety and security about the product Gardasil is the very same science that critics of Gardasil rely on to argue for a more cautious approach to the use of the new vaccine. Women's health activists, healthcare professionals and researchers point to a number of safety concerns overlooked by the marketers, manufacturers and proponents of Gardasil that contradict the rhetorical emphasis on safety and efficacy pointed to in the ads above, and raise important questions about the health and safety of the generation of girls and young women.
proposed to be protected. Opponents argue that there are insufficient studies to support claims of efficacy and safety on the one hand and insufficient evidence to warrant wide-scale vaccination on the other (Lippman et al. 2007; Canadian Women's Health Network (CWHN) 2007; Vancouver Sun, May 14, 2007).

To the questions of safety and efficacy, Lippman et al. turn to a systematic review of randomized control trials, of which they note there are surprisingly few (Rambout et al 2007), and conclude that these findings “caution against making overly optimistic descriptions of benefits and downplaying potential risks” (Lippman et al. 2007, 485). The authors pose a number of questions as a list of unknowns, like: How long does the vaccine protect? Are booster shots required? If so, when? If immunity is short-term, what effect will this have on infections in older people? Added to this list of unknowns is a concern with the lack of information about the efficacy of Gardasil when “co-administered with other immunizations”, and “perhaps more importantly”, the authors wonder, “might misunderstandings about what the vaccine does and does not do lead to a reduction in safer sex practices and Pap screening rates?” (Lippman et al 2007, 485). The authors also argue that there is limited data on school-age girls (9-15), the target of mass vaccination programs, to support such programs13, and worry about other iatrogenic effects of vaccination programs. Lippman et al. foresee Gardasil as just the first of many vaccines to come targeting “high-risk HPV strains” and admonish policy-makers “to take a breath and reflect on what we know and what we don’t know, and to develop a plan based on solid, reliable evidence that adds value for everyone” (2007, 486).

13 Only about 1200 girls in this age group were included in clinical trials and the youngest of these participants were only observed for 11 months (Lippman et al 2007, 485)
Concluding Concerns

The rhetorical strategies of marketers, by definition are intended to persuade individuals to purchase products, but it is interesting to notice how in the process cultural and social expectations are reinforced, reinvented or in some cases circumvented. The rhetoric of protection and the emphasis on Gardasil as a "cervical cancer vaccine" which "is only the beginning of the story" according to one Cosmopolitan advertisement should lead us to ask important questions about the necessity of a "cervical cancer vaccine" in a North American context. In Canada, approximately 1350 females are diagnosed with cervical cancer annually and approximately 400 or about .002% of the population will die of cervical cancer in a year (Comeau 2007). That puts cervical cancer 11th on a list of cancers that most frequently affect Canadian women and 13th on a list of the most common causes of cancer-related deaths (Lippman et al 2007). Generally speaking, in North America the incidence of cervical cancer has declined steadily since the introduction of regular Pap (Papianolaou) screening tests in the 1960’s. In British Columbia (B.C.), the first jurisdiction in the world to institute a cervical cancer screening program, rates of cervical cancer have decreased by 85% in the past four decades (British Columbia 2003). According to the Canadian Women’s Health Network, the programs in place to screen for and treat cervical cancer work well, and the women most likely to die from cervical cancer in North America are poor, lack the resources necessary for adequate nutrition, do not have consistent access to health care, or do not receive regular Pap tests (2007). The same social and economic factors that place these women at a higher risk for cervical cancer also make them less likely to be in a position to receive a vaccine.
When we consider this information in relation to the rhetoric of protection and safety presented in the ads it seems as though Merck’s choice to emphasize the link between cervical cancer and Gardasil might be more about finding a publicly palatable way to present a socially contentious product than any immediate need to protect a generation of girls and young women from the real and present danger of cervical cancer. In other words, it might be the appearance of Gardasil itself and all the complex relations that overlap and intertwine to make that possible that make “now” and “today” the time to vaccinate, and not an existing threat of cervical cancer. The emphasis on cervical cancer and the concurrent de-emphasis on HPV as a sexually transmitted infection work to include particular subjects, namely girls and young women, while excluding others, namely boys and young men. In doing so, we preclude connecting to whole other sets of available discourses about health, sex and safety that might actually be more relevant and effective in “protecting” females from conditions associated with the human papillomavirus. My concern is that the interests of pharmaceutical companies, and their influence in the form of multi-level, multi-phased informational, educational and advertising campaigns, not supersede the public interest. We ought to continue to ask whether Merck’s financial motivations lead marketers to construct meanings about Gardasil that, in the end, might do more harm than good for the girls and young women they purport to protect.
Bibliography


Leiss, William, Stephen Kline, Sut Jhally, and Jacqueline Botterill. Social


