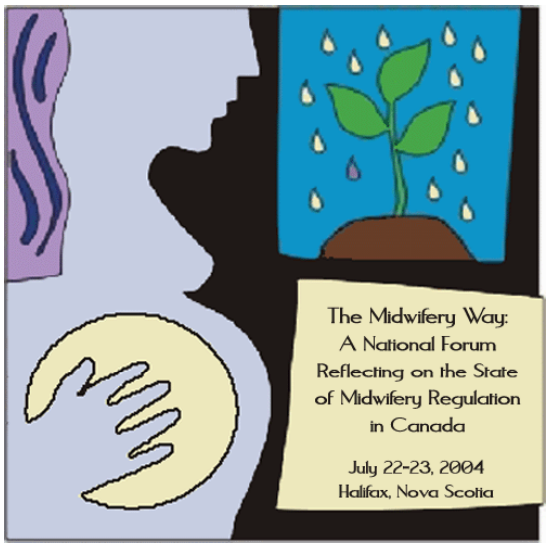

Proceedings from

THE MIDWIFERY WAY
A National Forum Reflecting on the State of Midwifery Regulation in Canada
July 22 – 23, 2004

Atlantic Centre of Excellence for Women's Health
Prairie Women's Health Centre of Excellence

DALHOUSIE UNIVERSITY
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PRAIRIE WOMEN'S HEALTH
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Atlantic Centre of Excellence for Women's Health

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THE MIDWIFERY WAY
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Partners:
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Prairie Women's Health Centre of Excellence
Dalhousie University
IWK Health Centre
Canadian Institute of Health Research
Social Sciences and Humanities , Research Council of Canada, Health Canada
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I. INTRODUCTION

It is a pleasure for the Prairie Women's Health Centre of Excellence and the Atlantic Centre of Excellence for Women's Health to present the proceedings from the *Midwifery Way Forum* we co-hosted in July 2004. We trust that readers will find within the proceedings a celebration of past achievements and considerations of how to ensure that midwifery is not only sustainable, but is supported in continued growth, for midwives and their clients.

The key objectives from the *Midwifery Way Forum* were:

- To explore the lessons learned thus far in Canadian jurisdictions that have legislated midwifery and translate those lessons for the not-yet-regulated provinces;

- To identify current best practices for advancing a midwifery regulatory framework that is particularly inclusive of marginalized or vulnerable populations including single mothers, teenage mothers, low income women, immigrant women, Aboriginal, visible minority women, women with disabilities and lesbians.

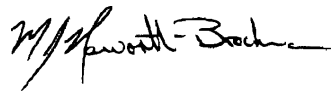
The challenges of building an inclusive midwifery model of practice - one in which services are provided by and to women who have been under-represented or under-served by the health care system - have been formidable. It is our hope that these proceedings will contribute to the development of inclusive strategies in those provinces that have regulated midwifery, and ensure that they are built into any new regulatory proposals.

Our shared ultimate goal is to work toward improving maternity and newborn services across Canada so that *all* women have access to a comparable quality of women-centred care, no matter where they live or who they are. We believe that there is ample research, as well as first-hand accounts, that demonstrate the value of midwifery for advancing such an agenda. It has never been more imperative to ensure its integration into the publicly-funded health care system - a time when we face a maternity care crisis.

We are very pleased that such a range of contributors (midwives, other health care practitioners, government bureaucrats, community leaders, consumers, activists, scholars, students, and others) shared their work for these proceedings. We want to thank all of our presenters, and roundtable participants for agreeing to participate in the *Forum* and to those who were able to share their work here. Due to the busy lives of midwives, not all presentations are represented in this document. Many of the presentations had to be altered because of the personal nature of photographs that were shared. Special thanks also to Rachel Rapaport Beck for liaising with contributors and editing, Pamela Chalmers for her formatting work and to Shelly Martin (assistant coordinator) who was absolutely indispensable in dealing with the multitude of details that ensure a smooth and enjoyable event!

It is an exciting time for midwifery supporters and practitioners in Canada. As is clear from the contributors in this document, a great deal of research has been produced in the last ten years. It is conclusive: we are no longer debating the value or safety of midwifery care. This is a major accomplishment. But we must move the agenda forward. It is our hope that the *Forum* and these proceedings will contribute to and strengthen the midwifery movement in Canada.

Christine Saulnier, Ph.D.
Senior Research Officer
Coordinator, Midwifery and Women's Reproductive Health
Atlantic Centre of Excellence for Women's Health



Margaret Haworth-Brockman
Executive Director
Prairie Women's Health Centre of Excellence

II. PRESENTATIONS

A. KEYNOTE ADDRESS

DAUGHTER OF TIME: THE POSTMODERN MIDWIFE

Robbie Davis-Floyd, Department of Anthropology, University of Texas

Abstract
This article presents the notion of "the postmodern midwife," defining her as one who takes a relativistic stance toward biomedicine and other knowledge systems, alternative and indigenous, moving fluidly between them to serve the women she attends. She is locally and globally aware, culturally competent, and politically engaged, working with the resources at hand to preserve midwifery in the interests of women. Her informed relativism is most accessible to professional midwives but is also beginning to characterize some savvy traditional midwives in various countries. Thus the concept of “the postmodern midwife” can serve as a bridge across the ethnic, racial, and status gaps that divide the professional from the traditional midwife, and as an analytical focal point for understanding how the members of each group negotiate their identities and their roles in a changing world.

For past millennia, midwives have served women in childbirth. In premodern times, midwives were usually the only birth attendants. With the Industrial Revolution and the arrival of modernism, male physicians either replaced midwives or superceded them in the modernist medical hierarchy, leaving them with plenty of women to attend but with relatively little autonomy. As the new millennium dawns on a growing worldwide biomedical hegemony over birth, midwives, the daughters of time and tradition, find themselves negotiating their identities, searching for appropriate roles, and seeking new rationales for their continued existence.

“Modernism” arrived in various parts of the world at various times; first in the industrializing countries of the North, and more slowly in the colonized and exploited countries of the South. So anthropologists consider “modernism” not to be a particular point in time but rather a univariate orientation toward “progress,” defined in terms of Westernized forms of education, technologization, infrastructural development (highway, rail, water, and air systems etc.), factory production, economic growth, and the development of the global marketplace. This univariate orientation identifies a single point in a given area toward which development should be progressing: in economics, that single point is capitalism; in health care, it is Western biomedicine. Thus in modernizing societies traditional systems of healing, including midwifery, have become increasingly regarded by members of the growing middle and upper classes as “premodern vestiges” of a more backward time that must necessarily vanish as “modernization”/biomedicalization progresses.

Yet around the world, the univariate orientation of modernization is increasingly contested in the new “postmodern” era. Postmodern thinking moves beyond uncritical acceptance of

modernization as good, noting the enormous environmental, social, and cultural damage modernization entails, and seeking to generate more polymorphous societies in which multiple knowledge and belief systems can coexist and complement each other. In postmodern societies, conservation and preservation of the environment and of indigenous or traditional languages, cosmologies, health care, and economic systems take on particular urgency and importance, and such endeavours are sometimes considered to be more important than expanding the reach of industrialization, capitalism, and biomedicine.

These postmodern efforts at conservation are fueled both by global organizations and by myriad local grass-roots social movements. In the cultural arena of childbirth, for example, as governments and development planners urge the elimination of traditional birthways, some international workers seek to conserve them in various countries, and many indigenous women who have tried out government-funded hospitals and clinics reject the impersonal care they receive there, and deliberately return to traditional midwives and out-of-hospital birth. And while in some regions, professional midwives trained in a modernist ideology of biomedical superiority act, in fact, superior, in others both professional and traditional midwives are displaying a variety of creative and highly relativistic responses to biomedical encroachment and constraints.

Informed Relativism: The Characteristics of the Postmodern Midwife

Around the world we are witnessing the emergence of a phenomenon that I call “postmodern midwifery” – a term aimed at capturing precisely those aspects of contemporary midwifery practice that fall outside the easy distinctions between traditional birthways, professional midwifery, and modern biomedicine. With this term, I am trying to make salient the qualities emergent in the praxis, the discourse, and the political engagement of a certain kind of contemporary midwife—one who often constructs a “radical critique” of unexamined conventions and monological assumptions. Postmodern midwives as I define them are educated, articulate, organized, political, and highly conscious of both their cultural uniqueness and their global importance. In other words, by "postmodern midwife" I specifically do not mean midwives who uncritically accept either their own ethno-obstetric system or that of biomedicine, but rather midwives who fully understand these in a relative way, as different ways of knowing about birth, discrepant systems that often conflict but can be complementary. The postmodern midwife is scientifically informed: she knows the limitations and strengths of the biomedical system and of her own, and moves fluidly between them to serve the women she attends. She plays with the paradigms, working to ensure that the uniquely woman-centred dimensions of midwifery are not subsumed by biomedicine. She is a shape-shifter--she knows how to subvert the medical system while appearing to comply with it, a bridge-builder, making alliances with biomedicine where possible, and a networker. She attends conferences and meetings, making connections with other midwives in other parts of the world, increasing her ability to translate between systems, and gaining consciousness of midwifery as a global movement. Through her transnational interlinkages with other midwives, she works to create a global culture of midwifery as well as to preserve, carry forward, and teach to others the best of her own cultural traditions around birth.

Lacking or actively rejecting a sense of structural inferiority to biomedicine, she is free to observe the benefits of traditional midwifery practices common in many cultures such as massage, external version, eating and drinking during labour, birthing in upright positions,

birthing at home, and uninterrupted contact between mother and baby. She compares these with what she sees in the hospital and what she learns of the scientific evidence, concludes that there is value in the midwifery approach that biomedicine does not recognize, and develops a sense of mission around preserving that approach in the face of biomedical encroachment. When she has the resources, she constructs her own midwifery knowledge and that of her community as a primary and valuable source of authoritative knowledge in ways that make it available to others, through writing pamphlets, articles, books, and by offering seminars to local, regional, or transnational midwives through which she can share this knowledge by speech and bodily demonstration. She understands that *for a midwife, the professional is always political*, and that she and her colleagues must have an organized political voice if they are to survive. So she works to build midwifery organizations in her community, to join national and international midwifery organizations, and to work with them for policies and legislation that support midwives and the mothers they attend. It would be easy to conclude that only professional midwives, with their greater access to high technologies and international networking systems can achieve the *informed relativism* I am highlighting as the primary characteristic of the postmodern midwife. But traditional midwives in many countries are undergoing radical changes, to which an emergent postmodern consciousness sometimes characterizes their responses.

The Traditional Midwife as Postmodern

Previous anthropological ethnographies of traditional midwives, from Jordan's work in the Yucatan to the Jeffreys' research on the Indian *dai*, to recent studies of midwives in Bangladesh, show them to be unselfconscious participants in their local ethno-obstetric systems and in structurally subordinate relationship to biomedical practitioners (Cosminsky 1977, Jordan 1993, Jeffrey and Jeffery 1993, Laderman 1983; Susie 1988; Rozario 1998), or as phased out altogether by the advent of modern biomedicine (Fraser 1995; Jenkins 2002). To me, these descriptions seemed inadequate to capture the self-awareness, relativistic perspective, political savviness, and drive toward autonomy I was encountering in my research on American and Mexican midwives (Davis-Floyd 1998a,b; 2000; 2001 a,b; 2002; 2003a,b). I formulated the notion of "the postmodern midwife" not only to encompass the informed relativism of various internationally oriented professional midwives, but also of increasing numbers of traditional midwives who are trying to re-negotiate their identities and to articulate new rationales for their continued existence.

Much anthropological research on birthing has shown the heterogeneity in the roles of folk specialists who provide birth assistance worldwide. Some are respected healers in their own right who provide important pre- and post-natal care, as in Mexico (see Sesia 1997) and Guatemala (see Cosminsky 1977, 2001). Others are low status birth attendants who simply perform the "polluting" tasks associated with birth, while decisions about how to manage labour rest with the family, as in some parts of South Asia (see Jeffery and Jeffery 1993). Some perpetuate physiologically harmful traditions like using dung to seal the umbilical stump or wiping the baby with dirty rags (Blanchet 1984); others (or sometimes those same practitioners) perpetuate physiologically beneficial traditions like breastfeeding and birth in upright positions. Some folk or traditional midwives operate from within relatively closed knowledge systems, while others expand their traditional systems to encompass a wide range of concepts and practices from other systems. Some traditional midwives are compassionate and woman-centred; others crossly order women to comply with their commands (for example,

Jordan (1993) shows how midwives in the Yucatan sometimes stuff a birthing woman's braid down her throat to make her gag so her pushing will be more effective, and Graham (1999) documents the occasional slap a traditional Ugandan midwife may administer to snap a woman out of self-pity during labour). Across this diversity, unity cannot be found in an ethos of woman-centred practice or an efficacious practical wisdom. Ironically, what does actually unite this heterogenous set of folk birth specialists is their common subjection to classification by modern institutions as "traditional birth attendants." As I will further explain below, I reject that appellation in favour of the term "traditional midwives," in part because this term reflects the community's role in defining who is a midwife, and also because it indexes the increasing elision between the training and roles of professional and traditional midwives—groups that have heretofore been profoundly separated by their separate appellations as "professional midwives" and "traditional birth attendants."

Postmodern Traditional Midwives in Mexico: Negotiating Knowledge Systems

For example, imagine my surprise when I rounded a corner in a birth centre owned by Doña Facunda, a *partera tradicional* (traditional midwife) in Morelos, Mexico, and encountered a flat marble delivery table, complete with metal stirrups. Laughing as I expressed my amazement (*!Ay, Doña Facunda! What's a traditional midwife doing with a table like that?*), Doña Facunda, with a mischievous glint in her eye, pointed out that the fathers, mothers-in-law, and grandmothers who accompany her clients believe in the efficacy of the hospital and its procedures, including giving birth in the lithotomy position. "If they want me to act like a little doctor (*mini-médico*)," she said, holding up her blue hat and booties, "I can do that! But when the mother-in-law says, 'Shouldn't she get up on the table now?' I say, 'No, it's not time yet,' and I encourage her to keep walking around or to rest comfortably in my big double bed. Most of my mothers give birth sitting, kneeling, or squatting. Very few want the table. It's here if they do, but its main use is just for show!" She added, "If having an IV makes them feel safer, for an extra 100 pesos I'm happy to insert it ... But I encourage them to wait before they get up on the table, until they are really pushing well, and then they find they like being upright." In what I have since come to think of as the perfect postmodern midwifery moment, Doña Facunda added, "So this is what we mostly use the IV pole for!" as she grabbed the metal handles from which the IV bag would be suspended and used them to support herself in the birth position known as a hanging squat.

Doña Facunda was fully aware that "the hanging squat" (which involves the woman squatting in front of a support person, who sustains her under the arms and sometimes by the knees) is not *per se* a traditional birthing position, most of which involve the woman squatting or kneeling alone or on a birthing stool or chair, often pulling on a pole or rope. Rather, the hanging squat had been named and displayed around the world by French physician and author Michel Odent; Facunda had attended one of his lectures in Xalapa, Vera Cruz, Mexico a few years before. Her self-conscious transformation of the biomedical IV pole into a support mechanism for the hanging squat exemplifies what I mean by "postmodern midwifery": a traditional midwife appropriates a biomedical artifact (1) to implicitly critique its normative use in modernist medicine; (2) to reinforce her traditional birthing system (which has long utilized upright positions for birth); and (3) to expand it to include a birthing technique currently in vogue in the international birth activist and midwifery communities.

Such examples (I could cite many!) confound the over-determined association of "midwife" with "tradition." They confront us with novel combinations, unexpected juxtapositions, ironies, reversals of what was once touted as medical "progress," and implosions of competing systems. They highlight the fact that exchanges of knowledge and technology across locales increasingly muddle our attempts to find "authentic" cultural practices and value systems. Most of all, they underscore the inadequacy of the modernist tale of linear "progress" that has for so long been used to narrate the relationship of midwifery to the biomedical management of birth.

Traditional Birth Attendant training courses and other forms of exposure to biomedicine have resulted in fundamental alterations in practice for many traditional midwives in Mexico. Across the country, it is now common for traditional midwives to give pitocin injections to hurry labour, insert IVs for hydration, and wear blue biomedical garb when attending births—practices that they themselves think of as "modern." Combining such practices with the traditional *sobada* (massage), herbal treatments, and religious beliefs, Mexico's contemporary traditional midwives practise at the intersection of various cultural domains. These trends have particularly influenced midwives who practise in urban areas, as my extensive interviews with Doña Facunda and her colleagues who live and practise in the city of Cuernavaca (in central Mexico) reveal. Most of these traditional midwives are in their forties or fifties, attended only elementary school, and became fully literate in their thirties. For at least a decade, they have been incorporated into the state health care system in the state of Morelos through bi-monthly seminars on family planning and other topics. All of them went through a period of using allopathic interventions like oxytocin injections; experiencing complications as a result, they have returned to the use of traditional herbs—in other words, they went through a period of modernization and have come out, as they themselves say, "on the other side." Marina Rodriguez, who is both a nurse and a traditional midwife, explained the difference between the biomedical and traditional systems as follows: "Allopathy is powerful, but it does too much. Its interventions are too extreme. Our traditional herbs take longer to work, but their effects are much more subtle and more precise."

Today traditional Mexican midwives like Marina routinely send women out for ultrasounds when they diagnose a breech or transverse presentation and offer their clients an eclectic potpourri of traditional and biomedical techniques. Into this mix they add multiple "New Age" or "alternative" modalities that they have learned (e.g. reflexology, homeopathy, iridology, Reiki, etc.) They all have birth centres attached to their houses, complete with autoclaves, sterile equipment, and two double beds, one for the birthing woman plus an extra one for family members. Some of them own Dopplers, and use them with delight to exhibit their technological expertise and to let the pregnant woman and family members hear the baby's heartbeat. Their walls are covered with laminated diagrams of fetal positions and the female reproductive cycle, and with certificates from the dozens of continuing education courses they have taken at local universities on topics from anatomy to aromatherapy. Their shelves are filled with homeopathic remedies and herbal oils and salves they have learned to make in such courses. Three of them have computers and email addresses. Dancing fluidly at the interface of biomedicine, holistic alternatives, and traditional birthways, these midwives are strategically negotiating the boundaries between knowledge systems and creatively producing a hybrid and increasingly well-articulated knowledge system of their own. These postmodern midwives of Cuernavaca elide and confound the usual distinctions between professional and traditional

midwives: trained through traditional apprenticeships, they are presently engaged in a visible process of self-professionalization. Their efforts constitute a very conscious attempt to preserve home birth in the face of biomedical hegemony: practising as they do in a city whose hospitals have cesarean rates of over 70%, they are very aware that they often constitute the *only* alternative to a cesarean.

Many traditional midwives still practice autonomously, except when they need to transport a client to the hospital (see Davis-Floyd 2002 for an analysis of "the trouble with transport"). From what I have been able to observe, their major drive is not for the autonomy postmodern professional midwives crave, but rather for some form, any form, of governmental or professional recognition above and beyond the status of "TBA." Aware that professional midwives in their countries have such recognition, and of the many benefits it confers, postmodern traditional midwives like Doña Facunda, Doña Irene, and Doña Nieves long for national certification and state licensure as the professionals they feel themselves to be, in spite of their lack of governmentally accepted training. But their status as TBAs keeps them in limbo, blocking them from recognition as professionals, and preventing state and national governments from even thinking about developing any sort of mechanisms for evaluating or validating their knowledge, skills, and experience.

I have personally met and spoken with traditional midwives from Guatemala and Brazil who also exemplify my profile of the postmodern midwife, so I know that the postmodernity of these Mexican midwives is not unique in the world. I suspect that their efforts to renegotiate their identities and restructure their practice to meet the demands of a changing world are mirrored by other postmodern traditional midwives in many countries, and therefore I suggest that much more ethnographic research on such traditional midwives should be conducted.

The Professional Midwife as Postmodern

Although the most recent trend at WHO and UNICEF is toward diminished support for traditional midwives coupled with increased support for professional midwives, recent anthropological ethnographies call into question the appropriateness of this approach. A distressing cross-cultural trend is showing up in the growing body of anthropological literature about midwifery and birth in the developing world. From Croatia to Tanzania to Papua New Guinea, anthropologists who observe professional midwives giving prenatal care and attending births increasingly note that, far from the midwifery ideal, professional midwives often treat women very badly during birth, ignoring their needs and requests, speaking to them disrespectfully, ordering them around, and sometimes even verbally or physically abusing them. At the same time, and in direct correlation, the professional midwives are themselves often treated badly by the healthcare systems in which they work. They are almost always underpaid, are frequently mistreated by physicians who rank above them in the medical hierarchy, and generally work long hours under stressful conditions that often include inadequate facilities and equipment and too many women with too few midwives to care for them well. In short, many professional midwives are trapped in the biomedical healthcare system, a system that is failing to meet the needs of birthing women in developing countries.

Although unlike traditional midwives, professional midwives have the structural benefits conferred by government certification, access to certain technologies, and the status-conferring white coat, they still must struggle with the pressures imposed on them by the modernist and

colonialist biomedical model. They work inside a system that defines biomedicine as structurally superior to traditional medicine, doctors as superior to midwives, and professional midwives as superior to traditional midwives. Where doctors are few and midwives predominate, professional midwives have opportunities to establish themselves as relatively autonomous practitioners and can make culturally and individually reasonable choices about how to interact with the local traditional midwives. Where doctors are many and professional midwives are clearly subordinate to them in medical hierarchies, they often find that their only route to biomedical status and respect involves rejection of, and often downright rudeness too, traditional midwives and their clients. Studies show that in some places, professional midwives trained in government-approved two-year courses and sent to rural villages work hard to get to know the village women, to give them nurturant care, and to cooperate with the local village midwives (Chen 1977; Kroeger 1996; Kwast 1992). But in others, professional midwives adopt an attitude of arrogance and superiority, often treating the village women badly, slapping them, yelling at them, and giving inadequate care (Allen 2002, Armstrong 1989; Byford 1999; GRMA 1990:49; Iskandar et al 1996; Kargbo 1986, Schwartz 1981, Velimirovic and Velimirovic 1981). In countries like Guatemala, where there are no professional midwives, labour care often falls to nurses who sometimes act arrogantly and scold both traditional midwives and mothers, in effect discouraging further referrals to the hospital (Hurtado 2001, Houston 2001, Cosminsky 2002). It is a paradox of contemporary midwifery that while some professional midwives are working hard to help traditional midwives creatively adapt biomedicine to their native systems (see Daviss 1997; Graham 1999; Davis-Floyd 2000, 2001b), other professional midwives and most physicians are working equally hard to further marginalize or fully eliminate their traditional predecessors (Whittaker 1999; Dieteker 2003; Cartwright 2003; Sieglin 2002; Geurts 2002, Jenkins 2002).

Postmodern professional midwives as I am defining them very consciously strive *not* to engage in such behaviours. When they interface with "TBAs," they apply the same relativistic perspective to the knowledge system of the TBA as they do to the knowledge system of biomedicine. In other words, they seek to identify and support efficacious aspects of the traditional birthing system, and, respectfully and sensitively, to change harmful practices (like coating the umbilical stump with dung). I could cite hundreds of examples of professional postmodern midwives. But for the sake of space and simplicity, I will confine myself to four studies recently published in a special triple issue of *Medical Anthropology* entitled *Daughters of Time: The Shifting Identities of Contemporary Midwives* (Davis-Floyd, Cosminsky, and Pigg 2001). This special issue contains articles describing midwives in Mexico, Japan, and the Netherlands who fully exemplify my profile of the professional postmodern midwife. Here I will briefly summarize these descriptions.

Postmodern Professional Midwives in Mexico

My ethnographic research in Mexico (Davis-Floyd 2001a,b, 2002) documents the emergence of an entirely new kind of midwife, the thoroughly postmodern *partera professional.* These women of diverse sociocultural backgrounds initially sought training from American direct-entry midwives in the independent out-of-hospital midwifery model; since then they have been reformulating that model for Mexico. Through their own practices, through intensive liaison work with traditional midwives, and through organizing national midwifery conferences and meetings, they are creating midwifery as both incipient profession and nascent social movement in Mexico. (Laura Cao Romero, a prominent speaker at the ICM 2002 conference in

Vienna, is one of these new Mexican professional midwives.) Some of them operate outside the medical system while others are carving a niche within it. These 30 or so women face a long struggle to define their identities, legalize their practices, and generate a sustainable space within the emergent Mexican technocracy. To their intense dismay, this struggle must take place within the context of the disappearance of Mexico's traditional midwives, who are vanishing at a rapid rate (in the 1970s, traditional midwives attended over 40% of Mexican births; today that figure is below 15% and the majority are over 65 years of age). Mexico's new professional midwives live in constant tension between their desire to preserve traditional midwifery and the need to create a sustainable form of professional midwifery. They cope with this tension by adding to their professional knowledge base many traditional birthing techniques (such as the use of herbs and of the *rebozo* (shawl) to shift the baby's position). And they help traditional midwives as best they can; for example, Laura Cao Romero created a foundation named *Ticime* (a Nahuatl word meaning "midwives") both to disseminate information about contemporary birth and midwifery, and to offer ongoing skills-sharing and informational workshops to traditional midwives in various Mexican states.

This effort to respectfully combine professional and traditional knowledge systems is particularly visible at the CASA School for Professional Midwives in San Miguel de Allende, where students undergo a professional three-year training program that combines didactic classroom work, clinical work in the CASA hospital, and five three-week apprenticeships with traditional midwives in small and remote rural villages. Anthropologically speaking, this is an educational model that works. These apprenticeships not only allow the professional students to incorporate traditional techniques into their practices, but also prevent them from developing the attitude of arrogance and superiority that many professional midwives around the world exhibit toward traditional midwives. Living in the homes of the traditional midwives, helping with their daily routines, and observing their forms of care instill an attitude of deep respect and admiration for these elder midwives in the younger professional midwifery students, and a strong desire to follow in their footsteps while making the path they traced viable in the postmodern technocracy.

Postmodern Professional Midwives in Japan

Japanese anthropologist Etsuko Matsuoka (2001) demonstrates how the shift in Japan from agriculture to industrial production to the contemporary service and information economy (which I call "the technocracy") has been mirrored by a shift from birth at home attended by traditional midwives, to hospital births attended primarily by professional midwives, to the emergence of new midwives who are beginning to offer Japanese female consumers a plethora of options for childbirth. In Japan's *premodern period* from the 1880s to the 1950s, licensed independent midwives exerted a strong influence in society as they organized themselves on both local and national levels. Japan's *modernization period* took place after WWII from the 1950s to the 1970s as Japan experienced rapid economic growth. In those days professional midwives went into hospitals to produce babies just as workers went into factories to produce goods. But since the 1980s, with the advent of the natural childbirth movement, a new type of postmodern Japanese midwife has emerged.

The midwives who have been playing a prominent role in this natural childbirth movement are different from either of the two previous figures: they practice independently but cooperate with and learn from each other. Many of them have worked in hospitals for years but have

passed in their thinking about birth beyond the limitations of the medical model and have "come out on the other side." They pursue their own midwifery model of care and are developing a new identity. Some have their own maternity homes or birth houses (known in the US as freestanding birth centres) and others work in hospitals trying to introduce a better way within a medical setting. They are mediators, crossing the boundaries between obstetric care and alternative care, home and hospital, modern and traditional, local and international. These Japanese postmodern midwives are increasing options for contemporary women giving birth in Japan. Ironically, these options include the re-incorporation of elements associated with "traditional" birth, such as out-of-hospital birth and the use of upright positions. The primary reason these Japanese midwives give for leaving hospital practice is the damage to mother and baby they observe to be caused by the application of routine technological interventions to the process of parturition. Their personal evolutions through hospital practice to attending births in birth centres and homes contradict modernist evolutionary notions that defined the movement of birth from home to hospital as "medical progress."

Postmodern Professional Midwives in the Netherlands

While other modernizing nations moved birth to the hospital and brought midwives under the authority of physicians, an autonomous profession of midwifery and home based maternity care were preserved in the Netherlands, where around thirty percent of births still take place at home. Many regard the Dutch midwifery system as one of the best in the world. But sociologist Raymond DeVries shows that the same system touted by outsiders as a postmodern vanguard is regarded by some within the Netherlands as a premodern vestige from the past. As the world around them has changed, Dutch midwives have had to find new strategies to protect their profession and the right of Dutch women to choose their place of birth. DeVries examines the transformation of premodern midwifery into postmodern midwifery in the Netherlands. Noting that Dutch women were among the last in Europe to enter the workplace, DeVries links the historical Dutch emphasis on home and family to the contemporary retention of autonomous midwifery and home birth. He shows that as more and more Dutch women began to enter the workplace, home birth began a rapid decline. But by the early 1990s the Dutch midwives and mothers, newly aware that they were losing something precious, embarked on a campaign to create a postmodern social movement around preserving home birth. In this endeavor they found support in scientific evidence, to which the even Dutch government paid close attention. Thus the Dutch case remains one of the premier examples of a thriving postmodern midwifery system that effectively incorporates autonomous midwifery care within the national health care system. From the Dutch case we see that one of the primary values of postmodernism in health care is that its relativistic approach allows each system to be judged on its own merits relative to the scientific evidence and to other systems, forestalling the univariate view of biomedicine as superior that characterizes the modernist approach.

The Local Midwife Meets the Global Plan: When Modernization Goes Awry

Transnationally speaking, any analysis of contemporary midwifery must take into account structures of power. In Foucauldian terms, biomedicine is biopowerful: it is inextricably linked to national modernization efforts and thus to the political power structures behind them. Yet when transnational blueprints encounter local realities, the actual clinical form biomedicine takes in a specific place often cannot live up to the plans behind it. Thus around the world, ideological and political pressures towards modernization have not supplanted ethno-obstetric systems with a set of universal "modern" practices so much as they have produced a

multiplicity of practices of accommodation and negotiation. Some of these are efficacious and some are not. To expand an earlier point, postmodern midwives as I am defining them take a relativistic stance, evaluating information and techniques in relation to each other and to the scientific evidence, and avoiding assuming that a particular technique or item of information is inferior simply because it is not biomedical (or vice-versa). The value of this kind of informed relativism is thrown into high relief by the following counter-example of what can happen when the only system valued is the modernist biomedical system.

Denise Roth Allen's ethnography of birth in Tanzania highlights some of the unintended consequences associated with the government-sponsored and biomedically oriented implementation of the global Safe Motherhood Initiative in Tanzania. Based on international recommendations, the Tanzanian government's policy regarding prenatal care includes the use of the prenatal card, or "home-based maternal record." In theory, the prenatal card, which the pregnant woman keeps in her possession, is meant to serve as a mobile medical record that ensures consistent care during pregnancy and childbirth. But in the rural Tanzanian community where Allen conducted her fieldwork, the professional midwives were so underpaid that they often sold clinic drugs and supplies out the back door to make extra money. So when a local woman showed up for care, they often had little to offer her except a birthing table, where she would be expected to labour without food or often water and with no family members present. And labouring women were often mistreated by the professional midwives, who frequently yelled at them when they complained or asked for help. Consequently many local women chose not to attend the clinic, instead turning to their local "TBA," who treated them with relative kindness and with whom overall costs associated with birth, both economic and emotional, were far less. But because the TBA was structurally defined as "outside the system," visits to her did not officially count as prenatal care and so could not be recorded on an official prenatal card. If a problem developed during labour for a woman who might need a cesarean, she would not be admitted to the clinic without the requisite card documenting the requisite number of prenatal visits. Thus because the clinic refused to accept her clients, the TBA was unable to transport in times of need and had to just do her best to deal with whatever arose; nevertheless, she was often blamed if the mother or baby died. So a modernist system imposed from the top that was intended to be supportive ended up being punitive--for the mothers who did not get the care they needed, for the TBA getting blamed for situations she was powerless to remedy, and for the professional midwives in the clinic who were overworked and underpaid—major reasons for their hostility toward the women they attended.

For another example of how existing power structures affect midwives, Morsy (1995) has shown that in the rural areas of Egypt, where maternal mortality rates are highest, sophisticated midwifery systems of health care were systematically disrupted during the 1800s by the British colonial officials, who gave authority to men only. Having destroyed a viable women's health care network, medical men then blamed the remaining midwives for the disastrous outcomes women in these regions experience. The medicalization of maternal mortality in Egypt has meant that these deaths are attributed to toxemia, postpartum hemorrhage, and the like, rather than to the politico-economic factors that keep women overworked and malnourished, and thus susceptible to life-threatening complications. Blaming traditional midwives enables development planners and government officials to pour millions of dollars in NGO money into stopgap solutions (like hospitals and clinics) that further medicalization without having to address the root causes of maternal mortality through socio-economic and infrastructural

reform. In fact, maternal mortality is often in fact medically induced: in some Egyptian hospitals, more than half of all maternal deaths result from infections after Cesarean section.

In 1978 with the publication of *Birth in Four Cultures*, Jordan issued a call for the replacement of top-down, culturally inappropriate, biomedically oriented systems with models of mutual accommodation between Western and indigenous systems. But the worldwide hegemony of Western biomedicine has made this kind of mutual accommodation an elusive goal. Why bother to accommodate to a system you regard as inferior? Why not, as has so often been done, demand instead that the indigenous system change to accommodate biomedical ways of knowing and managing birth? The answer is quite clear of course: *biomedicine is an inappropriate model for birth in any culture. It is too costly, too interventive, too drug- and technology-oriented, and does too much harm to mothers and babies for it to be a viable model to which developing countries should aspire.* Nevertheless, because of the general global dominance of the West, the legacy of colonialism, and the various dramatic successes of biomedicine, all developing countries do aspire to meet the standards set by Western medicine, despite the fact that these standards have been scientifically demonstrated to be inappropriate for normal birth and indeed for many of the world's health needs.

I vividly recall the 1999 Safe Motherhood (*Maternidad sin Riesgos*) conference in Mexico City, during which a UNICEF official stated that it was the fault of the village *parteras* (midwives) that women died in childbirth, because the *parteras* did not transport them when they should. Outraged, Doña Nieves, a *partera* from a small town in Oaxaca wearing her traditional *huipil*, grabbed the microphone and firmly responded, "Don't tell me that I'm responsible for this! I've been practising for 30 years and I *know* when to transport women to the hospital. But I have no way to get them there. If you want to reduce mortality in my community, don't *blame* me--give me a car!" As this postmodern traditional midwife illustrates, the problems the global Safe Motherhood Initiative seeks to address are real--far too many women die in childbirth in many parts of the world—but blaming "TBAs" only obscures the painful truth that the solutions generated by government and development planners, like TBA trainings, are usually ineffective because they are superficial. They do not address serious infrastructural problems like bad roads, lack of transport, or the poor care many women receive when they do make it to the hospital--not to mention the chronic malnutrition suffered by the poor—an ongoing legacy of colonialism and "modernization."

The blame cast on "TBAs" in Tanzania, Mexico, Egypt, and many other developing countries is now having serious repercussions for them. For the past three decades, TBA training courses worldwide have attempted to convince traditional midwives that their birthways are inferior to those of physicians and of professional midwives who graduate from government-approved professional training programs. Almost always, these courses are designed by biomedical personnel trained in biomedical institutions to think about and manage birth in biomedical ways. Very seldom do the "trainers" enter a community and spend time there learning about the indigenous birthways before they try to intervene. Rather, they attempt to educate traditional midwives in biomedical ways of thinking that are often totally inappropriate to local circumstances and realities.

Because in most places TBA training programs have not resulted in any demonstrable drop in maternal mortality, UNICEF and other agencies are now withdrawing funds and support for

trainings for "TBAs" all over the Third World, and increasing support for "midwives" who meet the international definition. Indeed, in Costa Rica, traditional midwives already have almost disappeared, having been deliberately phased out by government officials bent on modernization (meaning, in the health care field, biomedicalization) (Jenkins 2002).

As early as 1978, Brigitte Jordan demonstrated the cultural inappropriateness of the two-week TBA training programs initiated in Mexico, showing that their content was entirely biomedical and took almost no account of local beliefs and practices (whether harmful or beneficial). For example, perhaps the local custom is to cauterize the cord with a candle flame after cutting it. Trying to replace that sustainable custom with merthiolate in a place where supplies are scarce and merthiolate unavailable or expensive is an unsustainable and inappropriate intervention, but one nevertheless that typifies this training approach. Far more seriously, TBA trainers often think their job is done if they succeed in educating midwives about the multiple conditions that are biomedically deemed to require transport to a clinic or hospital. Transport may be unavailable or may result in inadequate care; nevertheless, the trainers leave when the training is "complete," and the midwives get blamed if they do not transport for the risks they have just been educated about. Here I emphasize Jordan's point: most such courses have sought not to train TBAs in locally effective practices, but rather to impose on them an unscientific and culturally inappropriate biomedical approach. In other words, *"TBA training" does not work because it has never been tried.*

In spite of their detrimental effects, TBA trainings often did have the positive effect of integrating midwives into local health care structures, enabling them to sign birth certificates, to develop relationships with physicians, and sometimes to obtain access to family planning information and devices. Midwives themselves often value this interface with the official health care system *far more* than the information provided in the courses. The sudden withdrawal of funding for such programs in various countries, including Mexico, leaves the midwives who have depended on them in official limbo. Professional midwives with the relativistic postmodern perspective I seek to highlight here want to see "TBA trainings" not eliminated but radically redesigned to address local realities and needs; some professional midwives have in fact designed trainings that begin with respectful evaluations of the systems of knowledge local midwives already use and stress the on-site development of viable forms of what Jordan (1993) calls "mutual accommodation" between biomedicine and community styles of birth. Such postmodern professional midwives have been working hard around the world to develop culturally sensitive training programs that respect traditional midwives' knowledge, experience, and skills, encourage the continuation of beneficial traditional practices (such as birth in upright positions), and offer culturally appropriate substitutes for harmful practices. The most successful of such programs also educate local biomedical personnel in the value of many traditional techniques and teach doctors and nurses to respect and work harmoniously with traditional midwives. These professional midwives acknowledge Doña Nieves' point that the problem of maternal mortality in developing countries is macro-structural and cannot reasonably be blamed on local "TBAs."

In an ideal world, the traditional community midwife is the first line of care and is backed up by professional midwives, doctors, and the biomedical system. In the real world, often there is no backup or no way to get to it, and the "TBA" must handle whatever comes as best she can. Clearly, the solution does not lie in giving her superficial training in biomedicine and expecting

her to get women to the hospital when they need to go; rather, the solution must be found in a system-wide approach that requires the equal flexibility of biomedicine, professional midwives, and "TBAs."

Professional vs. Traditional Midwives: The Ramifications of Definition

Any effort to make sense of the complexities of contemporary midwifery must deal not only with biomedical and governmental power structures but also with the definitions such structures impose upon midwives and the ramifications of these definitions within and across national and cultural borders. The international definition of a midwife, endorsed by the World Health Organization, UNICEF, FIGO, and ICM states:

> A midwife is a person who, having been regularly admitted to a midwifery educational program duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery." (World Health Organization 1996)

All midwives who have not graduated from such programs are thus not considered "midwives" (in English) but are labeled "TBAs" (traditional birth attendants). Since there are myriad local names for midwives in myriad languages (and many modes of birth assistance that occur but are not performed by named folk specialists), the impact of this naming at local levels can be hard to assess (Cosminsky 1976, 1983; Pigg 1997). But on the global scale, the ramifications of the distinction between midwives who meet the international definition and those who do not have been profound. Those who do are incorporated into the health care system (usually below doctors in the medical hierarchy and above nurses). Those who do not remain outside of it, and suffer multiple forms of discrimination as a result (see for examples Guerts 2002, Jenkins 2002).

As I hope I have made clear, the postmodern *professional* midwife as I am defining her is culturally sensitive and competent: she works respectfully and cooperatively with traditional midwives and, like the CASA students, includes traditional practices in her repertoire. And for her part, the postmodern *traditional* midwife gains exposure to both biomedical and professional midwifery information and techniques and selectively incorporates these into her practice, learning as she goes. My familiarity with midwives and midwifery systems in many countries leads me to see the midwife/TBA distinction not as a dichotomy but as a continuum, so I prefer the labels "professional midwives" to indicate those who have had professional accredited or certified training and "traditional midwives," to indicate those who practise within the traditions of their communities, without professional degrees or culturally valued certifications. From where I sit, it is clear that around the world, traditional midwives are gaining exposure to biomedical and professional midwifery information and techniques and are selectively incorporating some of these into their practices. Thus, as the postmodern traditional midwives of Mexico make clear, *the line between the professional midwife and the traditional midwife is becoming increasingly blurry*. This fact affects the ongoing viability of the international definition of a midwife and the ultimate goal of all midwives—the welfare of mothers and babies.

Space does not allow me to address this definitional issue in depth; here I will briefly and simply say that many social scientists studying contemporary midwifery find the arbitrary distinction between TBAs and midwives to be highly problematic in terms of its cultural effects. From a social science perspective, a government-approved midwifery training does not necessarily produce a midwife—it may produce a "mini-doctor" instead. Thus social scientists tend to define a midwife not only in terms of her attendance at births but also in terms of her social and community roles. In other words, for most social scientists, a "midwife" can be a practitioner who meets the international definition and/*or* one who is recognized as such by her community. In general, social scientists do not assume that the role or the practise of professional midwives according to the international definition is any more important to the welfare of women and children than the role of the practitioners officially classified as TBAs. Clearly, we social scientists are limited in our perceptions because we do not share a midwifery knowledge base. Yet our perceptions are expanded by our broader focus on society, culture, and community. And we do of course look at outcome data when they are available. As far as I know, every social scientist who studies contemporary midwifery (including social scientists who are also midwives) is *impressed* by the ongoing contributions of TBAs and *concerned* by the colonialist and biomedical limitations of professional midwives—limitations that, as we have seen, express themselves both in attitude and in practice.

It is important to note that every social scientist I know who studies midwives also supports them, as we know midwives to be the most suited practitioners for pre-and postnatal care and for attendance at the vast majority of births. Yet we almost universally question the hierarchical orientation inherent in the official definition, and deeply wish to expand the spectrum of those officially classified as "midwives." Traditional midwives have already vanished or are vanishing at a rapid rate in many parts of the world (Jenkins 2001; Davis-Floyd 2001). Yet those who remain, from the Indian *dai* to the Mexican *partera tradicional*, are providing vital services to the populations they serve, both rural and urban, and preserving knowledge systems that contain much that is of value and relevance in the postmodern world (for example, in both Brazil and Mexico where traditional midwives attend 15% of births, the vast majority of these are in remote rural regions with little or no access to biomedicine). Defining traditional midwives as TBAs is a powerful statement that their knowledge does not count in the global system. And indeed in some cases their practices have been shown to be scientifically unsound. *The point is not to romanticize traditional midwives, but to approach them with the same informed relativism that postmodern professional midwives apply to biomedicine*. A relativistic, postmodern perspective reveals that the same traditional midwife who uses cow dung on the umbilicus or tells a mother that her colostrum is bad for her baby can often skillfully and successfully attend births that would confound professional midwives accustomed to obstetrical backup. The same postmodern perspective reveals that professional midwives with years of government-approved training may withhold food and drink from labouring women and force them to deliver flat on their backs. (Indeed, the surest marker that traditional midwives have had contact with professional midwives and government-sponsored trainings is that they suddenly begin to demand that their clients deliver in that most unscientific of positions.) In other words, a midwife's attitude and ideology influence the care she gives far more than the technicalities of the training she receives.

Education entails socialization. If all professional midwives were socialized through their education into a woman-centred and culturally sensitive approach to birth, I probably would

not be writing this article. But such is not the case. As much as I wholeheartedly support professional midwives, I must acknowledge that all is not well in their world. Nor is all well in the world of traditional midwives, whose practices are always culturally appropriate but not always woman-centred nor science-based, and are in imminent danger of disappearing. Both as an anthropologist and as a woman, I seek a way of preserving and revitalizing traditional midwifery. Personally speaking, I would rather drink herbs if I need labour stimulation and pull on a rope while I am pushing than receive an oxytocin infusion and give birth flat on my back, and I would rather be yelled at by a traditional midwife who thinks I am a wimp than a professional midwife who thinks I am ignorant and unimportant. I have studied childbirth worldwide for years, and it is not clear to me that, globally speaking, professional midwives are going to offer me those options. The truth is painful: at this moment, in almost any country, I have a far greater chance of having a highly medicalized birth with a professional midwife than the natural one that I, *and science*, would choose. What is wrong with this picture? Must our daughters in the late 21st century face a birthworld in which no traditional midwives, and no traditional midwifery knowledge systems, survive to perpetuate their age-old skills and indigenous knowledge systems? *There is nothing postmodern about the willful eradication of traditional healing and birth systems, and everything postmodern about their preservation and their combination with science-based professional midwifery knowledge*. This is the challenge faced by all postmodern midwives, whether professional or traditional or an elision of both.

Conclusion

Postmodern midwives, for all their value, often find themselves living in a constant state of stress, lobbying legislatures for the right to exist, struggling to balance conflicting ideologies and knowledge systems, and arguing with each other about appropriate standards for education and practice. In developed and developing countries alike, the tensions between biomedical, traditional, and alternative knowledge systems permeate professional midwifery training and praxis and generate conflicts between midwifery educators, between educators and students, and among practicing midwives and those who regulate them. The professional midwives of the industrialized North are accelerating their long struggle for autonomy even as traditional midwives in the less affluent countries of the South continue to lose the autonomy they formerly held. In short, today nothing is easy about being a midwife of any type. Yet motivated by a shared desire to offer viable long-term options to biomedical birth, these daughters of time and tradition continue their struggle, with varying degrees of success, but always with the necessary determination to make sure that midwives, with all their limitations *and* all their power, remain available to serve the mothers and babies of the postmodern world.

Acknowledgements

I have adapted some of the material in this article from the following sources, which I have either authored or co-authored: (1) Davis-Floyd, Robbie, Sheila Cosminsky, and Stacy Leigh Pigg, "Introduction to Daughters of Time: The Shifting Identities of Contemporary Midwives," a special triple issue of Medical Anthropology edited by Robbie Davis-Floyd, Sheila Cosminsky, and Stacy Leigh Pigg, Volume 20, Numbers 2-3, 4, 2001-2002. (2) Davis-Floyd, Robbie, "Global Issues in Midwifery: Mutual Accommodation or Biomedical Hegemony?" *Midwifery Today*, March. pp. 12-16, 68-69, 2000; (3) Davis-Floyd, Robbie, "Home Birth Emergencies in the U.S. and Mexico: The Trouble with Transport," in Reproduction Gone Awry, a special issue of *Social Science and Medicine* edited by Gwynne Jenkins and Marcia Inhorn, in press. (4) Davis-Floyd, Robbie, "*La Partera Professional*: Articulating Identity and

Cultural Space for a New Kind of Midwife in Mexico" in Daughters of Time: The Shifting Identities of Contemporary Midwives, Medical Anthropology 2-3, 2001.

Endnotes

The title for this article, "Daughters of Time," springs from a formative moment in the history of the new midwifery in the United States. Santa Cruz midwife Karen Erlich described that moment to me as follows (personal communication, 2000):

> The First International Conference of Practicing Midwives was held in El Paso in January of 1977. It was an amazing, emotional gathering, the first ever, of homebirth midwives who had sprung up all over the continent, thinking they were the only ones who existed. Among the concerns expressed was whether we wanted to stay as iconoclastic, outside-the-system lay care givers, or allow a process of professionalization . . . During the open mike, women spoke passionately, eloquently, angrily, tactfully and not tactfully, about this calling and the political issues already confronting us. In the midst of this hot, compelling, fascinating, provocative session, Mary Offermann got up and, instead of politicizing, sang this song. It was fantastic! The conference ended awash in the true emotions of birth and womankind.
>
> > Daughters of Time
> > I am a daughter of time, My mother walked these hills in years gone by.
> > Her mother too once watched these trees, in blossom, bearing fruit and losing leaves.
> > We are the daughters, the daughters of time.
> > . . .
> > Last night I held a woman who was giving birth, She brought another daughter here to earth.
> > I feel happy with my man and with our son, but I wonder if a little girl will ever come to me
> > To join the daughters, the daughters of time. (Copyright1975 Mary Offermann.)

For these midwives, the poetic trope of "daughters of time," with its image of birth as the moment that embodies the continuity of generations of women, helped solidify a sense of what their project was about. The image expresses a hope that women today will be empowered to recuperate knowledges and skills maintained by women in the past, revitalize them for the present, and preserve them for the future. The phrase was further cemented in American midwifery lore in the early 1980s through a film about nurse-midwives called "Daughters of Time" (Durrin 1982). Here I ask, can the image of "daughters of time" be as meaningful, or as politically efficacious, for midwives elsewhere as it was for the group of US midwives who were so moved by it? A comparative perspective, so central to anthropology, is of renewed importance as we attempt to understand the relation between a resurgence of positive interest in midwifery and the growth of midwifery movements in some countries, and the marginalization, displacement, or medicalization of folk or traditional midwives in other places.

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B. PLENARY SESSION

CANADIAN MIDWIFERY IMPLEMENTATION: REFLECTIONS ON THE LAST DECADE

In this session three midwives spoke of regional issues that have affected the implementation of midwifery in each province. Through the regulation of midwifery, some basis tenets are held central within each province. However, with each province that has attempted proclamation comes a variety of challenges that are unique to that region. Here midwives, from the Northwest Territories, Manitoba and Quebec, share their experiences with regulation.

1. *Midwifery in Canada: Resurgence and Regulation*
   Co-Chairs and Opening Remarks: Christine Saulnier, Atlantic Centre of Excellence for Women's Health and Jane Kilthei, Canadian Midwifery Regulators Consortium

2. *The Challenges of Midwifery Implemention in the Northwest Territories*
   Gisela Becker, Midwives Association of the Northwest Territories and Nunavut

3. *Integrated into the System: Manitoba Midwives Speak Out*
   Beckie Wood, Midwives Association of Manitoba

4. *Birthing Centres in Quebec: Ten Years of Community Midwifery*
   Sinclair Harris, Maison de Naissance Lac-St-Louis, Pointe Claire, Province of Quebec

B.1 MIDWIFERY IN CANADA: RESURGENCE AND REGULATION

Christine Saulnier, Atlantic Centre of Excellence for Women's Health
Jane Kilthei, Canadian Midwifery Regulators Consortium

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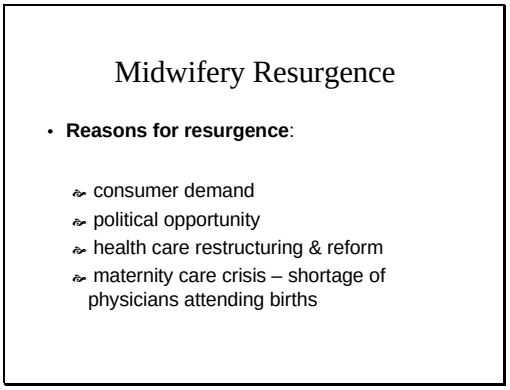

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Our goal with this presentation is to help set the stage for the discussions that are to come in the next two days. This forum is focused on regulation: Where is it at? What can we learn from the provinces that have regulated? And how can we move forward with regulation in the other provinces and territories?

We thought it would be important to provide some background to what we are calling the 'resurgence' of midwifery. For some communities it is more of resurgence than others that might actually be experiencing midwifery for the first time. We will also provide an overview of why there has been this move to regulated midwifery in Canada and what the regulatory models have in common, as well as what some of the distinctive features of their regulatory processes have been. We have tried to capture merely a snapshot of where regulated midwifery is in Canada. For some of you this is nothing new and indeed you will be able to clarify and add your own experiences.

We end our presentation today with a few highlights of what we have called midwifery milestones-events that indicate the extent to which midwifery has become integrated into the public health care system and is accepted as a valuable primary health care group.

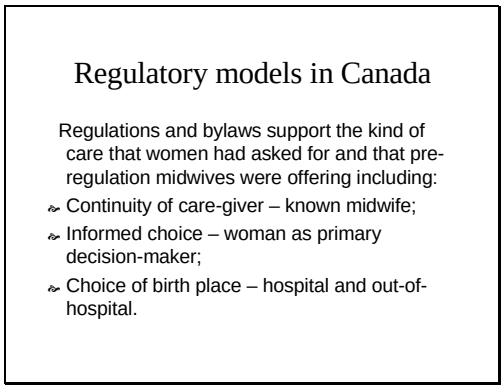
In terms of the resurgence or the movement to regulate midwifery, the factors that influenced it were many and varied. Here are but a select few: (1) Consumer demand played a role especially in the more populated areas. Despite the fact that midwives' care was not covered by public health care in Ontario, through the 1980's women continued to increasingly demand midwives.

(2) Political opportunity has taken many forms across the country. In Ontario, for example, the *Health Disciplines Act* was opened for review in 1983. This gave midwives an opportunity to present a case to the government's legislative review for the regulation of midwifery as a profession. This led to the establishment of a Midwifery Task Force that recommended self-regulation, an integration program for current practitioners and university-based midwifery education. Changes started with Conservative government, process was carried on by the Liberals and implemented by an NDP government with all three parties taking "credit" for midwifery when the legislation was proclaimed in 1993.

(3) This was also a time of health care **restructuring** and **reform**; with talk of restructuring hospital and community delivery systems, governments were seeking "cost-effective" solutions in the face of reduced federal transfer payments and budget cutbacks. Midwifery was considered **cost-efficient.**

(4) In addition, the system was facing a '**maternity care crisis'** because increasing numbers of family physicians were withdrawing from obstetrics and fewer medical students choosing to deliver babies. Indeed, health human resource management challenges were at the forefront of many health reform initiatives...as was the realization that the health care system's focus on illness as opposed to promoting health was both narrow and expensive.

(5) Discussion of the '**determinants of health'** and improving **'population health**' also provided openings for the **rebirth of midwifery.**



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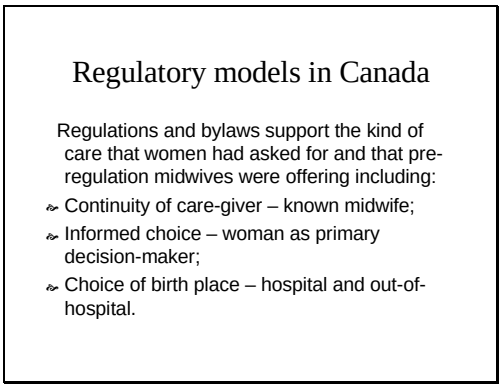
But these factors don't really get to the heart of the question: why regulate at all? Women wanted the **choice** as to *how* to give birth and with *whom* in attendance and many women felt that it was time to have this choice *legitimized and legally recognized*. Women wanted access to midwives as primary caregivers in the hospital as well as the home setting. They also wanted their midwives to be respected and listened to when transport was needed from a home birth into hospital. Finally, they wanted midwifery officially recognized so that services could be provincially funded increasing women's access to care.

Coroners inquiries and inquests into baby deaths in Ontario and BC and one case involving criminal charges all contributed to recommendations that midwifery be regulated and supported by government in the public interest. Whether the cases ended up supporting the care the midwives had provided or found it lacking, the need to have a system that could identify competent practitioners and set standards of practice was brought into the spotlight. This reinforced the recommendations of provincial task forces and commissions and gave an added sense of urgency to the need to protect the public.



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Midwifery advocates used all of these opportunities to inform the government, the courts and the public about their positive experiences of midwifery care. They made it clear that they wanted regulated midwifery to reflect the values of the movement that had given it birth.

In province after province, they were successful in having these values incorporated into the language of the legislation, regulation, bylaws and standards of practice governing this newly regulated profession. Briefly the three distinctive features of this care were: continuity of care, informed choice and choice of birthplace.

Regulated Midwifery in Canada: A Snapshot

Province / Territory	Education Programme	Method of Remuneration	Liability Insurance	Number of Midwives
BC	**4 yr undergrad – UBC Foreign-educated midwives assessed for equivalency**	**Course of Care**	**Self-insurance plan supported by provincial government**	**85**
Alberta	**None**	**Limited Project-based**	**Government subsidy (time limited, project based funding)**	**16**
Manitoba	**Funded AMEP[1]; Education policy allows for apprenticeship and other models**	**Salary**	**100% coverage for employees of RHAs**	**28**
Ontario	**4 yr undergrad Laurentian McMaster Ryerson (Consortium); Six-Nations Aboriginal Midwifery Training Program**	**Course of Care**	**100% coverage by provincial government**	**267**
Quebec	**4 yr undergrad Université de Quebec (Trois Rivières); 3 yr apprenticeship model for Inuit Midwives in Nunavik**	**Salary**	**100% Coverage by provincial government**	**55**

Slide 6

[1] AMEP is the proposal for an Aboriginal Midwifery Education Program submitted to the federal Primary Health Care Transition Fund. The application was successful and in December 2004 Manitoba Health announced the AMEP will proceed. (Editor)

Each province or territory's process of moving toward legislation has involved some kind of working group/task force, with consultations, an interim regulatory council of some kind and eventually a college. The provinces that currently regulate midwifery are BC, Alberta,

Manitoba, Ontario and Quebec. It is important to note however that **Saskatchewan** has legislation that has passed through their legislature but has not yet been proclaimed. In other words the regulatory process has stalled; the key reason is that the midwives are opposing proclamation until there is some commitment for the public funding of midwifery services. In addition, the **NWT** has legislation that has been proclaimed but the territory is still working on regulations. **Nunavut** has what was a pilot project in midwifery, which in 1995 changed from the Rankin Inlet pilot project to a full program with a staff of three midwives, two Inuit maternity workers and a clerk interpreter. While the Rankin Inlet birthing centre is currently functioning outside provincial legislation, its long–term survival seems promising.

Also, it should be noted that in remote Areas of **Newfoundland** and **Labrador** there still exists a special agreement between the Department of Health, the Newfoundland Medical Board, and the Association of Registered Nurses of Newfoundland, that enables midwives who are nurses employed by the two Health Boards in that northern area to practise midwifery. The midwifery legislation that is still on the books is, according to the government, no longer active because there is no longer a college.

Discussion of table (slide 6)
In terms of the regulated provinces then, there are approximately 60-80 midwives who enter the Canadian system per year. This is expected to increase by 2006 to 90-110 per year. Some of the distinct features are:

Quebec
Quebec chose to proceed via pilot projects in the face of the strong opposition of organized medicine. Birth Centre Pilot projects were integrated into Quebec's CLSCs or local community health centres. Legislation is now in place that enables Quebec midwives to practice in any setting: birthing centre, home, and hospital.

Ontario
After the *Task Force on the Implementation of Midwifery in Ontario* traveled to various countries and carried out public consultations across the province, Ontario was the first province to implement fully regulated, funded midwifery in 1994 under the *Midwifery Act* to the *Regulated Health Professions Act*. Section 8 of the *Midwifery Act* governs the use of the title of "midwife" and restricts it to those members of the college **except for Aboriginal midwives.** This means that Aboriginal midwives are exempt from the provincial midwifery law when they practice on-–reserve providing services to Aboriginal families. In 1996 the Six Nations birth centre was established and offers training to Aboriginal midwives from the Six Nations Reserve and other parts of Canada.

Alberta
Alberta first registered midwives in 1998 and the majority of them are in private community practice. There is one publicly funded, hospital program in Stonyplain, Alberta. Because of lack of public funding many midwives have been leaving the province as they can't afford insurance and other costs related to regulated practice. Midwives are discouraged that they cannot reach the populations they want to serve if they have to charge for their services - moreover they can go to another province and practise under better circumstances.

British Columbia

One of the distinctive features of BC's regulation process was The Homebirth Demonstration Project. All BC registered midwives and their home birth clients participated and the Ministry of Health recorded all data from their homebirths from the inception of regulated midwifery in January of 1998 until October 31, 2000. Some of the highlights of the December 2000 report are that: 76% of women who planned a home birth, birthed at home; the remainder of births occurred in hospital with decisions to transfer occurring ante or intra-partum. Slightly less than 4% of homebirths resulted in emergency transport to hospital. Midwives practiced cautiously, with a consultation rate of 32%. Care was transferred to a physician in 18% of births. Midwives put back-up plans in place with their local hospitals and sent client records into hospital prior to labour. The evaluation team for the HBDP recommended the continuation of planned home births in B.C. within the guidelines established by the College of Midwives of BC.

Manitoba

Almost all midwives work as employees of Regional Health Authorities, although working in private practice is an option. Midwives are paid on salary to take into account the 'special' needs of certain clients requiring more time and to be able to cover midwives doing committee work etc. Manitoba (and other midwifery) legislation does not prevent midwives from continuing to register and practice as nurses as well (this allows midwives in areas where there are not enough births to extend their practice; it also allows nurses who are currently working for RHAs to keep their pensions and benefits, etc.).

All regulated provinces

It has been important to establish a physician billing code for consultation with a midwife to support access to consultation.

All acknowledge or recognize Aboriginal midwifery in some way. Manitoba and BC each have committees on Aboriginal midwifery, Quebec has a northern Inuit birth centre, Ontario has an exemption and the Six Nations training program.

Integration processes and committees were put in place to support transition from unregulated to regulated practice; developing templates for defining roles and responsibilities; support new prescribing and diagnostic testing authority; work with public health nurses, ambulance services, hospital staff; provide supervision and updating for midwives with discrete competency gaps identified in assessments; supervised experience for those who have not worked in either the home or hospital setting before

Midwifery Milestones

Evidence of midwifery's tremendous evolution since regulation can be found in: university programs established, provincial funding programs support access and enhance professional practice; all midwives have professional liability insurance coverage; pilot projects have evolved into ongoing established programs.

Slide 7

Initial resistance from the medical community has shifted to support and interest in more collaborative care; e.g. the SOGC's policy statement on midwifery released in 1997 withdrew their former position that opposed home birth. Now its 2003 policy statement supports the continuing process of establishing midwifery in Canada as a regulated, publicly funded profession. This statement also stresses the importance of choice for women and their families. Midwives are now members of SOGC. Indeed, in provinces where it is regulated we are seeing the greater and greater integration of midwives into hospital departments and on hospital boards, and as tenured faculty in university-based midwifery education programs etc. Midwives are taking initiative in researching collaborative care models to reach women in inner-city and remote communities and in expanding the diversity of the profession.

In 2001 the regulatory bodies for the five regulating provinces and the associations and midwifery education programs from across the country signed a **Mutual Recognition Agreement** to support the mobility of midwives between regulating jurisdictions. Under this agreement a general registrant, who has been registered for a year or more in one of these jurisdictions, can have her qualifications recognized by a College in another province. This agreement rests on a national standard Canadian Midwifery Model, with continuity of care and choice birthplace as key elements. If an applicant does not meet all the requirements specified in this agreement she may be required to undergo additional assessment and may or may not register the applicant with or without conditions or restrictions.

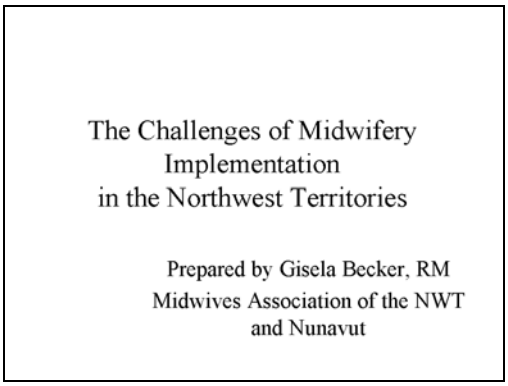
Also inherent in this agreement is the commitment to work with the not-yet-regulated provinces and territories to support them in moving toward integrating regulated funded midwifery into their health care systems.

The **Canadian Midwifery Regulators Consortium** was formed after the signing of the Labour Mobility Agreement in 2001 (represents all governing bodies in Canada). The CMRC's mandate is to facilitate the mobility of registered midwives across Canada through the implementation of the *Agreement on Mobility for Midwifery in Canada (23 March 2001),* to advocate nationally for legislation, regulation and standards of practice that support access to a high standard of midwifery care across the country, and to provide a forum for Canadian midwifery regulators to discuss issues of mutual concern.

The Canadian Association of Midwives was incorporated in January 2001, as the national organization representing midwives and the profession of midwifery in Canada. Formerly, the Canadian Confederation of Midwives, the Association's role as stated in our bylaws is to promote, protect, and enhance the profession of midwifery.

B.2. THE CHALLENGES OF MIDWIFERY IMPLEMENTION IN THE NORTHWEST TERRITORIES

Gisela Becker, Midwives Association of the Northwest Territories and Nunavut



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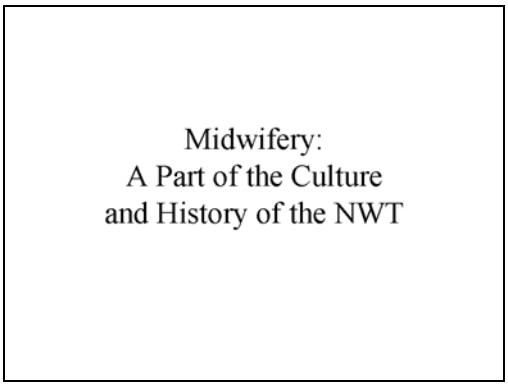

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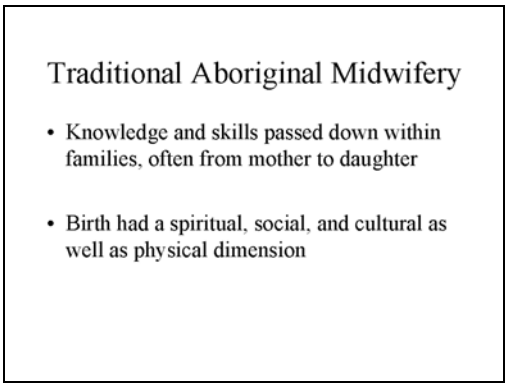

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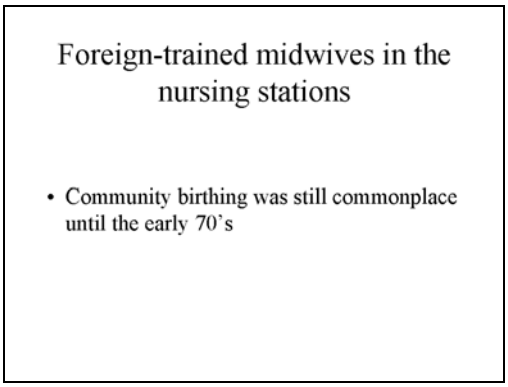

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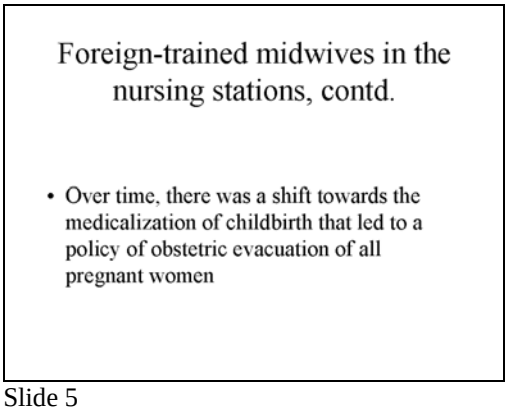

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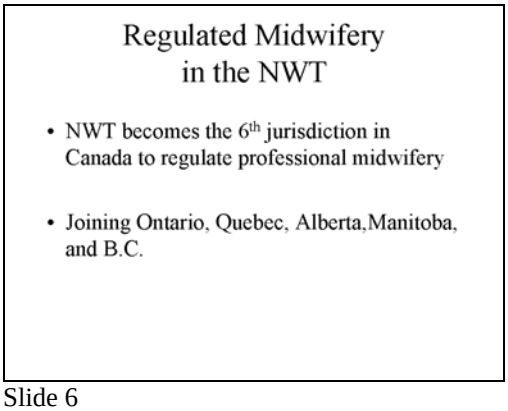

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Professional Midwifery, contd.

- The Midwifery Profession Act October 2003
- Broadly consistent with the Canadian model of midwifery

Slide 7

Midwifery Legislation in the Northwest Territories

Slide 8

The catalyst: Fort Smith

- Practising midwives since 1992
- Grassroots support from families
- Health Authority interest
- Birth Centre vision
- Political support

Slide 9

The events leading to legislation

- Stakeholder discussions spring 2002
- Cabinet proposal winter 2003
- Midwifery Implementation Committee
- spring 2003
- Practice Framework spring/summer 2003

Slide 10

The events leading to legislation

- Bill 24, 1st & 2nd Readings June 2003
- Public hearings and Standing Committee review September 2003
- Amended Bill 24, 3rd Reading & Assent October 2003

Slide 11

Summary of the Midwifery Profession Act

- describes the scope of practice of the "registered midwife", a protected title
- authorizes the Minister to establish or adopt a Midwifery Practice Framework
- authorizes regulations to be made re: code of conduct, continuing competency program, and various aspects of practice
- sets out procedures re: review of conduct of registered midwives
- consequentially amends a number of Acts

Slide 12

Pre-implementation Steps:

- Regulations to the Act
- Amendments to other legislation
- Policy amendments
- Remuneration model / funding
- Liability insurance

Slide 13

Implementation

- April 1, 2004 was target date for Proclamation of the Act
- Coordination between department and health authorities will be essential

Slide 14

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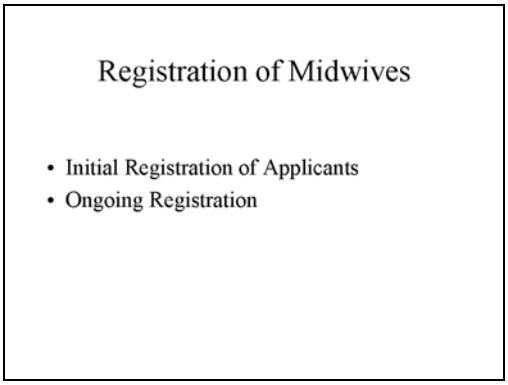

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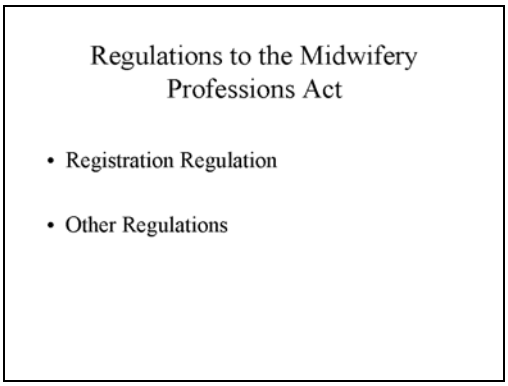

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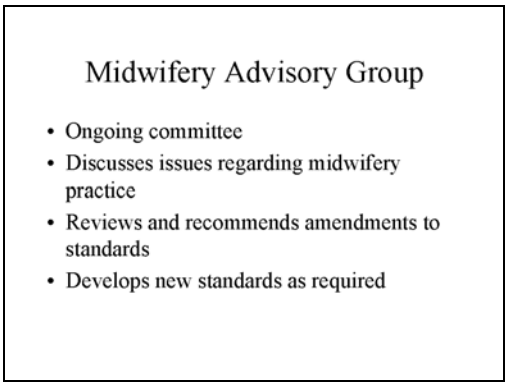

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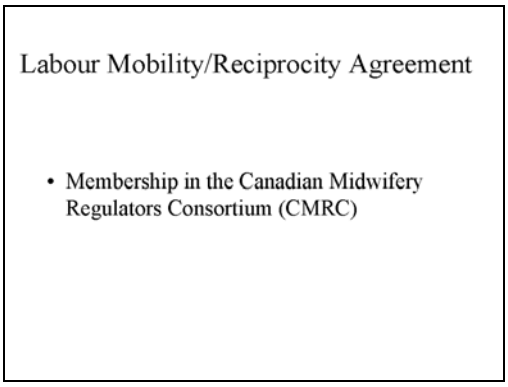

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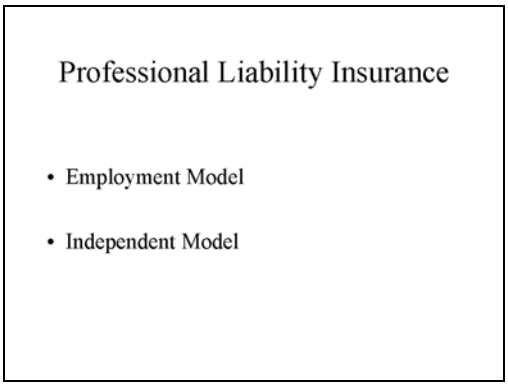

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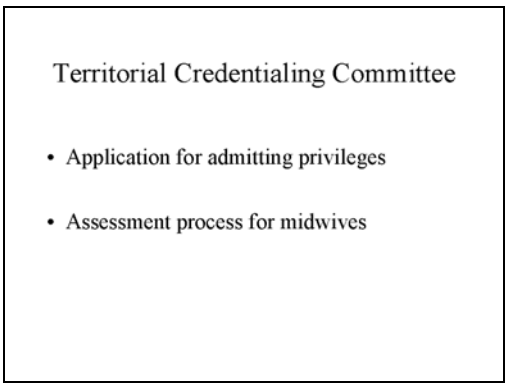

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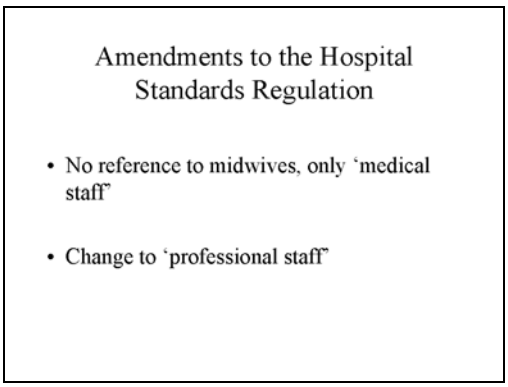


Slide 22

Midwifery Regulation to the Pharmacy Act

- Drug list completed
- Currently at the Department of Justice for approval

Slide 23

Medical Travel Policies

- Amendments to be made that midwives can transfer clients independently

Slide 24

Midwife Job Description

- Job description developed
- Job description evaluated for pay level

Slide 25

NWT Midwifery Practise Framework

- Developed by practising midwives
- Consistent with the Canadian model of midwifery practice
- Will be adopted by the Minister of Health and Social Services

Slide 26

The Canadian Context

Slide 27

Midwifery in Canada

- Currently over 450 registered midwives in Canada
- The majority are in Ontario
- Demand continues to exceed supply

Slide 28

Midwifery in Canada

- Canada is experiencing a maternity care crisis, especially in rural areas
- Midwives the only group of maternity care providers whose numbers are growing rather than declining

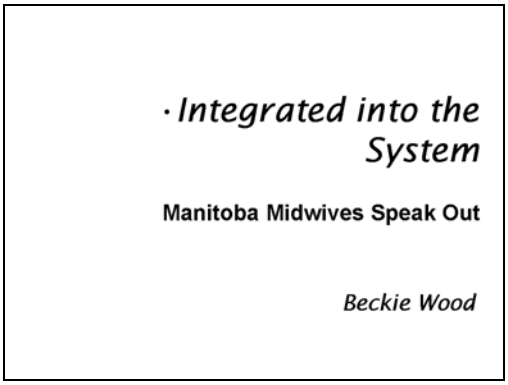
Slide 29

Integration of the Midwifery Profession

Slide 30

B.3. INTEGRATED INTO THE SYSTEM: MANITOBA MIDWIVES SPEAK OUT

Beckie Wood, Midwives Association of Manitoba



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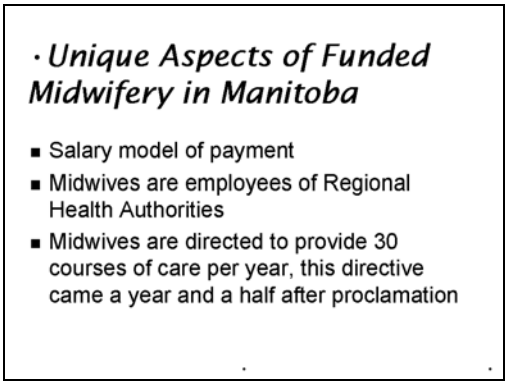

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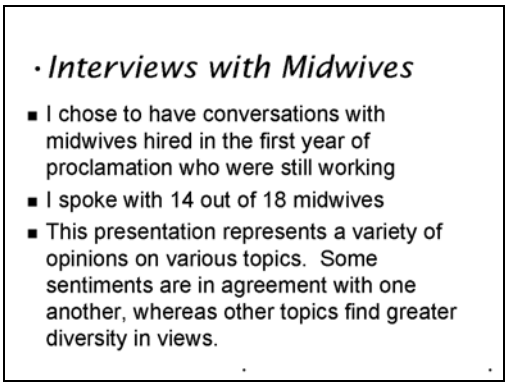

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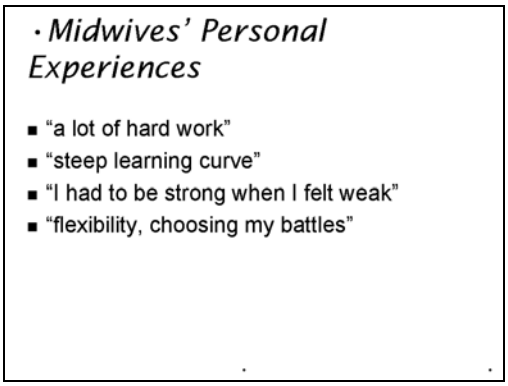

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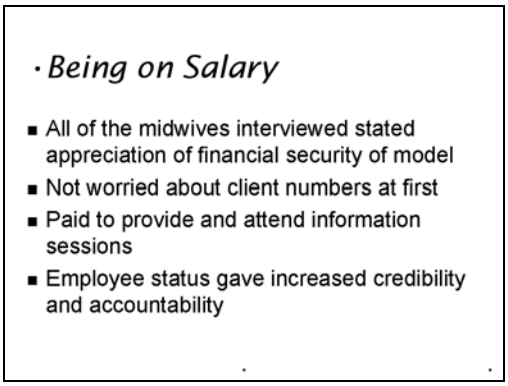

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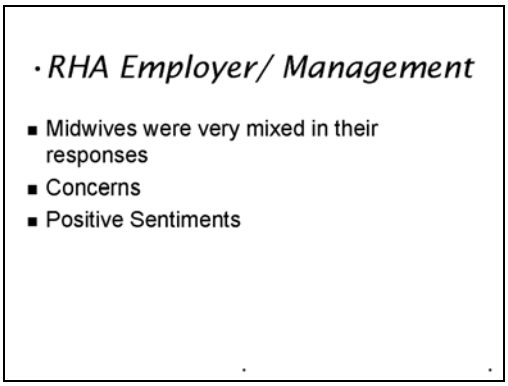

Slide 6

Concerns about Employers

- Not understanding midwifery
- Difficulty balancing employee status and being autonomous professionals
  - Micromanagement
  - Undermanagement
- Administration/management not midwives
- RHA too big

Slide 7

Positive Sentiments Re: Management and Employers

- Supportive and respectful
- Team leader, was a good idea
- Some employers receptive and inclusive in decision making
- Midwives participate on many regional committees
- One RHA pursued midwifery 2 years before proclamation

Slide 8

Hospital Integration

- No problem with admitting privileges
- Challenge was lack of respect by hospital staff
- Varied with previous experiences
- For many, hospital integration was most difficult aspect of integration

Slide 9

Second Attendants

- Second attendants need not be midwives
- Some midwives liked the support of having a second midwife present
- Most midwives now really like and feel positive about working with nurses as second attendants

Slide 10

Consultations

- Consultations were straightforward and generally proceeded with ease

Slide 11

Community Clinics

- Most midwifery practices were integrated into existing community clinics within the first year after proclamation
- Being wanted and welcomed was important
- "Where there is no interest, there is no integration"

Slide 12

Public

- In one area it was noted that many more women were seeking midwifery care now that it was funded and integrated
- In another area, the midwife felt the community was not eager to accept a new service, for various reasons

Slide 13

Client Care

- The presence of midwifery in the health care system, both in hospital and in community, has changed maternity care
  - One midwife stated: "The presence of midwives benefit everyone, not just midwifery clients"
- A challenge working with women who don't have understanding of equal partnership and informed decision making

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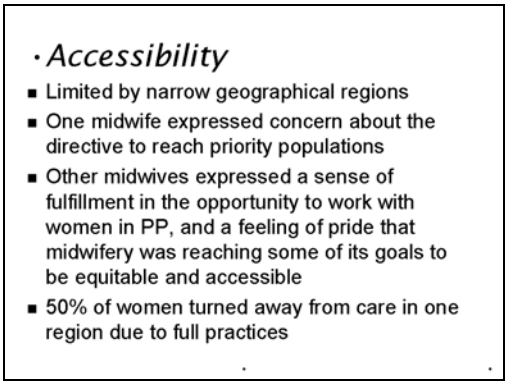

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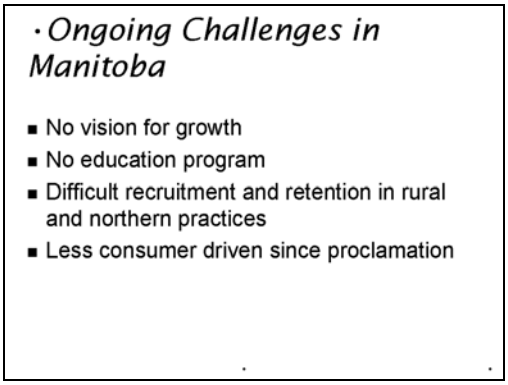

Slide 16

B.4. BIRTHING CENTRES IN QUEBEC: A SIGNIFICANT CONTRIBUTION TO MIDWIFERY PRACTICE IN CANADA

Sinclair Harris, Maison de Naissance Lac-St-Louis, Pointe Claire, Province of Quebec

In the last 10 years, the midwifery profession in Canada has made slow but steady progress. There are now five provinces with regulated midwifery practice, four of which also fund midwifery care. Although health care in Canada falls under provincial jurisdiction, there is reciprocity between provinces for most health care professionals, and thus all midwives are autonomous professionals practising community-based midwifery. There are now about 500 practising midwives in Canada and three university training programs, for which a nursing background is not required. In most cases women can choose to have their babies either in hospital or at home, and in all cases, prenatal and postnatal care takes place in the community.

Until recently Quebec has been the exception. While the Province of Ontario decided to legalize the practice of midwifery in 1991, and allowed midwives to practice both in hospitals and at home, the medical profession in Quebec remained opposed not only to home as a place of birth, but also to the concept of midwives as autonomous professionals. Consequently, the Quebec government passed legislation, which attempted to appease both the medical profession, and those women requesting midwifery care. The 1990 law created a pilot project whereby midwives would be able to practice midwifery in one of seven out of hospital Birthing Centres. These Birthing centres opened in 1994.

Other than the creation of Birthing Centres, the purpose of the pilot project was to evaluate the effect of autonomous midwifery practice on:

- The safety of mother and child;
- The humanisation and continuity of care and services provided by the midwife and within the community;
- The prevention of premature and low birth weight babies;
- The use of obstetrical technologies.

The compromise in fact satisfied neither the women, nor the midwives, nor the medical profession. Although it gave more women access to midwifery care, many resented not being

able to birth in their own homes. The midwives were not fully recognised as professionals within the system, and consequently had limited access to medical technology. The medical profession refused to accept the idea of out of hospital births, and in fact were advised not to visit the birthing centres.

However, the birthing centre principle was a good one. It provided primary midwifery care in a home-like environment, where families were welcome. Birthing centres were established within and supported by the community, and to ensure safety, were all situated close to an existing hospital that provided obstetric services for emergencies. It was hoped that they would eventually provide a location for the training of student midwives.

The research phase of the pilot project was completed in 1997 and when the final report and recommendations of the research committee were published, they indicated that the pilot project had fulfilled its mandate. The report noted that in comparison with a similar number of hospital births, midwifery clients in general received fewer interventions. There were fewer caesarean sections and fewer episiotomies. Women giving birth in birthing centres also experienced fewer premature births and delivered fewer small babies. These latter statistics were particularly apposite in Quebec where both the numbers of premature births and small babies had increased between 1980 and 1994.

Table 1: Interventions 2001 - 2002

	Quebec	**Birthing Centre Clients**
Total Births	72000	1329
C. Sections	18%	6.2%
Episiotomies	30%	2.2%
Premature Births	7.5%	3.3%
Babies < 2500 gms	6.1%	0.92% (Lac St Louis)

Source: Rapport sur la santé périnatale au Canada, 2003

It is difficult to truly compare neo-natal mortality statistics within birthing centres with those among the population at large, because birthing centres accept only low-risk clientele. Thus, it is not unexpected that the centres have a lower incidence of neo-natal deaths, as shown in Table 2 with the most recent figures available.

Table 2: Perinatal Mortality for Midwifery Practice in Québec since the opening of the Birthing Centres

	Midwifery Practice in Birthing Centres 1995-98[1]	**Midwifery Practice in Birthing Centres Sept.98/Dec.02[2]**	**Québec 1998[3]**
Total Births	3379	5050	75606
Perinatal Deaths	20	20	-
Rate per 1000	5.92	3.96	7.34 (6.70)
Foetal Deaths	19	16	-
Rate per 1000	5.6	2.57	4.25
Neonatal Deaths	1	4	-
Rate per 1000	0.32	0.79	3.09

1: Pilot Projects. Data from the report of the Conseil d'évaluation des technologies de la santé (CETS).
2: Data from the Comité d'étude et d'enquête sur la mortalité et la morbidité périnatales de l'Ordre des sages-femmes du Québec.
3: Data from the 1998 report of the Comité d'étude et d'enquête sur la mortalité et la morbidité périnatales du Collège des médecins du Québec.

At the same time, the cost of a complete course of care with midwifery services was estimated to be in the region of $3000: even though it is very hard to fully estimate the cost of any services in a publicly funded system, this figure seems considerably lower than hospital costs for low risk women.

In 1998 the Quebec government approved the legalisation of the practice of midwives and on Sept 24th 1999 the midwifery law came into effect. The law declared midwifery to be a regulated autonomous profession, and gave midwives the right to practise in both hospitals and birthing centres. Provision was made for midwives to attend home births once the necessary regulations were approved. There are now about 60 midwives practising in the 7 birthing centres in southern Quebec while another 3 or 4 work in northern Quebec with trained and student Inuit midwives.

A description of the birthing centre where I work will give a sense of how this Quebec model has been implemented. It is an integral part of a Community Health Centre, occupying space in a modern purpose-built building. To date it has accommodated over 2100 women in nearly 10 years of operation. We are a large practice: 10 midwives in total filling the equivalent of 7 full-time positions. There is one midwife-in-charge, 9 midwives, 5 birthing assistants and one secretary/receptionist. A full-time midwife has responsibility for 40 courses of care a year, so the capacity of our birthing centre is 250-300 births per year. All midwives work “on call” for 10 days out of 14, so that women may reach us 24 hours a day by phone or by pager.

Most prenatal visits last 45 minutes and take place in comfortable relaxed consulting rooms which are situated in the clinical, consulting and administrative area, separate from the “Birthing Home” where labour and birth take place.

Once labour starts the midwife will often visit the woman in her own home and they will decide together when to go to the birthing centre. When the woman and whichever family members or friends she chooses arrive at the birthing centre, she will be met by her midwife, and will be free to labour as she chooses within an environment that resembles a large home-like apartment.

At the time of birth there is also a second midwife present, but no medical practitioner. The second midwife's responsibility is to receive the baby and provide resuscitation, should it be necessary. Additional support services are provided by birthing assistants who are invaluable members of the team, with training and experience in breastfeeding support. They are on hand during each birth to help the woman, her family and the midwife, and in the event of an emergency will call the ambulance and greet them when they arrive. Following the birth women may stay up to 24 hours, although many choose to go home within the first 6 hours after having had a rest and a meal: during their stay they are always accompanied by a birthing assistant. They usually receive 3 home visits in the first week, interspersed with a daily phone call, and the midwives remain in contact for 6 weeks.

****

As we approach the 10th anniversary of Birthing Centres in Quebec, we realise that we have much to celebrate! What started as a compromise between home and hospital births has proven to be a treasure. The implementation of midwife-led birthing centres in other jurisdictions or,

indeed, other countries may provide a valuable alternative for childbearing women. For governments and policy planners we have demonstrated that community based birthing centres can provide accessible, safe, cost-effective maternity services for women experiencing healthy pregnancies. For midwives, birthing centres allow them to continue to be the specialists of normal birth and to focus on their strengths. Women and midwives learn to work with increasing confidence in the natural process.

We accept and work with an acceptable level of risk, but not with fear. Our cups are half full rather than half empty. For women, we provide a climate of loving and caring which improves outcomes and levels of satisfaction, leads to feelings of empowerment and increased self-esteem, and fights the culture of fear that has grown up around childbirth.

C. CONCURRENT SESSION

COLLABORATIVE PRIMARY MATERNITY CARE MODELS FOR RURAL AND REMOTE POPULATIONS

The looming maternity care crisis is a critical issue for midwives in Canada. Midwives have the opportunity to provide care where physicians are no longer practising in Canada. Nowhere is this situation more crucial than in the vast rural and remote areas of Canada. This workshop was facilitated by Judy Rogers who opened her talk with ideas for collaborative care among midwives, physicians and nurses. She posed questions to the attendees that would allow them to think through the local issues that would allow for effective collaborative care in their communities. Marion Alex followed with an example of collaborative care from New York state.

1. *Collaborative Maternity Care Models for Rural and Remote Communities*
   Judy Rogers, Midwifery Education Program, Ryerson University, Toronto, Ontario

2. *Maternity Care for Rural and Remote Populations*
   Marion Alex, School of Nursing, St. Francis Xavier University, Antigonish, Nova Scotia

C.1 COLLABORATIVE MATERNITY CARE MODELS FOR RURAL & REMOTE COMMUNITIES

Can Midwives Make A Contribution?

Judy Rogers, Midwifery Education Program, Ryerson University, Toronto, Ontario

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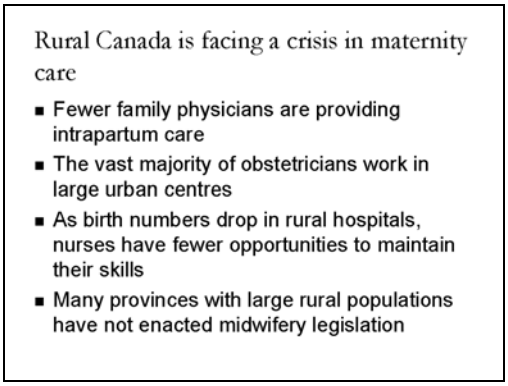

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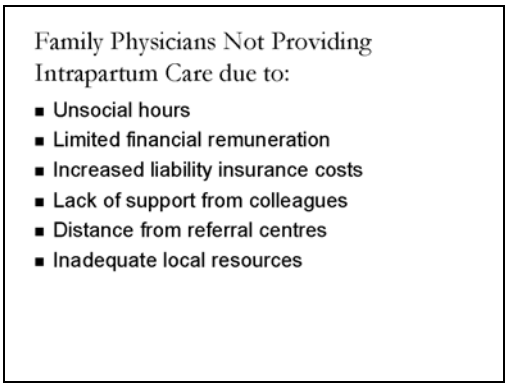

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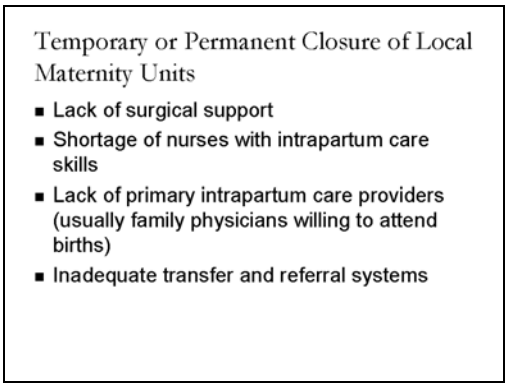

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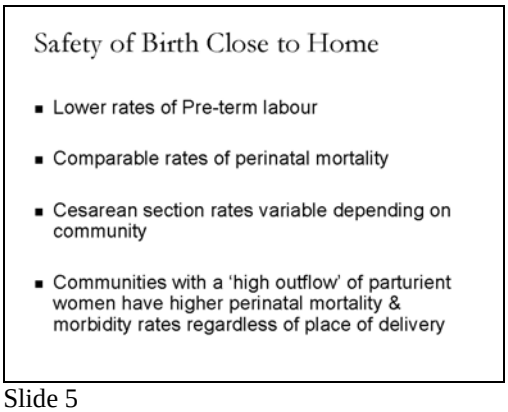

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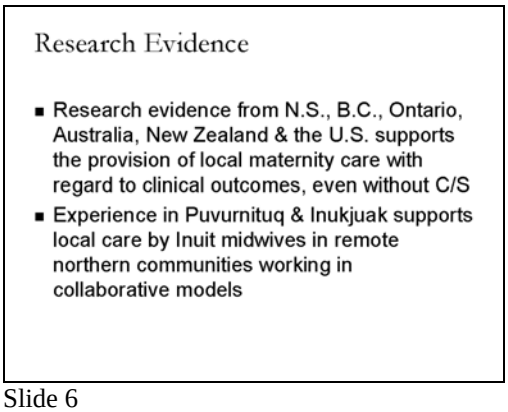

Slide 6

Joint Position Paper on Rural Maternity Care

- Society of Rural Physicians of Canada
- Maternity Care Committee of the College of Family Physicians of Canada
- Society of Obstetricians and Gynecologists of Canada

Slide 7

B.C. Reproductive Care Program-2000 Consensus Conference on Obstetrical Services in Rural or Remote Communities

"The primary consideration for perinatal care providers is that team competency is required. Competency of the individual practitioner or discipline is insufficient to offer a consistent service."

Slide 8

The Future of Maternity Care in Canada: Crisis and Opportunity-London ON 2000

- Inter-disciplinary collaboration
- Team competency
- Community responsive care

Slide 9

What do midwives bring to the collaborative care model?

- Strong knowledge and skills in care for healthy low-risk women
- Expertise includes prenatal, intrapartum and postpartum care
- Able to identify deviations from normal and respond in emergency situations
- Experienced in use of consultation and referral for care outside of scope
- Experienced in providing woman-centred, community-based care

Slide 10

Midwifery scope of practice in Canada

- Assessment and monitoring of women during pregnancy, labour and post-partum
- Post-partum care of women and their newborn babies
- Provision of care during normal pregnancy, labour, and post-partum period
- Conducting spontaneous, normal, vaginal deliveries
- Counseling and education of clients
- Management of obstetrical emergencies in the absence of a physician

Slide 11

Expanded scope in some Canadian jurisdictions

- Augmentation of labour
- Vacuum deliveries
- 1st assist at C sections
- Suturing of 3rd degree tears
- Evacuation of the uterus
- Well-woman care
- Family planning
- Intubation of the newborn
- Placement of umbilical vein catheter
- Well-baby care
- Health promotion, counseling and education for women, families and communities

Slide 12

Care for Childbearing Women

Slide 13

Challenges to collaborative models of maternity care

- Natural resistance to change
  - Whose idea is it?
  - Top-down or grassroots?
  - Is it win-win?
- Shortages of nurses, physicians, & midwives
  - What mix is needed?
  - Experience levels are important

Slide 14

Challenges (continued)

- Educational models
  - Do they foster collaboration and mutual respect?
  - Are there shared experiences?
- Regulatory barriers
  - Do they unduly limit scope?
- Funding barriers
  - Are some care providers financially penalized by collaborative practice?
- Liability insurance barriers - CMPA

Slide 15

Small Group Work

- Identify the 3 priority goals for your community.
- Look at the mix of providers in your community. Think about the need to provide 24/7 coverage for maternity care.
- How can your care providers be used most effectively?
- What is the most effective type of remuneration?
- What barriers need to be removed for this model to work in your community?

Slide 16

How could midwives contribute to interdisciplinary models of maternity care?

- Midwives could share primary care with family physicians in rural communities
- Midwives could provide primary care in rural hospitals or birthing centres, working with nurses and having access to consultation and referral by telephone
- Midwives could work with obstetricians, providing care for all low-risk women, the obstetrician only providing high-risk care and gynecological care

Slide 17

Additional possibilities…

- Midwives could work with nurses in remote birthing centres, consulting by telephone and transporting women out by medevac to referral centres
- Aboriginal care providers could be supported to develop the skills and knowledge to provide midwifery, nursing and medical care to their communities

Slide 18

Communities with low birth numbers

- Outreach prenatal care for underserved women
- Prenatal classes
- Nutritional counseling
- Breastfeeding support
- Extra postpartum home visits for women in need
- Well-woman care
- Well-baby care
- Contraception clinics

Slide 19

Episiotomy Rates

Quebec midwives	6.9%
B.C. planned home births	3.8%
B.C. planned mw hospital births	10.9%
Ontario midwife births (2002)	7.2%
ON FP low-risk births (2001)	16.5%
Quebec physicians	36.5%
B.C. physician low-risk births	15.3%

Slide 20

Cesarean Section Rates

Quebec midwives	6%
B.C. planned home births	6.4%
B.C. planned mw hospital births	11.9%
Ontario midwife births (2002)	12.7%
ON FP low-risk births (2001)	20.5%
Quebec physicians	13.2%
B.C. physician low-risk births	18.2%

Slide 21

Operative Vaginal Delivery Rates

Quebec midwives	2.8%
B.C. planned home births	3.2%
B.C. planned mw hospital births	13.5%
Ontario midwife births (2002)	5.4%
ON FP low-risk births (2001)	14.4%
Quebec physicians	15.6%
B.C. physician low-risk births	13.5%
Nova Scotia (2001)	13.5%

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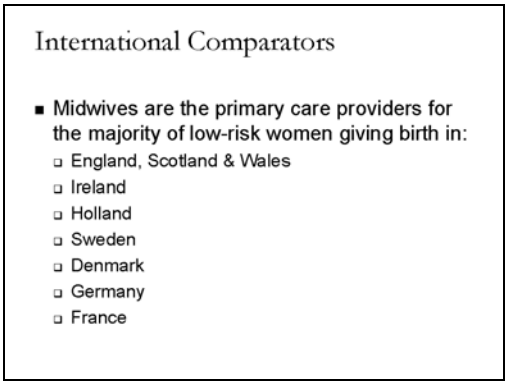

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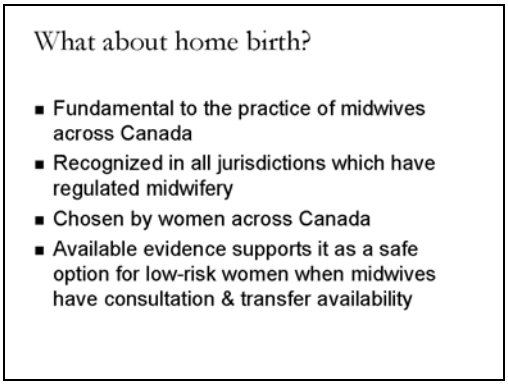

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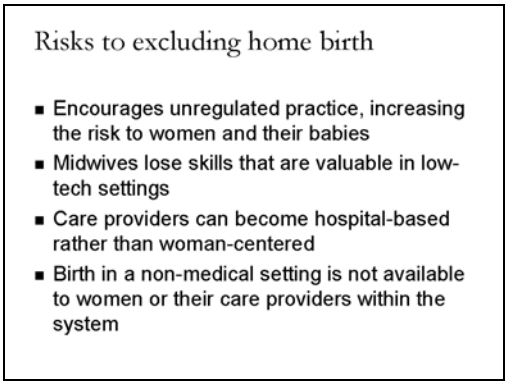

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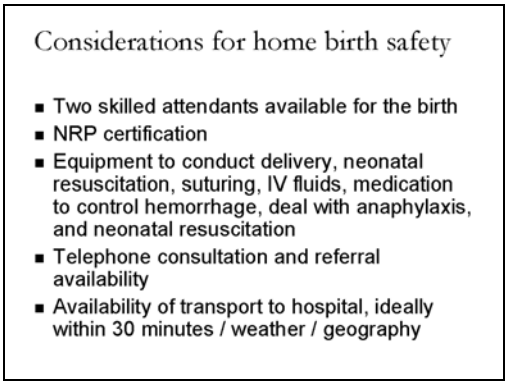

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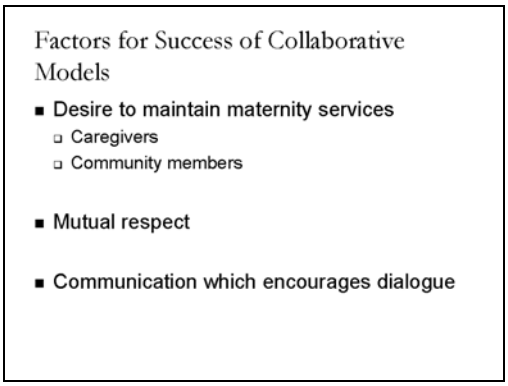

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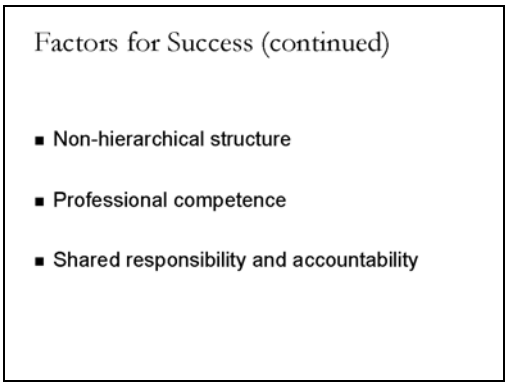

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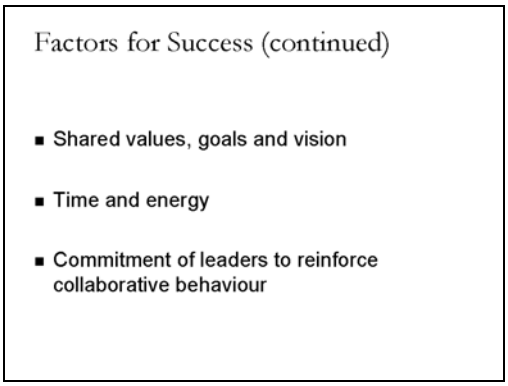

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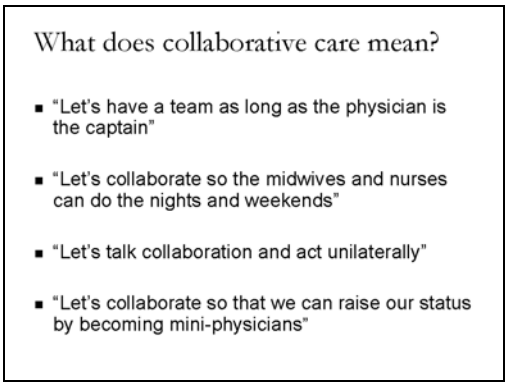

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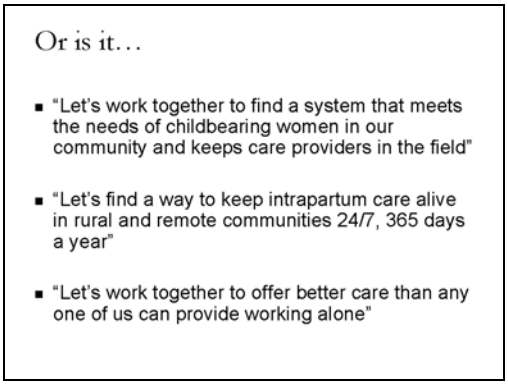

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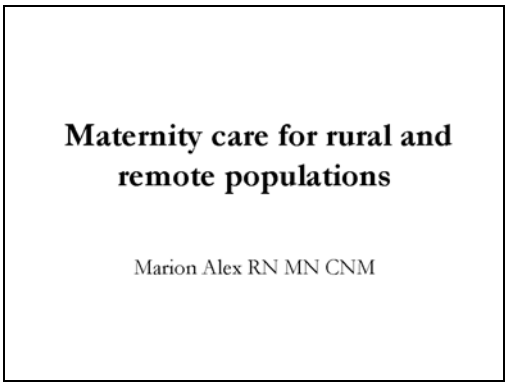
C.2 MATERNITY CARE FOR RURAL AND REMOTE POPULATIONS

Marion Alex, School of Nursing, St. Francis Xavier University, Antigonish, Nova Scotia



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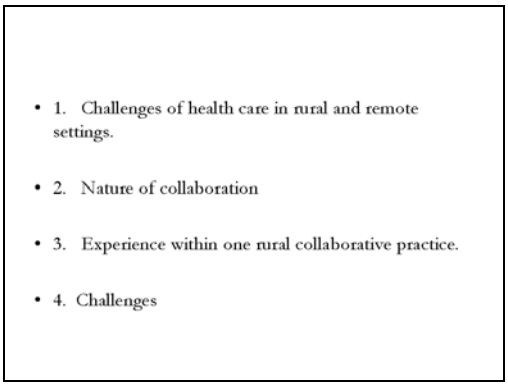

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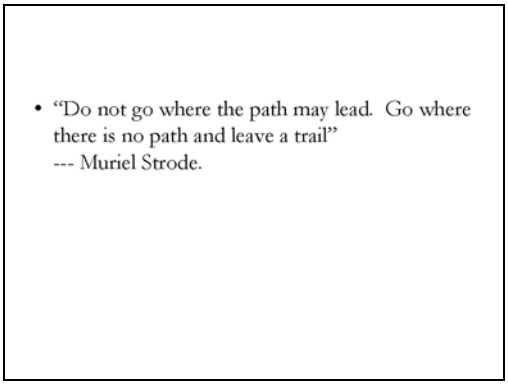

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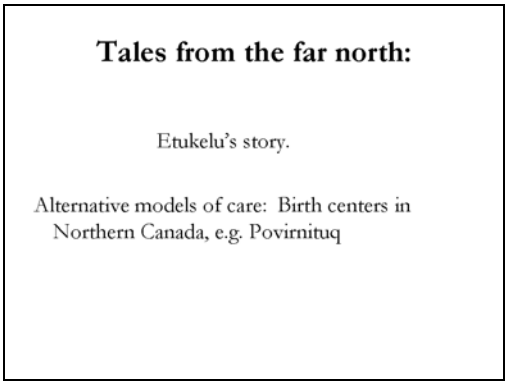

Slide 4

Oh, Canada!

- Most of our geography is rural and remote.
- Most (78%) Canadians live in urban centers with populations > 10,000.

(MacLeod, Kulig, & Stewart, 2004).

Slide 5

Rural Nova Scotia

- Most of our geography is rural. Most of our population resides in the Halifax Metro area, and in industrial Cape Breton.
- Little towns like Canso, Cheticamp…involve travel of over 1 ½ hours to regional hospitals… and have difficulty attracting health professionals.

Slide 6

Challenges of rural health care

- Provider shortages, with more population:provider rates than in urban Canada
- Midwives rare…
- Nursing shortage… expected to worsen
- Physician shortages. Some physicians often ill-prepared to work without the technologies available in tertiary centres where they studied medicine…

Slide 7

Limited study of experiences of rural/remote health providers

- Concerns of 150 rural/remote nurses:
  - access to continuing education
  - lack of support for aboriginal health care workers
  - "how to" support development of broader scopes of practice
  - need for a national rural/remote health resource strategy.

(MacLeod, Kulig, & Stewart, 2004).

Slide 8

Challenges of rural health care

- Rural poverty and economic disparities
- Rural isolation / transportation difficulties.

Slide 9

Collaborative models

- What does that mean, anyway?
- How can we be autonomous professionals and work collaboratively with others?
- _____

from the Latin *col* meaning *together* and *laborare* meaning *to work.*

Slide 10

Successful collaboration is a way of thinking and relating that requires knowledge, open communication, mutual respect, ability to share responsibility, and commitment to providing quality care.
(ACNM, 1995)

Collaborative maternity care is family-centred care.
(Keleher, 1998).

Slide 11

- Working in isolation as a single professional is inefficient… no one profession can address the complex problems of health care.

(Keleher, 1998).

Slide 12

And yet it is critical.

IOM in US: >98,000 deaths in US hospitals due to errors. One significant cause is the fragmentation within the system, and communication failure among professionals. IOM acknowledges this is usually more systemic than grounded in 'individual recklessness'. (US Institute of Medicine, 1999)

Survivorship has been found to improve when both nurses and physicians report perceptions of collaborative working relationships! (Baggs et al, 1999)

Slide 13

Barriers to collaboration include:

- Separate education pathways in the health professions / lack of sensitivity to the perspectives of others
- Gender-oriented communication pathways involving hierarchical patterns of dominance or submissiveness
- Differences in social and economic status

(Stapleton, 1998)

Slide 14

Making any partnership work is hard work and involves:

open, honest communication;
mutual trust and mutual respect;
familiarity with each others styles and scope of practice;
equality and shared power;
professional competence;
shared values and visions;
willingness to openly discuss differences;
frank discussion of financial issues.

(Stapleton, 1998).

Slide 15

One rural midwifery practice

Cooperstown NY.

Economy based in agriculture and tourism… Some wealth, but significant levels of poverty among families with young children. Geography and economy not unlike rural NS.

About 150 kms from Albany, the nearest city, which served as our tertiary referral center.

Slide 16

- Offered quality maternity services involving partnerships b/w maternity providers.
- Certified midwives available to any woman wanting a midwife.
- Midwifery service est'd 1986

Slide 17

The staff

- 8 Certified Nurse Midwives regulated under NY Board of Midwifery.
- 6 OB/GYN physicians. Several pediatricians.
- 4 Nurse practitioners (family nurse practitioners served families with young children within the PEDS dept; women's health nurse practitioners involved in GYN services to the non-childbearing population).
- Approx. 12 RNs, some certified as childbirth educators and/or lactation consultants. Although rural, this was a magnet hospital for nurses committed to maternity care.
- One student midwife. One medical student.

Slide 18

The setting: Prenatal, postpartum, and well-woman care

- Central clinic in Cooperstown; three satellite clinics for prenatal/postnatal/ well woman care in Herkimer, Cobleskill, and Oneonta.
- 8 midwives staffed 4 clinics.
- The RNs who taught prenatal classes were the same RNs who provided labour support (along with a midwife) and provided postpartum care.

Slide 19

The setting: births

- Hospital-based birthing center providing 24/7 in-site midwifery service. Midwives rotated in 24h shifts. Typically, a midwife would attend 1-3 births during a 24h period. (600 – 700 babies/year).
- RN support 24/7. Most perinatal women served by one midwife and two-four nurses while in hospital.
- OB/GYNs available for consultation 24/7 but rarely involved in vaginal births or with healthy moms and babies.

Slide 20

Description of practice

- Primary care providers for the majority of pregnant women in three counties of upstate NY. Medically low-risk women were generally not seen by physicians.
- Prescriptive privileges …
- Collaborative care for high-risk women in "TLC clinic"…with a range of providers: OB/GYN, Psych, Endocrinology, Social Work…

(Stone, Brown, & Westcott, 1996)

Slide 21

- Few women chose physician-only care. MDs would say: "If you want the best care, see the midwives. I'm here if there are medical problems or need a section… but that's far less likely to happen if you see the midwife".
- Women seeking readier access to inductions or epidurals or were otherwise uncomfortable with midwifery could access services in Oneonta.

Slide 22

Supporting collegial communication

- Daily 8 am "report"—review of any clients in birthing center so MDs and CMs were familiar with current events at shift changeover.
- TLC "rounds"—review of plan of care for any high-risk clients involved both MD and CM.
- Medical and midwifery student shared available learning opportunities and perspectives.
- Any newly hired OB-GYNs must state commitment to midwifery model of care!
- Informal socialization. Most MDs and CNMs had worked together for years.

Slide 23

Outcomes

- Of 614 births in 1999, 81.4% were attended by CNMs
- Cesarean rate: 15.2%
- Episiotomy rate: 7%
- Epidural rate: 2.3% of vaginal births, all cesareans.
- Of vaginal births, 44.4% were VBACs
- Oxytocin induction/stimulation: 17.3%
- Breastfeeding rate: >80%

(Bassett Healthcare Perinatal Information for Parents)

Slide 24

Compare to …

- St. Martha's Regional Hospital, Antigonish NS
- In 1999, of 486 births:
- 123 were cesarean births (25.3%; NS c/s rate of 20.9%)
- 90 were vacuum-assisted births
- 7 were forceps extractions
- Episiotomy rate: 35.5% among nulliparas (down from 55.5% in 1996).
- (NS RCP Atlee Database)

Slide 25

Challenges and problems: Lessons from south of our border

- Language remains hierarchical. For example, in the US, midwives and nurse practitioners are referred to as "mid-level providers"
- Practising midwifery in the US requires a "collaborative relationship" with OB/GYN, but practicing OB/GYN does not require a "collaborative relationship" with midwifery.

Slide 26

- Medico-legal climate in the US promoting 'defensive practice' among all providers; malpractice insurance costs are skyrocketing.
- Fears of litigation create some ethically questionable practices. In the US, there is no evidence that working with midwives creates increased medical malpractice suits. Any reference to seeing MDs as 'captain of a ship' and legally responsible for actions of non-MDs is obsolete and based in myth. Yet, fear remains.
(Jenkins, 1994)

Slide 27

- Homebirths are not always an an option.
- According to JCAHO Standards, hospital privileges "may" be extended to fully-licensed non-physician providers.
- While no one was denied care, and pregnant women and babies were covered by NY's PCAP program… corporate model of health care pressures providers to see more women/babies in less time for the same pay. Yet, spending time is essential for the outcomes and successes of midwifery care.

Slide 28

Challenges and problems: The big picture!

- Need to look beyond caring for individual mothers and babies to caring for the environment – social, political, economic, ecologic – which sustains us all.
- Promoting health involves promoting that which determines health!

(Health Canada, Population Health Model, 2002).

Slide 29

- North Americans have built elaborate networks of medical care based, at least in part, on fears of baby-dying, bleeding-to-death complications.
- Sometimes sophisticated medical technology is lifesaving.
- BUT…

Slide 30

The REAL causes of maternity risk

- Poverty…
- Violence… within families and among nations.
- Environmental degradation… Toxicity of soil, air, and water.
- The real challenge in true collaboration in maternity care is both community-based and global.

Slide 31

Some population health facts

- Child poverty in Canada is 15.5%... Ranked 15th among the world's developed nations, and worsening.
(UNICEF, 2000).
- The incidence of low birth weight, acute and chronic illness, neurodevelopment problems, and accidents… are significantly higher among poor children in Canada.
(CCSD, 2001).

Slide 32

- Incidence of debilitating postpartum depression: 10-15%
(Kennedy, 2002).
- New parents go home today with less and less help.
(Wilf, 1998).
- Violence by intimate partners is common, and often escalates during pregnancy
(Espinosa & Osborne, 2002).

Slide 33

Big issues, yet midwives make a difference

In the US, midwives tend to handle a higher proportion of women in certain sociodemographic risk categories, such as teen mothers, women living in poverty…

And midwifery serving socially at-risk populations has reduced risk of neonatal mortality by 33%.

Midwives spend time…emphasize support and empowerment, teach and affirm…
(MacDorman & Singh, 1998).

Slide 34

- Peace on earth begins with birth.

—American College of Nurse Midwives

Slide 35

Many thanks to:

- Mothers, babies, midwives, nurses, and physicians of Bassett Healthcare Women's Health and Midwifery Associates.

My preceptors:

- Patti Brown, MScN CNM
- Laura O'Shea, RDt, MScN, CNM
- Kathy Breault, CNM
- Jeanne Westcott, PhD CNM

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D. CONCURRENT SESSION

CRITICAL REFLECTIONS ON REGULATION AND THE CHANGING NATURE OF MIDWIFERY IN CANADA

The process of regulating midwifery necessarily brings changes to the practise of midwifery. Midwifery in Canada is in a unique position, “a brand new tradition”, as presenter Lisa Nussey describes it – somewhere in the middle between the old and the new, while carving out a space that will only occur once in its history.

Unfortunately, we are unable to provide readers with the proceedings from this section of the Midwifery Way forum.

E. CONCURRENT SESSION

EXPLORING INFORMED CHOICE: MULTIPLE PERSPECTIVES

Informed choice is a central tenet to midwifery care throughout Canada. The relationship that develops between a midwife and her client is largely based upon the concept of informed choice, whereby the midwife makes options available to her client based upon current literature and the client maintains the responsibility to ultimately make her choice based upon the information provided. In this session three women take a close look at the informed choice process from three perspectives - a client, a midwife and a student.

1. *Exploring Informed Choice from a Consumerist Perspective*
   Philippa Spoel, Department of English, Laurentian University, Sudbury, Ontario

2. *Exploring Informed Choice from a Student Perspective*
   Kirsty Bourret, Ontario Midwifery Education Program, Laurentian University, Sudbury, Ontario

3. *Exploring Informed Choice from a Midwife Perspective*
   Susan James, Midwifery Education Program, Laurentian University, Sudbury, Ontario

E.1 EXPLORING INFORMED CHOICE FROM A CONSUMERIST PERSPECTIVE

Philippa Spoel, Department of English, Laurentian University, Sudbury, Ontario

This presentation and our panel as a whole emerge out of a SSHRC funded project entitled "The Textual Formation of a Healthcare Profession: A Rhetorical Analysis of the Regulatory Documents Governing Ontario's Midwifery Profession." Within this project, I'm the textual/rhetorical analysis person, Susan James is the healthcare/midwifery profession representative, and Kirsty Bourret—a student in Laurentian's midwifery program—is one of the project's wonderful research assistants. In today's panel, we are focusing specifically on the issue of informed choice in the context of midwifery regulation.

For me, this issue is not only academic—or textual. As a former midwifery "consumer" shortly after regulation in Ontario, I've experienced directly the value of midwifery's emphasis on informed choice; in my own case, the informed choice process that the midwives facilitated led my husband and me to plan a home birth for our first child despite our initial assumption that hospital birth was the "obvious" choice for the first baby. Likewise, the informed choice process allowed us to choose not to have maternal serum screening. So I have experienced first-hand—and deeply value—the kind of client-centred knowledge, support, and empowerment that the midwifery practice of informed choice helps to create. The purpose of this talk, then, is not to argue that informed choice in midwifery is an undesirable principle nor that it is impossible to practise effectively. The purpose is, however, to raise some questions about the meaning and ethics of informed choice in midwifery, given that informed choice is a common ideal in the larger healthcare culture as well.

In particular, I want to interrogate the connections between informed choice and healthcare consumerism. After giving birth to my first child, I was invited to become a member of the "Sudbury Community Midwifery Consumers Network." At the time, I remember being very keen to participate in any group that would help to strengthen the role of midwives in our community—but I also remember being uneasy with the use of the term "consumer": it made me think of choosing a car or finding the best deal for my natural gas consumption; it didn't seem to me a term that reflected my identity as a woman who had received intimate care from her midwives through the life-changing process of pregnancy, birth, and the post-partum period. I joined the group anyway, of course, though as far as I know it hasn't been active for several years now (but that's an issue we can discuss later).

Now, through my other identity as a researcher on the discourse of midwifery regulation, I have again returned to this question of consumerism as a way of trying to better understand both the challenges and the possibilities for informed choice in midwifery.

On one hand, I see the principle of informed choice as integral to midwifery's distinctive, alternative, woman-centred model of care, which provides a crucial contrast to traditional medical paternalism, biomedical interventionism, and the more recent but nonetheless reductive emphasis on informed consent. And in many ways, the language of the standards of practice for regulated midwifery reinforce this view: for example, in the Ontario *Model of*

Practice, informed choice is described as "a decision-making process which relies on a full exchange of information in a non-urgent, non-authoritarian, co-operative setting." (College of Midwives, 3). According to the *Model of Practice* guidelines, through informed choice, midwives simultaneously demonstrate their respect for women's rights and their responsiveness to women's needs. The language of these policy documents clearly reveals that the midwifery approach to informed choice means more than health professionals simply providing patients with information about treatment options; rather, informed choice is an empowering, relationship-building process that allows midwives to implement key aspects of their woman-centred philosophy of healthcare.

At the same time—as I know from listening to midwives, students, and women cared for by midwives—both defining and practising this essentially feminist principle of informed choice can be a challenging and confusing process. And I think this is at least partly because, whether we like it or not, the midwifery version of informed choice is an ambiguous, polyvalent ideal whose multiple possible meanings are, at least to some extent, shaped by common assumptions and largely unquestioned values circulating within Western culture. Therefore, I want to try to understand possible tensions and ambiguities in the midwifery approach to informed choice by looking at it in relation to the meanings of informed choice in the broader context of healthcare consumerism in Western culture. My claim is that within this broader context, the ethics of caregiving implied by the principle of informed choice at first glance appears consonant with midwifery's alternative, woman-centred ideal but on closer examination, it reveals potential challenges and limits to this ideal.

Informed Choice and Healthcare Consumerism

Although the term "consumer" occurs directly only occasionally in the regulatory documents for informed choice (and most frequently in the Alberta standards of practice where it is associated with "responsiveness to consumer needs"), the consumer lobby has of course played—and continues to play—a vital role in achieving self-regulation for midwifery in Canada. At the most fundamental level, this lobby is based on the premise that, as consumers, women have the right to *choose* midwives as their caregivers. For example, Ontario's highly influential consumer lobby group, The Midwifery Task Force of Ontario, argued in their submission to the provincial government that their selection of midwifery care was based on "responsible decisions and informed choices" (6); they also warned that should the government *not* regulate midwifery as an autonomous healthcare profession, "an underground midwifery system that remains *responsive to consumer needs* would [continue to] develop" (8). The brief from the Ontario Association of Midwives reinforced this basic consumerist perspective by arguing that consumer demand for alternative forms of maternity care demonstrated the need for midwives to be included in the healthcare system: "Due to consumer demands, midwifery has re-emerged across Canada. . . . Parents are seeking out care-givers who familiarize them with their options and support them in making informed choices appropriate to their own needs" (4). In this context, clearly consumerism has functioned as a progressive movement for social change, a discourse that has supported women's healthcare rights and needs, and that has sought to give us greater freedom of choice and control over our reproductive lives.

This perspective on consumerism in midwifery coincides with a common view of consumerism expressed in other areas of healthcare. For example, in a recent review of the meaning of

"consumerism" in the *Journal of Advanced Nursing*, Palo Almond defines consumerism in healthcare as a progressive ideology that "aims . . . to create a better balance of power between consumers and providers, indicating a move towards less paternalism and more democratic relationships between consumers and providers" (895). From this perspective, consumerism is frequently associated with such values as freedom of choice, individual rights and autonomy, responsiveness to consumer needs and preferences, and patient empowerment. And informed choice is presented as a key mechanism to help implement these values.

But as several healthcare critics have recently pointed out, the concept of consumerism is complex and double-edged: it can act as a framework for social activism and mobilizing for long term change, but it can also be used as the basis for re-regulating bodies and lives, and—by focusing on the individual consumer—for obscuring collective rights and larger social change (Henderson and Petersen). Sociologist Deborah Lupton notes how the discourse of consumerism can be deployed in "different sites with different political objectives, including both the state and advocacy groups seeking to challenge the state." According to her, on one hand, advocacy groups tend to draw on "the principles of liberal humanism in their efforts to achieve equitable access to health and medical care" by focusing on "patients' rights and capacity for autonomy. In contrast, participants in the development of public policy working from a rightwing approach have often made calls for increased consumerist behaviour on the part of patients to accompany their suggestions that health care should be reformed by being subjected to a free market model" (373). Lupton's comments indicate the danger of assuming that consumerism is necessarily or always a socially progressive, empowering movement in healthcare.

But Lupton's critique of consumerism goes beyond identifying what we might simplistically call the "good" advocacy model versus the "bad" free-market/rightwing model. For her, a fundamental problem with consumerism in all its versions lies in the assumptions that it makes about the kind of person the healthcare consumer is supposed to be. As she explains, "In all usages of the notion of the patient *qua* consumer, regardless of political orientation, the dominant and privileged representation is that of the dispassionate, thinking, calculating subject." This identity, she argues, tends to be non-differentiated: "there is little discussion of how gender, sexual identity, age, ethnicity, social class and personal biography or life experience affect the taking up of [the] "consumerist" . . . position"; it does not take into account that the consumption of health care is "a dynamic and intersubjective sociocultural process rather than . . . an outcome of an individualized calculation" (374).

Other critics of consumerism in healthcare include nursing philosopher Sally Gadow, who thinks that "the hallmark of consumerism is indifference to outcome. In health care this is expressed as professional disappearance from clinical decision making. As moral agents, professionals cease to exist; they function only as adjuncts to patient autonomy. Patients too disappear, to reappear as consumers" (Gadow). In the context of informed choice, this "disappearance" of the caregiver from decision-making seems associated with the assumption that the responsibility of the healthcare professional is simply to convey information to the patient who will then be enabled to make an "autonomous" decision. Such an assumption, however, does not fit with a midwifery ethics that value the development of a supportive, responsive, committed relationship of trust and shared decision-making between caregiver and client. As I see it, one of the potential problems with an uncritical consumeristic approach to

informed choice is that midwives may not sufficiently engage with women in developing this relationship; they may think that their professional responsibility is simply to make information available to women who will then go off and make choices on their own. Indeed, they may believe (and I have heard this view) that the midwife's professional responsibility is precisely *not* to "influence" or "bias" her client's decision-making by presenting her own views and opinions as part of the informed choice process.

The form and nature of the information provided by health practitioners also affects the degree to which the informed choice process fosters real communication and inter-subjective engagement between the health practitioner and the consumer. For example, most patient information leaflets developed to support the principle of informed choice tend to privilege "evidence-based" bio-medical information over other forms of information or knowledge. According to M. Dixon-Woods, this poses a potential constraint on "the patient empowerment process" because "in cases of conflict between bio-medical and 'lay' knowledge . . . 'information for choice' might better be replaced with the more honest 'information for compliance'" (cited in Henwood 591). The assumption that printed leaflets or information packages are the best—and sometimes the only—means for facilitating the informed choice process is likewise, of course, highly problematic both because this method is non-interactive and uni-directional (you can't talk back to a leaflet!) and because it ignores issues of access and comprehension in a culturally, socially, and linguistically diverse population.

Susan James argues in her article "The Changing Face of Midwifery" that traditionally Canadian midwifery has been guided by an ideal of the caregiving relationship as one in which women and midwives exchange diverse forms of knowledge (including not only objective, scientific knowledge but also emotional, intuitive, spiritual, narrative, and other ways of knowing (James,184)) in an intimate, trusting, and continuously evolving environment. However, given midwifery's new position as a regulated member of the larger healthcare system in more and more provinces and territories, clearly new cultural pressures exist for it to adopt a more reductive, uni-directional, and "evidence-based" model of communication for informed choice.

For feminist ethicist Susan Sherwin, the concepts of individual rights, autonomy, and freedom that underlie mainstream bioethical and consumerist approaches to informed choice are especially problematic. She argues that this ethical framework may foster an "illusion of choice that can be part of the mechanism for controlling behaviour . . ." In her view, efforts to guarantee the exercise of individual informed choice may actually make the exercise of medical authority even more powerful and effective than it would have been under more traditionally paternalistic models" (28). For Sherwin, a feminist ethics of healthcare must actively resist and redefine, rather than complacently accept, dominant bioethical assumptions about individual "choice" and "autonomy."

Abby Lippman similarly points out that although "choice" has functioned as a key principle of the women's healthcare movement, this concept is becoming problematic for a feminist discourse of healthcare because the term "choice" is increasingly embedded in a consumerist discourse that "encourages, and reflects, an atomised, individualized view of social life, a society in which private citizens are presumed to act alone and only in their best interests. . . . To frame choice merely as an individual consumer's self-expression is to ignore the intricate

webs in which women live their lives." As well, "fostering individualism this way hides the social conditions that produce ill health" (284-285) and it masks "the operations of power that construct choices" (282). Lippman's comments highlight the complex, "double-edged" nature of a consumerist approach to informed choice in midwifery: does it function as a progressive, feminist framework to motivate meaningful, collective social change and to introduce a truly alternative, woman-centred model of healthcare, or does its ideology of individualistic autonomy obscure the larger social-systemic issues that affect women's health and limit midwifery's ability to develop a fundamentally different approach to healthcare?

Of course, I don't have a clear answer to this question, but I do think it's one worth considering. In conducting this brief review of some critiques of a consumerist approach to informed choice, I certainly don't mean to imply that the Canadian midwifery approach to informed choice is guilty of all these offences! In fact, I strongly suspect that people like Susan Sherwin and Abby Lippman would consider the midwifery philosophy of informed choice to provide a vitally important counter-balance or resistance to the normative discourse and values that they critique. And I too believe that it may well be possible for midwifery to conceptualize and practise informed choice in ways that are consistent with a feminist ethics and epistemology of healthcare. However, the more that I research the subject, the more that I am beginning to think that such a feminist approach requires the midwifery profession and midwifery supporters to more actively question and resist the language, values, and normative assumptions of consumerism that currently dominate the larger healthcare context. I, for one, don't mind thinking of myself as a consumer when I'm gathering marketplace information to help me choose which car to buy or what natural gas company to sign up with; but it's not really how I want to speak about myself in relation to my midwives and to the informed choice care that I experienced with them.

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E.2 EXPLORING INFORMED CHOICE FROM A STUDENT PERSPECTIVE

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Hello and thank you for joining us. First, let me begin by saying what a great honour it is to be speaking to you as my first time discussing midwifery in a public sphere. Prior to being a third year midwifery student and enrolled in the Ontario midwifery programme, my academic focus was women's health at the University of Wisconsin, Madison. I was also quite involved in the Madison birth community, working, volunteering as a doula, coordinating doulas, and independently studying to be a midwife. For myself, midwifery is holistic and international and I see my work on Canadian midwifery philosophy and policy as a tool to understand the complexities and joys of being with women universally.

It is indeed visually fitting to be sitting on a panel with my two colleagues and mentors, Susan and Philippa, for both women are symbolic of the connections other midwifery students and I build within my midwifery programme. From one perspective, I am constantly learning, improving and building upon my relationship as a care provider with women seeking midwifery care. On the other hand, I am simultaneously working my way through an academic programme, which includes classroom, clinical and community learning and evaluations. Often, these relationships include professors, tutors and preceptors, most of whom are midwives. Now, my intention is not to create a dichotomy between my interactions with the client and the programme, instead I would like to suggest a vision of three circles, each overlapping and interacting inclusively or exclusively from each other. For this talk, and especially in regards to informed choice, I ask you to turn your focus to the middle of the three circles, where student, midwifery programme and client all intersect, or what I like to call the grey zone.

From my perspective, I must learn to somehow navigate autonomously within this grey zone with clients, professionals and practitioners who form broader groups, such as midwifery practices, associations, professional colleges, government bodies and academic institutions. I see an essential and most challenging component of the grey zone to involve the application of "informed choice". I have purposely encased the words informed choice in quotation marks, simply because I believe this concept to be very fluid and find that there are many different

methods beyond those of "informed choice" to describe the process of decision-making and personal autonomy. "Informed choice" also exists in Ontario as A) a legislated philosophy as defined by the College of Midwives of Ontario and B) taught and evaluated within the Ontario Midwifery Education Programme (MEP). *The paradox that I see and experience is how I apply a concept I believe to be quite fluid within a specific manner defined, taught and evaluated by the profession.* In other words, what are my challenges as a student with informed choice in the grey zone? I have divided these challenges into three main categories:

(1) *"learning" informed choice*
(2) *applying informed choice – political and relational conflicts*
(3) *evaluation of informed choice*

"Learning" informed choice

What is informed choice and how do midwives foster it? Most importantly from my perspective, how do I "learn" it? This topic is very challenging for me, because I have purposely studied and familiarized myself with the complexities of the term outside of Ontario midwifery and have found that within my educative programme it has been simplified and streamlined to support medical forms of hegemonic knowledge.

Let me begin by describing to you the perspective I have gained regarding informed choice within the context of the MEP. Informed choice is taught and accepted as a cornerstone philosophy of our care. Yet, most importantly it is also a tangible and required way of interacting with a client. For example, the "informed choice discussion" is a standard way of describing actual conversations a student has with a client relating to the compendium of choices a woman makes throughout pregnancy, childbirth and postnatal period. Furthermore, informed choice discussion cards are being created and circulated and an informed choice discussion paper is a standard component to our clinical courses. What is a standard informed choice discussion?

As stated within the College of Midwives of Ontario registrant's binder within the "Informed Choice Standard" document (1):
The College of Midwives of Ontario requires registered midwives to provide each client with the following information throughout the course of care:

- Potential benefits and risks of, and alternatives to, procedures, tests and medications
- Relevant research evidence
- Community standards and practice

For example, the common time to have an ultrasound screening is around 20 weeks gestation. Picture an 18, 19 or 20-week prenatal visit. It is expected of the midwifery student to sit down with the client and have an "informed choice discussion" regarding this upcoming possible screening. Obviously, the individuality of decision-making is essential to how each woman listens, understands, shares and chooses. But risk discourse based on percentages and statistics, is strongly suggested by the MEP and my college to be a crucial piece of the puzzle. In fact, it is essentially how I "learn" to provide informed choice. I provide the evidence - benefits, risks, and alternatives – and the client makes a decision. This sounds suspiciously like evidence-

based practice, because it is. Now, I am not suggesting that evidence-based practice is a bad thing, I am merely pointing out that it has become the cornerstone if you will, of how I have learned informed choice. If I were to put it linearly: evidence-based information = knowledge = power = autonomy = choice. Shorten it a bit and you get informed choice.

The synonymy of evidence-based information and informed choice raises all sorts of questions for me. Particularly, to what degree should it represent the idea of informed choice? Additionally, by focusing on the centrality of evidence-based practice, what discussions and teachings regarding the multiplicity and complexities of decision-making are being de-valued or under appreciated.

Realistically, informed choice cannot be compartmentalized into simply providing a certain type of information to the client. It creates a totalitarian method of teaching "informed choice" to the student, it minimizes the importance of information sharing beyond the objective facts, and it supports a more paternalistic model of practice, which disregards the realistic fluidity of the client/student/preceptor relationship.

Applying Informed Choice

Political and Relational Conflicts

This section deals entirely with applying "informed choice" to my clinical experiences with the client. As much as knowledge and choice cannot be compartmentalized, neither can the student/preceptor/client relationship. As I enter a practice during clinical placement, or more specifically, a particular midwife's practice, I am faced not only with the expectations of my program and informed choice, but with the expectations and personal interpretations of an already practising midwife. Furthermore, I am now engaging with women who are making-decisions in a multiplicity of ways based on a multiplicity of factors. Therefore, I must adjust my own understanding of informed choice to the preceptor while delicately balancing my relationship with the client and her existing relationship with her midwife. A fine dance indeed!

Outside of my experience, research done by British midwife Valerie Levy examines how midwives facilitate informed choice. She found that midwives often guide a woman towards a choice based on the perceived safety of the choice. They orient information based on their own personal views of what is 'right'. And I quote, "midwives control the release of information and choice in order to protect their professional territory and credibility, as well as against ethically or aesthetically undesirable outcomes" (2:111). While these may be generalizations, we practitioners cannot and do not function apart from our own values and beliefs. Indeed, our interactions will be based upon them! In fact, I support subjectivity within midwifery and believe that in combination with awareness of the factors that influence care, a midwife can foster a reflective and supportive learning environment for the student. Essentially, she is the teacher of ethics and must therefore know her own beliefs, prejudices and assumptions. She should know her students backgrounds, cultures and fears; know her content, theory, practice, its limitations and contradictions; and know her clients' hopes, fears, beliefs and traditions (3:188). Awareness of these factors is no doubt challenging, especially within the

confinements of a very busy practice. From my perspective, it is unfortunate that less awareness is correlated with less support and greater challenges for the student.

Undoubtedly, my relationship with my preceptor also affects my interactions with the client. In regards to informed choice, if I am expected to follow my own midwife's methods while continually aware of the MEP's standards and expectations, the conversations with clients become quiet mechanistic and rehearsed. With this in mind, I have to ask myself whose knowledge dominates? To borrow from feminist Foucauldian thought for a minute, knowledge is intertwined with power (4). If I am at the centrality of the conversation, I am privileging the knowledge I am providing. This knowledge is clearly from a professional perspective and as discussed in the previous section highly modernistic. How does this type of interaction marginalize the knowledge and experience of the client? How do I disembody her voice? I daresay that this is yet another way in which the concept of woman-centred care is challenged.

Realistically, my role as student adds another dimension to the process of decision-making and to the role of the care-provider within the client-midwife relationship. The question of responsibility comes to mind and I wonder if the expectations of my preceptor and the program could override my ability to learn how to support an environment built on trust and open-information sharing. Yet as much as I might question the manner in which informed choice is facilitated and to what degree a woman's knowledge is marginalized, I cannot ignore the powerlessness of my role as well. How much can I challenge my position and views on informed choice if I'm being evaluated and graded based on certain requirements?

Evaluation of Informed Choice

The biggest challenge I foresee in the realm of evaluation lies within the contradiction of personal autonomy and responsibility. As fore mentioned, how can I communicate with the client based on her needs while remaining in harmony with my preceptor and programme? As a student, where does my responsibility lie? On one hand, it is important to acknowledge the value my schooling and preceptors have to my path to midwifery. Yet by the same token, what value does my critical reflection and the knowledge of my clients have as well? From a utopian perspective, equality would exist between them all and the grey zone would be a smooth and even shade.

As a friend and fellow colleague of mine wrote: Utopia,
"When the word is said we think of an ideal or perfect place. What I didn't realize is that the word is actually derived from two Greek words *ou* meaning: not and *topos* meaning: place. Therefore literally speaking, it means no place. By combining the literal and contemporary definitions we have an ideal and perfect place that doesn't exist. Informed choice is part of a utopian society. It is perfect and ideal but does not exist. It can't exist in its purest form in a real world because we, as humans, are incapable of perfection. However what we can do is try to get as close as possible to this ideal and to use it as a tool to analyze why other methods like informed consent are so problematic" (5).

I believe that my colleague's point is key. Informed choice is simply a model with which we can compare already existing models of care. We can also use this type of reasoning to analyze and critique the reality of the midwifery student as others and I learn to balance our interactions with the client, preceptor, programme and other structures within our grey zone.

Essentially what I propose is that informed choice could be a guiding ethical principle as I move through the programme. Therefore, the context of how I learn and apply informed choice shifts from describing "what" I do, to a model that supports how I communicate and build relationships with my clients. In this sense, I believe that the mask would be removed and we would simply be left with what midwifery education and practice is in Ontario. For example, if the programme believes and values evidence based-practice, then I should be taught and thus evaluated for my ability to give evidence-based information to my clients NOT an informed choice discussion. By upholding informed choice as a guiding principle, the synonymy of the two concepts disappears and the limitations of evidence-based practice become clear. Furthermore, room to grow in my understanding of the broad and limitless forms of knowledge available to the client and myself is created. I believe that the study of decision-making that takes into consideration internal and external factors, circumstances, intuition, feelings, fear and values is the study of ethics. Why not teach the students ethics and include informed choice as one type of ethical model within midwifery? Ethics would also allow me the tools to understand the complexities, limitations and joys of the interactions I come to culminate within the grey zone. Decision-making cannot exist simply within the context of hegemonic care, because hegemonic care is not woman-centred care. And without woman-centred care, what is midwifery?

As I wrap up my talk today, I would like to emphasize the great appreciation I have for all my relationships within the grey zone. Critique does not serve the purpose of putting down another, but rather, values and builds upon the work and analyses of other pioneers. This type of thinking allows midwifery to grow in a fluid and holistic manner and gives voice and space for all midwifery students to contribute. Similarly, it also provides openness to the limitations of practising within, or some might say closely with, a bio-medical model of care. These limitations exist for the midwifery student in Ontario as we learn to facilitate women within the decision-making process. As ethical scholar Bergum states: to ignore the limitations of decision-making is to be in "danger of losing the capacity to care deeply for each other – as people who are dependent yet independent, autonomous yet connected to others, sharing yet coming to personal decisions, responsible for others yet anticipating rights for oneself"(6).

Thank you.

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E.3 EXPLORING INFORMED CHOICE FROM A MIDWIFE PERSPECTIVE

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Abstract:

As a midwife and an academic in the field of midwifery, I am constantly balancing the tensions that arise in the understanding and operationalizing of the concept "informed choice." In practice, the hegemony of the healthcare culture, with its natural science bias influences midwives to turn to "evidence based practice" as the basis for legitimate information. An emphasis on risk management further informs the midwife's approach to informed choice. Balancing these are the philosophical positions of woman-centred care and belief that birth is generally a normal physiological and social event in the life of a woman and her family.

What is the midwife's role in the process of informed choice? Is she a source of information – the walking encyclopedia of what is good, bad and indifferent in all things in maternity care? What place is there for professional expertise and judgment? Is there a place for the midwife's own opinion – how does the midwife balance the personal and professional? What role does the relationship between woman and midwife play?

In this presentation, I will address questions that arise from an examination of informed choice from the position of practitioner and educator. Gaps and challenges in regulatory documents will be identified. The re-union of midwifery philosophical underpinnings of relational care and informed choice practices will be proposed.

Midwives are very proud of their association with "informed choice" – at times we seem to have a singular claim on its implementation within healthcare. When I attend conferences focused on women's health, ethics, and feminist theory, I commonly find one or more presenter who used midwifery informed choice as a positive example of women centred practice.

And with good reason – as both Philippa and Kirsty have pointed out, informed choice is highly appealing to women and practitioners. The practise of informed choice can be empowering and equalizing.

Despite our attraction to informed choice, the operationalization of this value under the scrutiny and responsibilities of regulated practice poses challenges to midwives, students, clients and the profession generally.

One might initially suggest that the practise of informed choice is relatively unproblematic. Regulatory standards "tell" us what to do. Once one shifts from a paternalistic stance to a commitment to a woman's right and ability to be an active, informed decision maker, the practice ought to flow from there. As both Philippa and Kirsty have articulated, the apparently

unproblematic becomes complex and challenging as we begin to uncover the layers of our values and practices and the socio-cultural context in which we carry out our practice.

Midwives consciously or unconsciously balance numerous competing and complementary interests in the practice of informed choice. There is not time to explore each of these in depth. For this presentation, I will introduce some reflections about some that may contribute to our challenges and others that may provide us with some future directions for practice, policy, education and research.

1. Consumerism

The consumerism approach to healthcare plays a significant role in current midwifery practice. In addition to the information that Philippa presented, I will make a few brief comments. From a practice and education perspective, reflection on what it might "mean to me" as a professional to regard the woman as a "consumer" or "customer" constantly pushes us to consider our actions, values, and beliefs in a less profession-centric way. We encourage students to put themselves in the footsteps of the woman in care. What is it like to make choices, to be faced with options? What is it like to balance a personal desire to know more about a test or procedure or what is happening in your body right now with the cultural experience in healthcare of uncritically accepting professional advice?

However, as a former Alberta midwife, I am very aware that politically, any emphasis on practices as consumer choices can have devastating effects on a profession. The language of consumerism and consumer choice played an active role in moving regulated midwifery in Alberta into a private service rather than a fully funded integral part of the healthcare system.

2. Modernism

Modernism is associated with a privileging of the objective – the scientifically derived measurable, replicable and observable. In healthcare, evidence based practice is one of the prominent manifestations of modernism. Pre-regulation midwives demanded evidence based practice in enacting their roles as advocates and activists. The call "show me the proof" was commonly heard for issues like episiotomy, hospital birth and VBAC. Midwives are also held to the standard of evidence based practice. The "informed" part of informed choice tends to be defined as "evidence." The midwife is expected to provide the facts of the issue at hand: how a procedure is done, incidence, risks, costs and benefits. Some may argue that objective information is too narrow a definition of "evidence." But, the word evidence does have at its roots the verb "to see" – evidence is the observable, the objective.

Kirsty's description of the student experience is a special yet highly informative example of modernism. Not only is the relevant information that the student is required to organized for her informed choice "discussion" biased toward objective facts, the way of evaluating the practice of "performing" informed choice is often restricted to the objective as well. The student is asked to produce a "card" with her listing of the "facts" and students often find that their evaluation is only related to the ability to recite relevant facts.

A second feature of modernism is the requirement to be objective – to distance oneself; to establish clear boundaries; to practise from a position of unbiased neutrality. As midwives we may be attracted to this objectivism. Many of us may have had experiences in healthcare or other aspects of our lives where another's personal biases have had a negative impact on our experience. We have also heard from clients that they felt as though their family physician was biased against their choice of having a midwife or of having a homebirth and that this bias at times was strongly felt in the type of care received. And so, under the expectations of any regulated profession, we develop codes of ethics or codes of conduct that caution us about our relationships our opinions, beliefs and values. We caution against giving one's opinion or advice – what the midwife herself might do or have done in similar circumstances. The apparent "indifference to outcome" suggested by Gadow (in Philippa's presentation) may be a logical progression of taking an "objective" stance in matters of decision-making.

3. Neoliberalism

Closely tied to the previous two influences is neoliberalism. While this view is most closely associated with economics, its emphasis on individual responsibility for risks (as opposed to communal support to attempt to reduce the likelihood of risk) has brought neoliberal values into healthcare practices. We probably should not have been surprised that the insurance industry was initially very interested in midwifery. Our emphasis on informed choice may have sounded like a "poster child" for neoliberal values. Research of neoliberal practices in the insurance industry has revealed that the emphasis is on providing education and the expectation that the educated worker, patient, client should not put themselves at risk and expose their employers, care providers, etc. to liability. And, the educated individual who puts herself at risk has no one to blame but herself. And so, on the advice of our insurance risk managers, we develop schedules of informed choice discussions, we produce detailed written resources for clients and we ask students to develop cue cards so they can "give the talk."

Coming full circle

The challenging aspect of studying the practice of informed choice is that all of these influences have had both positive and negative effects in practice. The scheduling of topics for discussion may feel contrived and disrespectful to individual concerns. But, at the same time, this is a useful tool for continuity in group practices. Even Kirsty's concerns have another side: beginning students often crave some organization, pattern, predictability. What might feel mechanistic to an experienced student can be a life raft for a nervous novice who needs something to stay afloat until she gains confidence in doing it herself in her own way.

However, the concerns about the practice of informed choice continue to be heard: what is informed, whose information, what is choice, which ones are offered, what do we do when women don't seem to want to 'do" their part, what about language and culture challenges, and how do we contend with personal beliefs and values?

I'd like to spend the end of this presentation on what I think of as 'coming full circle" – a coming into our wisdom as women with women, the roots of what called many of us to midwifery. This work (whether we call it a profession, a vocation or a calling) is highly relational in nature. The very word midwife implies relations. "With woman" is a relation in a

broad sense. It need not imply close or friendship relationships. Indeed, “with” can also imply against e.g., “I am at war with you.” Relations can be wonderfully positive, but they can also be complicated, uncertain and introduce conflicts.

While relations may make us feel at our most vulnerable, this is where we are most “full-bodied” and “full-blooded.” Postmodern ethicists such as Bauman and Løgstrup suggest that relations provide a synergy for knowing and trust. In relation we are best able to learn about others and about ourselves; we see ourselves reflected in the eyes of another. Culturally, we begin with an assumed ‘knowledge” based on a generalized sense of another – the woman knows that the person before her is a midwife (and of course her detail of this understanding will vary) and the midwife knows the pregnant woman is a (potential) client. That generalized knowledge will take us far enough for basic care. When the midwife invites the woman into relations, the possibilities for knowing are magnified. Tim Lambert (an environmental ethicist) says, “it is through the experience of inequality and interconnection that gives rise to the critical importance of relationships.” The reality that there is a power imbalance between midwife and woman makes attention to relations all the more important rather than a “risky business.” Lambert goes on “the seed of morality arises from competing moral impulses found in the particular moments in relationship with another person. Mutually respectful relationships are the middle ground where neither the person, community, nor healthcare providers are alone, but each co-exists in relationship in making decisions through genuine dialogue (p134). The conflicts that are potentially present in genuine relationships where dialogue is the normative form of communication create possibilities.

Relational ethicists suggest that our moral responsibility lies in relations – not in questions of consequences or greatest good. How can I enter a mutually respectful relationship with another? How can two selves retain their sense of self while at the same time forming a connection? How do I continuously develop my own perspective while seeking opportunities for creative insight and new facts? How do I remain open to the expression of the perspectives of others? How do we respect varying forms of information and knowledge? How do I express my invitation to relationship with women in my care – in ways that are respectful and safe, realistic and meeting the needs of the context of midwifery care?

These are the challenges we face should we elect to move the profession against the tides of the “isms”: consumerism, modernism, and neoliberalism. Relational care does not result in the elimination of attention to “evidence” or “professional standards.” These become part of the dialogue – what are the possibilities, what are the limitations – both professional and personal?

Our questions continue: How do we communicate a commitment to relations in regulatory documents? Is “word-smithing” alone enough to convey these values or do we need a fully different way of expressing our practices such as informed choice? How do we prepare students for relational practice? Is role modeling by faculty and preceptors enough or are there curriculum elements that more fully reflect a commitment to relational practice while at the same time reflect respect for learning styles and progress?

F. CONCURRENT SESSION

WHAT EVIDENCE COUNTS? WHOSE EVIDENCE COUNTS?

Midwifery practice brings many questions to the fore in terms of the process of establishing "evidence". This forum asks two very important questions regarding evidence. The clearest distinction between types of evidence is between qualitative and quantitative research. Midwifery practice draws on both and demonstrates that both are necessary to care for childbearing women; the narratives are as important as the "facts and figures". One way of measuring and assessing midwifery practice is through an audit which, as Kryzanauskas points out, generally brings out fear in midwives and is not seen as an opportunity to improve practice based upon the evidence that each midwife creates through her practice.

Quality Assurance Practice Audits: The Fear Factor
Michelle Kryzanauskas, Registered Midwife, Ontario

QUALITY ASSURANCE PRACTICE AUDITS, THE FEAR FACTOR

Michelle Kryzanauskas, Registered Midwife, Ontario

Abstract

Midwives are regulated in many different ways in jurisdictions across North America. In Canada and the United States midwives have varying degrees of autonomy and work in a variety of in-hospital and out-of-hospital settings. The process of assessing the quality of the care they provide will be exercised upon them at institutions where they work, by their governing bodies, by their funding agencies, or in most cases by all three.

So why do midwives fear clinical practice audits and not simply acknowledge the reality of quality assurance programs in health care and expect to let it happen? Is it possible to consider the practice audit as constructive and educational for midwives? How will practice audits improve the quality of care provided by midwives?

The quality assurance practice audit has become the fear factor of regulated midwives. The fear of examination or scrutiny of our work may be completely unfounded but the fear has been well socialized into midwives' work ethics. The fear of not being prepared for the audit is also very large for busy, working midwives.

Is the fear factor emphasized by the lack of knowledge of the quality assurance practice audit process? If so, where do midwives enroll in pre-practice audit classes to be better prepared for the "QA Practice Audit"? How do midwives prepare for the labour of the audit; do they need a practice audit doula? Or maybe they need a specialist to help them? Or do they need a midwife to see them through the normal process of self examination or the delivery of the "QA Practice Audit"? What of the post-practice audit period? How and where will midwives find continuity of support for their quality assurance practice audit program recommendations?

Midwives need and deserve informed choice with respect to quality assurance practice audits. The sharing of the experiences gained in the area of practice audits will afford midwives the ability to make choices for change to improve the quality of the care they are providing.

Behavioural Objectives

Midwives will become informed with respect to quality assurance practice audits and experience behavioural change in the quality assurance practice audit arena:

1) Midwives will be able to develop knowledge and understanding of the quality assurance audit process.
2) Midwives will be able to develop audit tools and mechanisms to perform on-going mock audits of their care provision to clients within given practice settings.
3) Midwives will begin to develop the self examinations skills and abilities to make change for improvement to the quality of the care they are providing to clients.

Detailed Content Outline

Context for Presentation

- **Unregulated Midwifery**
  - *Voluntary standards and policies*
  - *Consumer involvement and demand*
  - *Laws of the land*

- **Regulated Midwifery**
  - *Provincial law*
  - *Federal law*
  - *Relevant midwifery Act*
  - *Midwives will be regulated in each province and territory.*

- **Quality Assurance Programs**
  - *College of Midwives of Ontario (CMO)*
  - *College of Midwives of Manitoba (CMM)*
  - *College of Midwives of British Columbia (CMBC)*
  - *Institutional programs in hospitals, birth centres, health centres*
  - *Provincial and federal funding agencies*

Context for Presentation

- Three decades of professional experience in the clinical and financial audit fields, including inspections and investigations.

- Individuals being audited, in any profession, express concern and fear about the audit process, The Fear Factor.

- Provision of informed choice for midwives regarding the audit process may facilitate reduction of stress over pending audits.

- Provision of support for the midwife to fulfill the possible recommendations from the audit process may help realize improvement and change in the quality of care provided.

- References and research listed at end of presentation in support of Fear Factor Prevention.

The Fear Factor

- The fear of the unknown practice audit process
- The fear of the punitive aspect of audits
- The fear of increased workload created by the audit
- The fear of increased time requirements made on you
- The fear of lack of prior preparation for the practice audit
- The fear of self examination and peer examination
- The fear of the final recommendations of the auditor
- The fear of financial burden and expense due to the audit

Unregulated Midwifery

- Voluntary development of standards, bylaws and policies sets the foundations for benchmarks that may well be used in regulation.
- Consumer involvement in the establishment of the model of care sets a standard for a quality model of care.
- Use of peer case review process is a pro active approach to pending regulation. Historically, in Canada, regulated primary care providers have been expected to participate in some form of peer case review within a quality assurance program.
- Use of quality of care evaluation forms for clients to complete is reflective of the models of care offered by midwives in Canada.
- Continuing education and professional development opportunities used to improve skills and knowledge within the midwifery profession.
- Accountability to self and clients for quality of midwifery care sets tone for future of midwifery.

Regulated Midwifery

- The health care professions are regulated provincially under the regulated health professions legislation.
- The health care professions then have their own profession-specific acts contained within the regulated health professions legislation.
- Midwives are governed provincially by Councils that include public and professional members.
- The Council, as protectors of the public in each province, must measure or examine the quality of care provided by regulated midwives.
- Profession specific regulations, bylaws, standards, policies and guidelines are entrenched.
- Regulated midwifery is also bound by relevant Federal, Provincial and Municipal laws.

Quality Assurance Programs

- The structure of governance of the profession will be the foundation on which the Quality Assurance Program practice audits will be built.
- Quality Assurance Programs exist in institutions where midwives hold privileges and possibly employed or contracted to provide a specific model of care.
- Midwifery funding agencies will also be involved in Quality Assurance for the care provided by funded midwives.

- The Quality Assurance Programs offer methods for assessment of the quality of care provided in out of hospital settings.

- Midwives have a degree of autonomy and this requires Councils to provide them with ways to evaluate and examine their practice if improvement is to be supported.

- Continuing education and professional development components of quality assurance programs promote ongoing education and learning for midwives.

- Peer case review is a progressive component of the Quality Assurance process that stands alone from continuing education.

- Quality of care evaluations completed by your clients are a component of quality assurance programs to provide direct client input into the model of care you provide.

- Self assessment components of quality assurance programs are reflective self directed tools for the midwife as a professional health care provider.

- Random practice audit programs offer ongoing examination of the quality of care provided and are well suited to the improvement of the midwifery model of care.

- The practice audit process will inform and provide input to the Quality Assurance committee to allow for review, revision and development in the governance area.

- The model is as good as the materials used to construct it!

Definitions in Regulation

Regulations

- Regulations provide details required for an Act to operate. They have the force of law, and as such must be approved by the legislature of the provincial government.
- Midwives will be held accountable to the Regulations.
- Regulations are benchmarks.

Standards of Practice

- Standards developed to ensure consistent, safe, and ethical practice and support approved regulations, providing direction to regulate the practice.
- Midwives will be held accountable to the standards.
- Standards are benchmarks used in practice audits.

Policies

- Policies are an overall plan respecting general goals and accepted procedures in development of standards of communication.
- Midwives may be held accountable to the policies.
- Policies may be considered benchmarks.

Definitions in Regulation

Bylaws

- Bylaws describe governance, boards and committees and set out rules and procedures to register and regulate midwives consistent with the Act and the regulations.
- Midwives will be held accountable to the bylaws.
- The bylaws contain many benchmarks for audit purposes.

Guidelines

- Guidelines provide an indication or direction for the execution of policies, standards, regulations or bylaws.
- Midwives may be held accountable to guidelines.
- Guidelines may direct specific benchmarked areas for the audit process.

Protocols

- Protocols are developed by practitioners or institutions to support their practice within standards, bylaws, community standards and laws.
- Midwives may be held accountable to protocols.
- Protocols may serve as benchmarks in the audit process.

Why Practice Audit?

- Practice audit has been shown to be the component of quality assurance that may best improve quality of care provided by the midwife member.
- If audited by a health professional peer, a midwife, physician or nurse may alter their behavior to improve standard of care when provided recommendations to achieve this end.
- Practice audit may be used to examine the midwife's practice as the result of a direction from a complaints panel or a registrar's investigation.
- Practice audits may be random audits of a Quality Assurance Program.
- Random practice audits do not carry a punitive direction in their recommendations but harbour values of continuing education and professional growth.
- The random practice audit provides a means for a midwife to have her practice reviewed and improve the quality of care she provides.
- Public is provided a process to assure the quality of care received from midwives.

What is a Practice Audit?

- Review of care provided by the midwife in a period specified in the regulation and prompted by random selection, a complaints panel decision or for non-compliance under bylaws, regulations or standards.

- The review and examination of the midwife's practice in accordance with the governing body's regulations, standards and policies. This includes the midwife's clinical and business practices.

- Recommendations and suggestions are provided to the midwife in order to improve the quality of midwifery care provided to her clients.

- All practice audits involve an in-person visit to the practice site and a meeting with the midwife and an off-site component prior to and following the on-site visit.

- The audit may be a general practice audit or an audit of particular components of the midwife's practice: antepartum, intrapartum or postpartum.

- Financial implications for burden of cost of audits will be different in each jurisdiction.

Audit Method

- The midwife is informed of her selection and she considers any conflict with the proposed auditor.

- The auditor is appointed by the College and she will perform a practice audit which includes the onsite and offsite components.

- Assess the midwife's compliance with midwifery regulations, standards, policies, guidelines and by-laws and applicable provincial and federal laws using and completing practice audit tools.

- Practice audit tools will be used to assess the midwife's compliance to the model of midwifery care.

- A written Audit Report with recommendations compiled for the midwife member and QA panel consideration and response is prepared by the auditor.

What is a Practice Audit Tool?

- A template or form designed to follow the care provision from intake to discharge and determine that the scope of practice and authorized acts have been adhered to.

- The chronological structure of the tools supports the way obstetric care "unfolds", similar to the flow and format of the charts to be audited.

- Audit tools allow the auditor to assess the provision of informed choice by the midwife to her clients.

- The tools must function for the auditor as the charts must function for the midwife member.

- Audit tools will allow the auditor to examine the clinical care the midwife provided as required by the governing body, recording findings as compliance/non compliance with recommendations and suggestions.

- The audit tool provides a consistent mechanism for examination of each midwife's practice.

Practice Audit Behaviours
Midwife

- You must consider any conflict of interest with the auditor and declare it immediately.

- On-site component requires you to be off call, and you may find it very inconvenient. You may feel angry.

- You may be anxious because you do not have a back up to cover, have too many women ready to deliver, or have an off call period arranged prior to being informed of the pending practice audit.

- The practice audit is an inconvenience to staff and other midwives in your practice and this causes everyone to experience anxiety throughout.

- Ensuring the auditor is oriented to the site and provided with a workspace may have physical limitations outside your control, adding more anxiety to your experience of the practice audit.

- Financial costs such as couriers, long distance and copies makes you feel like you are paying for making work.

- Some of you may have concerns that practice audits are performed in order to find wrong doing and consequently discipline you. This may make you feel paranoid, anxious and angry.

- Some of you fear you will be judged by a midwife not accustomed to the demographics of your practice, your practice's profile or your practice arrangements.

Fear Factor Prevention Measures

- Self Examination
- Records Review
- Mock Audits
- Informed Choice Discussion Record
- Protocol Development

Self Examination

- Regulatory review should be undertaken. (Review the binder!)

- Midwifery experience, past, present and future and other relevant professional experience should be considered and made available to clients.

- Records, discharged and current charts considered clinically and including security, privacy and consent considerations.

- Equipment and supplies and the records of maintenance of equipment used in provision of midwifery care must be maintained and a record kept.

- Protocols, administrative and clinical, referenced and dated.

- Continuing education and professional development opportunities of the past, present and future should be recorded.

- Clients and practice profile and needs. Consider questionnaires clients complete to ensure profile reflected and required questions included.

- Business practices and agreements should be considered and reviewed.

Self Examination

- Best practice considerations to be included in the midwife's model of care are extracted from the following sources:

    - Results of a midwife's continuing education, professional development and current research efforts.

    - Recommendations of peer case reviews and case management work undertaken with peers.

    - Results or directions received in clients' evaluations of care.

    - Trends or changes identified in the midwife's clinical data collection may be used to improve or change.

    - Recommendations and suggestions from audit reports will assist in developing best practice approaches.

Records Review

Consider the records you keep. If it is not recorded, it will be considered to not have happened. If it is not legible, it will not be readable and not useful in support for the information you are recording.

The following framework or the midwifery records standards, regulations, or bylaws may be used to develop an audit tool to review the record:

- Name of care providers and practice group
- Name of client and address
- Client medical/family/obstetric/contraceptive history
- Routine prenatal care record including psychosocial topics
- Informed choice discussion record
- Protocols discussion record
- Intrapartum record
- Immediate postpartum record, maternal and newborn
- Postpartum record, maternal and newborn
- Birth and newborn summaries
- Consultations, transfers of care and follow up plans or outcomes
- Signatures, designations, registration numbers and initials
- Forms utilized to their potential

Mock Audits

- May be interesting and enlightening to examine your own or practice associates' work and records.

- May give you a sense of ease when you realize you are actually doing as required of you by the governing body.

- Begin small with the intention to examine one current course of care and one discharged course of care.

- Place in a practice meeting so all midwives and students will benefit. This is an excellent form of professional development that costs you in your time only.

- Use your records standard as a check list and you will have your own consistent practice audit tool for mock audits.

- Use the College direction on place of birth, informed choice and protocols to develop a practice audit tool to review care provided.

Informed Choice Discussion Record

- Consistent recording of the routine or scheduled informed choice discussions throughout care will ensure evidence of them having occurred, when and with whom.

- To support routine informed choice discussion you may use numbered practice protocols and numbered client handouts. This reduces charting of the same discussion yet it ensures consistency in information provided to clients.

- Informed choice discussions that are not the routine or scheduled discussions must be clearly and simply charted, dated and initialed. These are often the more contentious areas of care and for this reason accuracy of charting becomes essential.

- Use of protocols and handouts supports consistency of information provided by students involved in the clients care.

- The use of checklists in the record or the discussion topic lists on antenatal forms to evidence informed choice discussions in the record must bare a date and an initial to substantiate the discussions.

Protocol Development

Your best practice approach to the inevitable practice audits of regulation is through the development of comprehensive and relevant protocols:

- Protocols should be clear, simple and relevant to you and your midwifery practice. Routinely review all protocols.
- Protocols should be accessible and understandable to your clients.
- Protocols should be supported where possible with a client handout.
- Use your regulatory references, Provincial, Federal and Municipal law requirements.
- Always include current clinical references and research.
- Community specific standards and institutional protocols may be considered.
- Dating of each of the developed or revised protocols provides a point of reference.
- Consider numbering protocols.

References and Organizations

Organizations:

- American Society for Quality
- Canadian Evaluation Society
- Council on Licensure, Enforcement & Regulation
- College of Midwives of Ontario
- College of Midwives of British Columbia
- College of Midwives of Manitoba

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G. CONCURRENT SESSION

MIDWIFERY EDUCATION AND LEGISLATION IN ONTARIO

Ontario was the first province in Canada to pass midwifery legislation and to develop an education programme. Many changes occurred at the time of legislation and it is through the education programme that these changes are presented to the next generation of midwives. What is included (and excluded) in the education of midwives is an ongoing issue, as well as the role of various texts in the practice of midwifery and how they change over time.

1. *Redefining the Clinical: Social Science Learning in Clinical Education*
   Nadya Burton, Midwifery Education Program, Ryerson University, Toronto, Ontario

2. *Exploring Legislated Midwifery: Texts and Rulings*
   Mary Sharpe, Midwifery Education Program, Ryerson University, Toronto, Ontario

G.1 REDEFINING THE CLINICAL: SOCIAL SCIENCE LEARNING IN CLINICAL EDUCATION

Nadya Burton, Midwifery Education Program, Ryerson University, Toronto, Ontario

Abstract

The Case of Midwifery in Ontario

This paper explores the role of social science training within current midwifery education in Ontario. The place of the social sciences in clinical training is an interesting one going beyond the bounds of midwifery to include medicine, nursing, and numerous other clinical programmes. It constitutes a contested terrain of exploration, where debate about what is enabled and what is limited when clinical education programmes devote scarce time and resources to social scientific study is rife. This paper explores what midwifery educators believe is the advantage of this (social science) training and asks what social science training enables or fosters within a clinical education programme. It examines how social science training might best be understood and implemented within a primarily clinical programme. At the centre of this paper is the desire to explore and redefine notions of the 'clinical' in ways that will allow for the complex training midwives currently experience and which will reflect the array of skills they acquire. What is the role of social science training in creating good practitioners, when 'good' is understood to include far more than strictly clinical skills? This paper will address the negotiation that takes place in midwifery-based social science courses, between pure and applied knowledge. A significant portion of midwifery-based social science training involves theoretical and practical training in ways to work creatively and effectively across differences. Social science courses based in the midwifery education programme have the opportunity to gear their theoretical analyses of difference to a focus on skills to be acquired for practice, skills no less important than traditionally clinical ones. Pure and applied knowledge can merge, providing future midwives with a set of essential and practical tools and skills for working effectively responsibly and compassionately in an environment where culture, sexual orientation, class, religion and ability all play significant roles in understandings and experiences of pregnancy and birth.

G.2 EXPLORING LEGISLATED MIDWIFERY: TEXTS AND RULINGS

Mary Sharpe, Midwifery Education Program, Ryerson University, Toronto, Ontario

Introduction

In 1994, with the passage of the Midwifery Act, the status of midwives changed, which required the establishment of new work structures, processes, and relationships. In this talk, I examine the role that texts—that is, written documents, official language, structures, and institutionalized processes—have increasingly played in midwives' work through the integration process. To do this, I draw upon the theoretical work of sociologist Dorothy Smith

(1990, 1995). I also bring my own reflections and those of midwives I have interviewed (Sharpe 1995,1997). I argue that the texts midwives use frame women's experiences in particular ways that can inhibit care. These texts also protect women, midwives, and the profession of midwifery.

Dorothy Smith

Dorothy Smith's idea is that texts not only alter, shape, and rule people's lives, but over time become invisible limiting forces. What people experience and speak about in their ordinary lives, their "primary narratives," is often not captured or understood in the various texts that are created from the primary narrative. Special attention called a "bifurcated consciousness" is necessary to recover a measure of freedom to coexist with these texts. These arguments, presented in Dorothy Smith's work, resonate in my grappling with the implications of legislation.

Pre-legislative practice and lay midwives

After the birth of my first child, Jenny, I began to meet with other women. We formed a subculture exploring, sharing and critiquing childbearing, breastfeeding, and parenting experiences and practices. Some forms of knowing become critically visible along what Dorothy Smith calls "fault lines" (1995, 13), where one can see distinctions for instance, between the obstetrical care to which some feel subjected, and the kind of birthing care they desire. This "knowing" led me toward becoming a midwife and influenced my future personal birth choices.

In the late 1970s some of us lay midwives were attending home births, usually with family doctors. We set up informal prenatal clinics in our homes. At one home, one morning a week, children played and women conversed while they waited to see the lay midwife of their choice in a bedroom upstairs. Care was approached together as friends; the woman told the lay midwife what she wanted and the lay midwife responded with a minimum of interpretation. At noon, the lay midwives would gather over a potluck lunch *separately* from the women and discuss what they had learned from the morning contact.

In our early work, we were shielded from certain clinical details and from the large body of paperwork required after legislation. Prenatally, the woman would visit the doctor as well as the midwife. The division of labour that existed between physicians and midwives prelegislation reproduced elements of traditional male/female roles. The physician, with access to laboratory tests and the obligation to do the formal documentation of care, dealt with "public" matters, leaving "private" matters to the midwife. For some midwives, this exchange facilitated their role, while for others it restricted and undermined them as primary caregivers (Van Wagner 1999).

Perhaps the earliest record by some lay midwives of events surrounding the birth of the baby, the gender, the date and time of birth – if not for a birth certificate, certainly for the child's astrological chart – casually written on the back of sterile glove packages or on note paper, were primarily for the woman, or the midwife's personal diary. Gradually, we began to develop discourses and texts that influenced our practices and interpreted the woman's experiences.

In 1982 and 1985, inquests were called into the deaths of two babies whose births had been attended by midwives. We quickly learned that written accounts were key in investigations and that to protect ourselves we should keep "good" records. Experience taught us that, *if it is not written down, it did not occur.* We created record-keeping systems and a disciplinary process for our members. This process helped us become clear about what we collectively wanted for women, midwifery, and ourselves.

Working with the Health Professions Legislative Review, a group of midwives in Ontario learned the necessary ingredients and processes of professionalism in order to prepare documentation with specific language and categories so that Ontario midwifery would fit within the requirements of a regulated health profession. The professional project implicated midwives in what Dorothy Smith would call "father-tongue language: a condition of speaking beyond what we learned from our mothers"(1990, 4).

Professional registered midwives

With legislation, some midwives experienced profound changes in their practices. The midwife's role of primary caregiver now expanded in prenatal, intrapartum, and postpartum care; midwives were no longer emphasizing the alternative view to the one often offered by the doctor. Now they were required to incorporate views that reflected the community medical standard as well. This shifted the focus to *verifying* rather than *assuming* that pregnancy would be normal.

When a pregnant woman enters into clinical "care", she brings her "primary narratives", drawn directly from her experience. The midwife picks out certain aspects of that narrative for a written report. One could say that certain obstetrical schemata operate upon this narrative where parity, gravidity, blood pressure, and certain measurements are extracted as data important to providing good care. The midwife engages in selecting terms and grammatical and logical connections that express the appropriate sequencing when she utilizes prenatal, intrapartum, and postpartum records. Even the items the midwife is interested in picking out of the narrative are determined by an interpretive schemata (Smith 1995).

Some midwives found that during visits with women, attention was given more to notes than to the mother and baby. Standardized prenatal and postpartum forms were found constraining. If a place on the form was not filled out, the record was incomplete. Much of the affective care provided to the woman was lost on this record. It was alarming how readily aspects of the primary narrative that didn't easily fit could be discarded. Much of the woman's story was invisible in these records. Nonetheless, midwives were clear that careful documentation was an important aspect of the business of their care. Indeed, forms offered an important reminder of the necessity of monitoring clinical details and of offering an ongoing record for the woman and midwifery partners.

Regulated midwifery involved an intersection with the texts of other existing professional acts. Many Acts already in place had to be altered to accommodate the professional midwife so that she could dispense and prescribe drugs and write requisitions for ultrasounds and laboratory testing, for example. Most notable was the change to the Ontario Hospitals Act, which legislated admitting privileges for midwives, previously held exclusively by doctors. Most midwives felt that this access allowed them to ensure the wellbeing of women in a more holistic way; care was now less fragmented and there was more continuity.

Midwives found themselves on a steep learning curve attending to hundreds of new details with respect to hospital procedures, protocols, equipment and paperwork, and client admission and discharge. These they found distracted them from caring for women. Yet proper documentation and careful reports to doctors for consulting purposes were seen as important ways that midwives showed their professionalism.

Early on as a registered midwife, I received a notice from a hospital health record's department that a chart I filled out while attending a woman's birth had not been completed properly. I had to complete it within a designated time or my hospital privileges might be suspended. With fear and trembling I entered that office, the great repository of hospital texts in the bowels of the institution, to accomplish this task. The chief record keeper's assistant directed me to my single chart. All around I saw piles, one or two feet high, of charts with physicians' names on top. I had been initiated into the massive world of text that links me to all other professionals in the hospital. Paperwork is a great leveler. No one else can do this work; you can't escape. This is one way in which you, as midwife or physician, pay for your privilege.

Midwives reported that obstetrical departments in different hospitals have various protocols around testing that differ from each other and sometimes from midwifery standards. Perhaps midwives have been thrown, as Dorothy Smith would say, into a situation that may undermine their original intentions and trap them in the very institutional web from which they endeavored to extricate women. It seems essential that midwives continue to try to influence policy and local rulings.

Language

Roles and ideologies are powerfully connected with words; the sound of the voice permeates everything. In an attempt to distance themselves from "patients", used in medical professional language, implying passivity in a patriarchal model, Ontario midwives began to call the women they worked with "clients". Like "consumer", this appellation is problematic. While it accents the advocacy and contractual nature of the relationship, it is a shift to the language associated with law and business and a more formal working relationship.

Dorothy Smith provides illustrations of how particular language is representative of rulings, and she inspired me to look at similar occurrences in birth language. We see how certain phrases express ideologies and represent different paradigms. Smith compares the two phrases: "she committed suicide" and "she killed herself" and notes a disjuncture between them. They are embedded in different social relations and contexts, and as the phrase "she committed suicide" replaces "she killed herself", there takes place "an ideological move that subordinates the individual within the relations of rulings" (1990, 142-3).

The phrases "the doctor/midwife delivered the baby" and "the woman gave birth" colour our picture of the same event quite differently. In the first, it may be implied that the woman is merely a vessel, a foil or background for the occurrence, whereas the practitioner is at centre stage. Although in the phrase "the doctor/midwife delivered the baby", there appears to be some formal connection or act occurring between the doctor/midwife and the baby, the woman herself is invisible. Her name isn't even mentioned. Furthermore, this phrase may imply that the woman is subject to the rulings of the practitioner's discipline and the local setting, usually a hospital, to which the practitioner is connected. One might imagine that assistants, nurses,

anesthetists, and pediatricians were gathered around to help the doctor/midwife deliver the *baby* rather than to help the *woman* give birth. One could also say that the word "delivered" is part of the "institutional discourse" (Smith 1995) of the hospital, and a particular mode of telling what happened.

At the time of legislation, Ontario government antenatal forms required a notation of EDD, the expected date of *delivery*. Midwives became implicated in this discourse by the required use of the antenatal forms that used this term. Earlier, the acronym for this event was EDC, the expected date of *confinement*. Here the woman is suggested; it is she who is *confined* or as my thesaurus notes, bed-ridden, incarcerated, or restricted. By saying the doctor/midwife "caught" the baby rather than "delivered" the baby, we shift the concept of agency somewhat. The attendant's job is less active. It is to receive the baby already *delivered by the woman*. "Caught" was used pre-legislation by midwives and is used predominantly now, but there are pressures to move toward the mainstream use of "deliver". In the phrase "the woman gave birth", the word "woman" is in the nominative case; the focus is on the woman and her agency, not on the practitioner or the baby. Here, the practitioner is invisible; in fact, there may not even have been one. Indeed, some women who have felt obstetrically abused say they dream of going to the woods to birth their subsequent babies by themselves.

Because research claims that births unattended by an experienced and equipped practitioner bear greater risk, the phrase "the woman gave birth assisted by the doctor/midwife" would be more consonant with current midwifery ideology and practice, which acknowledges the woman's central position in her own experience accompanied by trained caregivers. If we further expand this phrase to say, "the woman gave birth *assisted by her supporters, (as defined by her*) and by *her* doctor/midwife" we add other important elements. Here *her* friends and family are acknowledged caregivers; *her* practitioner is personalized and is optimally someone that she knows and has chosen.

Grandmother/midwife

When I first became a grandmother, I was acting as my daughter Jenny's midwife. I was living on the cusp of professional/public and private/familial that Smith describes. This was bifurcation! Could I be both a professional midwife and my "client's" mother? Being my daughter's midwife seemed as natural as simply putting her to my breast twenty-six years earlier. However, I see how the discourse of midwifery entered into my caring activities with her at specific points along the continuum of her "lived experience" of carrying her baby, releasing him from her body, and caring for him in the days and weeks following that moment. (For a detailed description of Jenny's birthing experience see Sharpe 2001).

A question arises for me from this experience with my daughter. Should midwives work with their own families? So far, midwifery is still associated with many cultures where mothers, mothers-in-law, aunts, and grandmothers often are the midwives. It may also be associated with a postmodern feminist ethic that encourages reciprocal and open relationships in health care.

I asked my colleagues what they thought: One said that the authority of the professional relationship might be overruled by motherly sensitivities. If I felt I needed Jenny's cooperation in some situation, she might not respond as readily as other women, hampered by some mother/daughter dynamic or power struggle, or by habits that had evolved from our long and

intimate association. These considerations were mitigated by the Ontario requirement of having a second midwife present at every birth.

Another midwife said that if the outcome were unfortunate, our relationship might be jeopardized. Midwives, though watchful for difficulties, see themselves as guardians of the "normal". The consideration of "something going wrong" is more consonant with the discourse of obstetrics with its crisis management, reliance on technology, intervention and expensive malpractice insurance. Others thought that working with one's family was desirable and appropriate.

Similarly, physician Michael Klein, in his article "Too Close for Comfort" (1997) questions whether medical professionals should be excluded from their loved ones' care. He concludes that this ethic should be re-examined. After all, the health professional has the best interests of his or her family member in mind and should, in Klein's opinion, be integrated into the loved one's care.

Texts and medico-legal considerations

Predicated by medico-legal considerations, I have become aware of yet another discourse, that of the insurance company to which my profession is contracted. When discussing a difficult situation recently with a woman and her family, what was profoundly disturbing was that, along with my caring for the woman, I found myself playing a role influenced by the insurance company and prompted by my colleagues. This role was scripted to protect the insurance company, the midwifery profession, and me, and to model a way of interacting appropriately with the woman under these circumstances. What was required was a carefully mediated way of behaving, rehearsed before meeting to discuss the issue with the family. Although I found this role disturbing, it brought a heightened consciousness with it. It was a similar kind of discipline that I observed while attempting to reconcile, adapt, and enter into with fullness, the roles of midwife and mother with my daughter Jenny.

Conclusion

Central to the issue of texts and rulings in the context of midwifery is the interplay between public interest and self-interest. I want to conclude by exploring the concept of protection. We suspected that legislation was meant to control us midwives and protect the public. Midwives began their work to offer women more choice and protect women from mistreatment around their births. Now the insurance company and its texts offer to protect us. The record keeping, the note taking, the guidelines for care are all to protect. Perhaps one could look at the continuum between public interest and self-interest. The success of a profession may be in how it locates itself practically in relation to these interests. Bad service may be the result of too much self-interest, and burnout the result of too much attention to the needs of the public and too little to the needs of the profession or the professional. The purpose of texts may be to clarify and organize behaviour so as to find the ideal balance between these interests. However, texts can never encompass all situations that will arise and can become a Procrustean bed if followed too literally. One can too radically alter the lived experience to fit the text.

Through our attention to the details of our practices, we might re-evaluate the degree to which the practice of midwifery in fact ultimately supports women and woman-centered care. We need to hold our behaviour in question. Central to this issue for me is caring about the details of practice, being careful: full of care, midwifing the material. Vigilance is required to

maintain what some would say are midwifery's gains and others call our compromises. And we must continue, as Dorothy Smith would urge us, to examine our practices in order to recognize how, for better or for worse, we are implicated in the rulings of our profession.

Notes

1. This is a revised version of two previously published papers. See Mary Sharpe 2001 and 2004.

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H. KEYNOTE ADDRESS

ABORIGINAL MIDWIFERY IN CANADA: REFLECTIONS FROM A MANITOBA MIDWIFE

Darlene Birch, Manitoba Midwife

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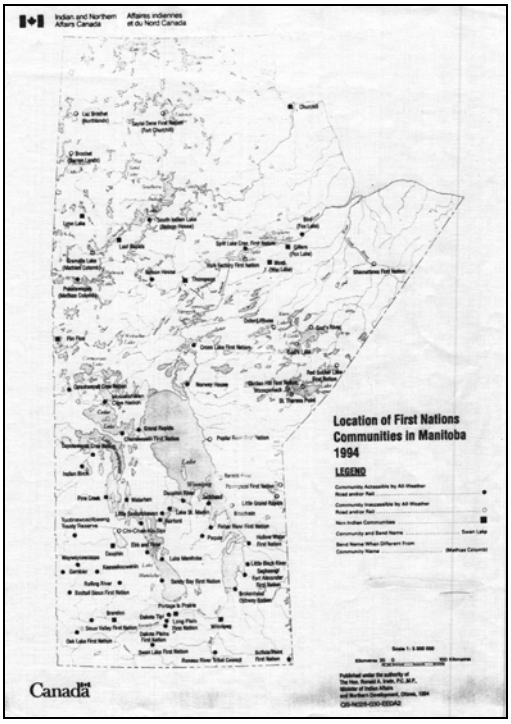

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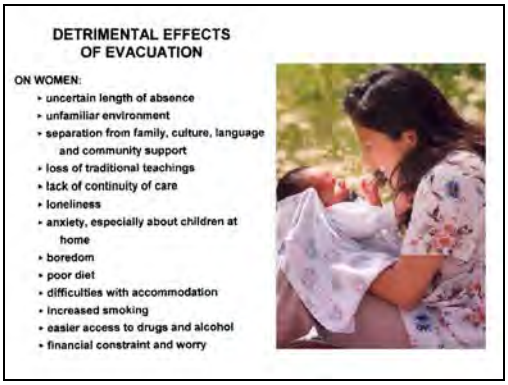

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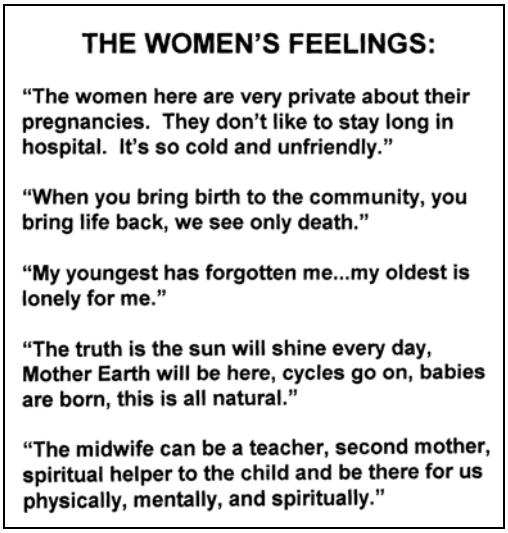

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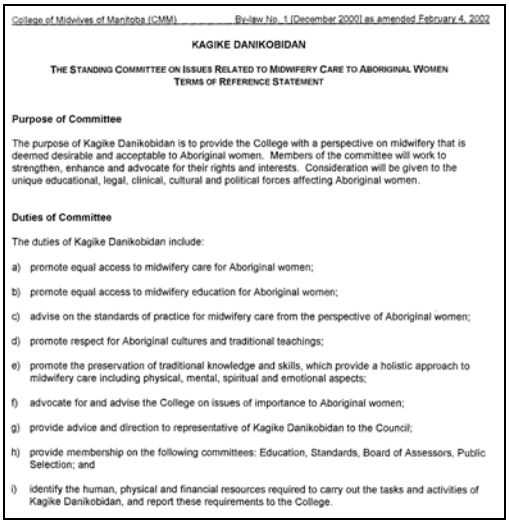

College of Midwives of Manitoba (CMM) By-law No. 1 (December 2000) as amended February 4, 2002

KAGIKE DANIKOBIDAN

THE STANDING COMMITTEE ON ISSUES RELATED TO MIDWIFERY CARE TO ABORIGINAL WOMEN
TERMS OF REFERENCE STATEMENT

Purpose of Committee

The purpose of Kagike Danikobidan is to provide the College with a perspective on midwifery that is deemed desirable and acceptable to Aboriginal women. Members of the committee will work to strengthen, enhance and advocate for their rights and interests. Consideration will be given to the unique educational, legal, clinical, cultural and political forces affecting Aboriginal women.

Duties of Committee

The duties of Kagike Danikobidan include:

a) promote equal access to midwifery care for Aboriginal women;

b) promote equal access to midwifery education for Aboriginal women;

c) advise on the standards of practice for midwifery care from the perspective of Aboriginal women;

d) promote respect for Aboriginal cultures and traditional teachings;

e) promote the preservation of traditional knowledge and skills, which provide a holistic approach to midwifery care including physical, mental, spiritual and emotional aspects;

f) advocate for and advise the College on issues of importance to Aboriginal women;

g) provide advice and direction to representative of Kagike Danikobidan to the Council;

h) provide membership on the following committees: Education, Standards, Board of Assessors, Public Selection; and

i) identify the human, physical and financial resources required to carry out the tasks and activities of Kagike Danikobidan, and report these requirements to the College.

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I. PLENARY SESSION

MIDWIFERY AND DIVERSITY: BUILDING AND INCLUSIVE MIDWIFERY FRAMEWORK

Midwifery must create a framework that recognizes and responds to the needs of a diverse clientele in every jurisdiction in Canada. As well, midwives who have been trained outside Canada and want to practise in this country need a national programme that will assess their skills and prepare them for work in any province.

Developing a National Assessment Strategy for Bringing Foreign-Trained Midwives into Registration in Canada
Jane Kilthei, Canadian Midwifery Regulators Consortium

DEVELOPING A NATIONAL ASSESSMENT STRATEGY FOR BRINGING FOREIGN-TRAINED MIDWIVES INTO REGISTRATION IN CANADA

Jane Kilthei, Canadian Midwifery Regulators Consortium

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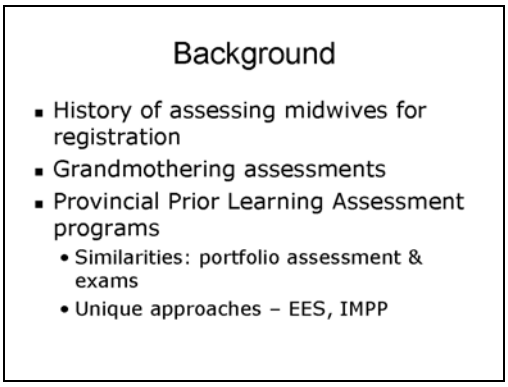

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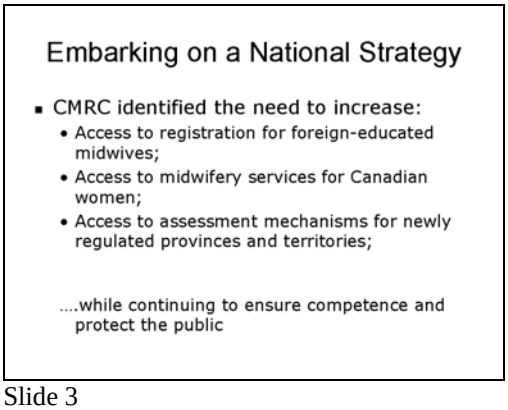

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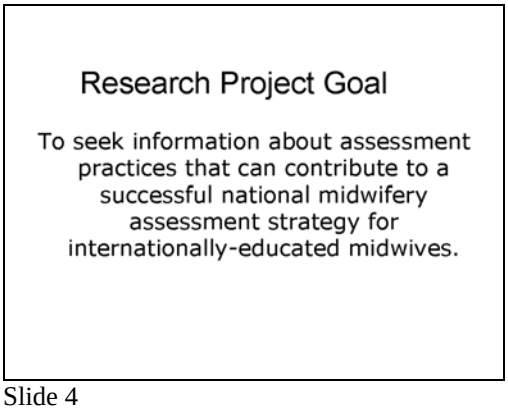

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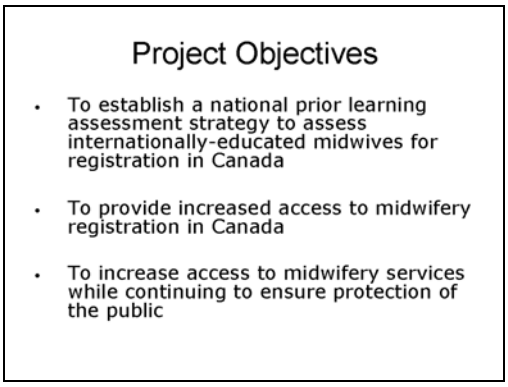

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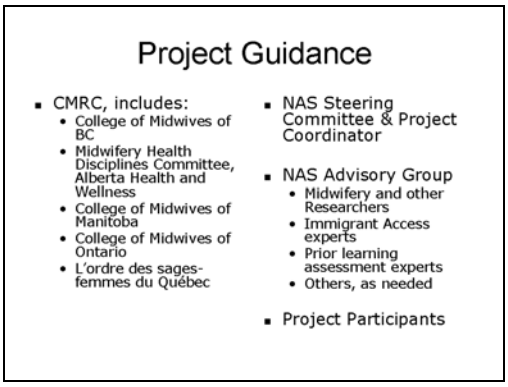

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Funding

- Human Resources and Skills Development Canada (HRSDC)
- Members of the CMRC

Slide 7

Background

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Need

- By 2010, all of Canada's labour force growth will be dependent on immigrants.
- There is a looming maternity care crisis
- Midwifery education programs are small and in only three provinces

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Current Challenges and Barriers for Immigrants

- Lack of occupation-specific language skills
- Direct and indirect cost can be prohibitive
- Incorrect or incomplete information about registering, especially prior to arrival in Canada
- Lack of networking, mentoring, or other opportunities to learn about Canadian practice and culture

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More Challenges and Barriers for Immigrants

- Lack of exam preparation supports
- Exams and assessments may not provide adequate identification of weak areas
- Lack of opportunities to upgrade or refresh professional skills and experience

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Challenges and Barriers for Regulators

- Lack of adequate $ and personnel
- Difficulty obtaining information about the profession worldwide
- Regulators' difficulty balancing support for candidate and protection for public
- Changes to legislation or regulations to adjust requirements take two years or more
- Lack of models of competency-based assessment for professional regulation

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Issues in Assessing Internationally Educated Midwives

- Resource intensive processes (labour and $)
- Duplication of workload across Canada
- Insufficient sharing of information and resources among provinces
- Very small numbers of candidates
- Small numbers of preceptors/supervisors
- Lack of upgrading or refresher programs
- Cdn model of care different from many countries (many applicants don't have the complete skill-set)

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Committment to Issue

« We will deepen the pool of Canada's talent and skills by ensuring more successful integration of new immigrants into the economy and into communities. Immigrants have helped to build Canada from its inception and they will be key to our future prosperity »

Govenor General Clarkson,
2004 Throne Speech

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Regulators' Committment

- Critical need to grow the profession
- Ongoing involvement in related initiatives
- Agreement to commit time and finances to research project to identify:
  - midwifery assessment processes to date;
  - competency-based assessment models;
  - Evidence-based exams –competence, language fluency
- Adoption of national assessment strategy

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NAS Project Outline

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Developmental Phase

- Completed Dec 03 – March 04
- Literature review of relevant midwifery, prior learning assessment, and immigrant access documents
- Creation of 2-yr bilingual research plan for the development of national assessment strategy

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Phase One

- Currently in progress
- Literature analysis
- Creation of draft national competency document
- Interviews with key informants in Canada
- Survey of regulators in 25 countries
- Focus groups with Canadian assessment graduates
- Focus group with supervisors

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Phase One (cont)

- Survey on cultural diversity
- Meta-analysis
- Report - recommending how to proceed on creating a national assessment strategy

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Phase Two

- April 05 – March 06
- Revise and create assessment tools and materials necessary for a pilot of national assessment strategy

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Phase Three

- April – Sept 2006
- Evaluate research process
- Evaluate if project has met stated goals
- Identify next steps (eg pilot)
- Publish a final bilingual project report

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Any Questions?

Contact:
Wendy Martin,
Project Coordinator & Researcher
plea@cmbc.bc.ca

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J. CONCURRENT SESSION

PROVIDING COLLABORATIVE MATERNITY CARE FOR MARGINALIZED WOMEN

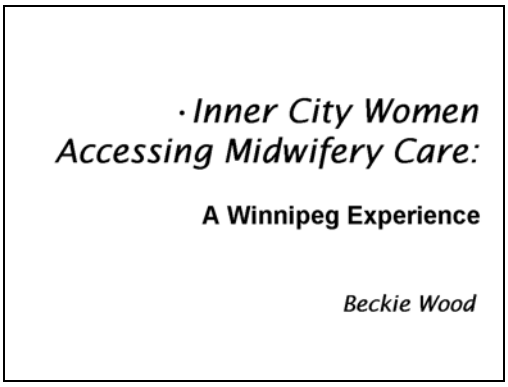
The vision of midwifery in Canada involves reaching marginalized women throughout the country in order that maternity care responds to the diverse needs of all women. In this session three presentations are made regarding unique approaches to providing care for a diverse client population. Each practice presented here responds to the distinct local needs of their communities.

1. *Midwives Reaching Women in Priority Populations: An Inner-City Winnipeg Experience*
   Beckie Wood, Mount Carmel Clinic, Manitoba

2. *Collaboration for Maternal and Newborn Health. An Interprofessional Initiative*
   Lee Saxell, Department of Midwifery, Children's and Women's Hospital, Vancouver, British Columbia

J.1 INNER CITY WOMEN ACCESSING MIDWIFERY CARE: A WINNIPEG EXPERIENCE

Beckie Wood, Mount Carmel Clinic, Manitoba



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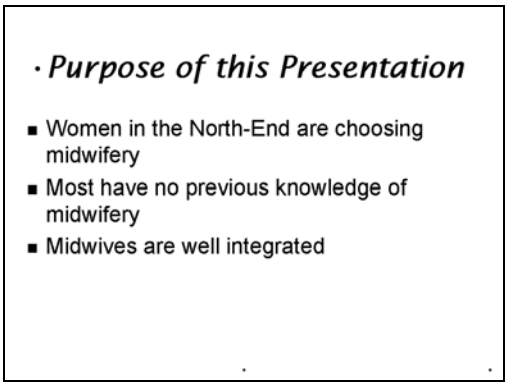

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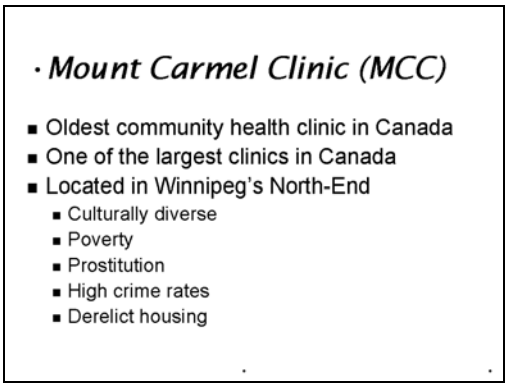

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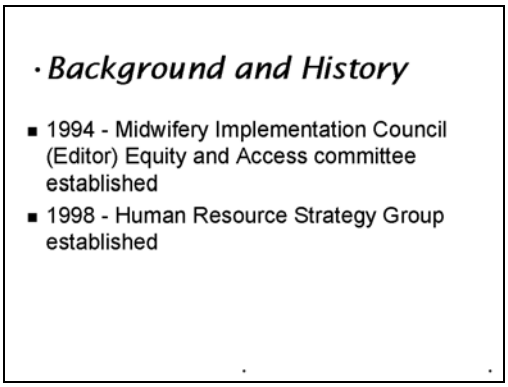

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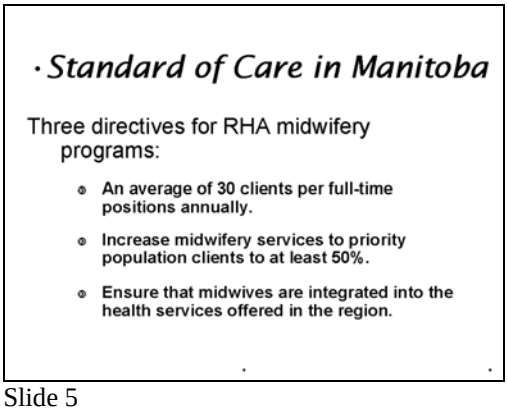

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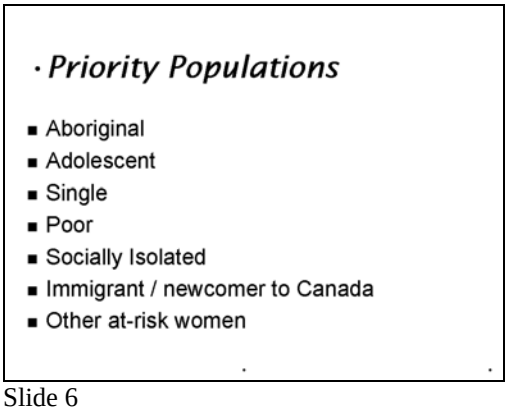

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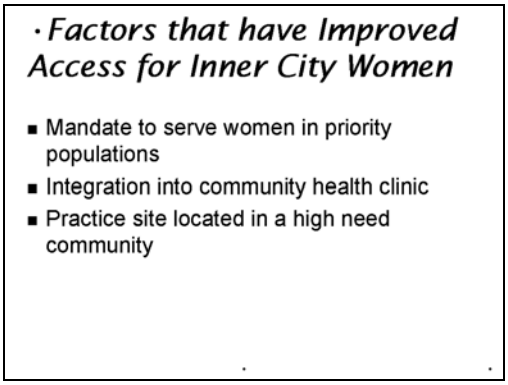

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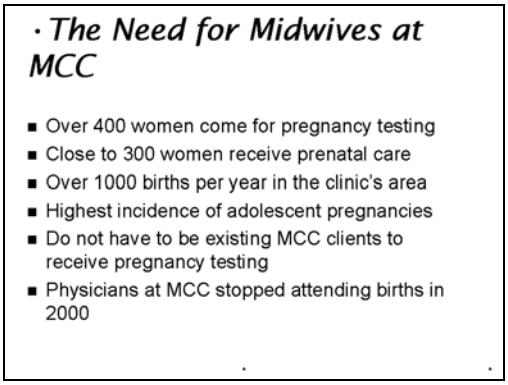

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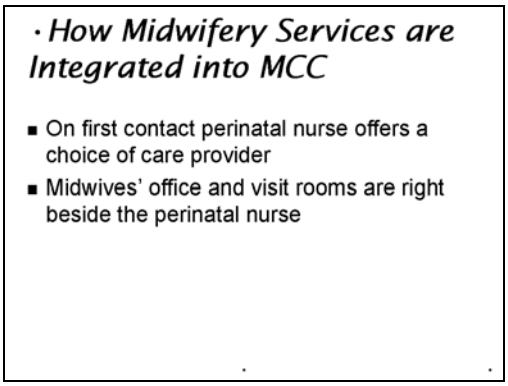

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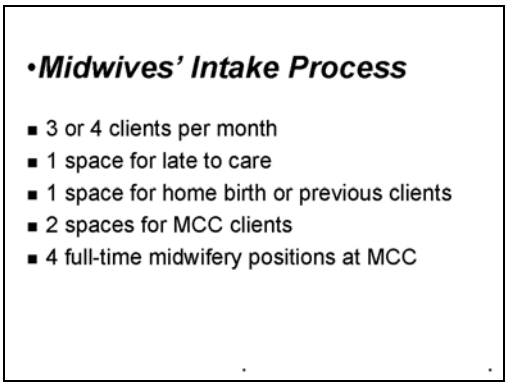

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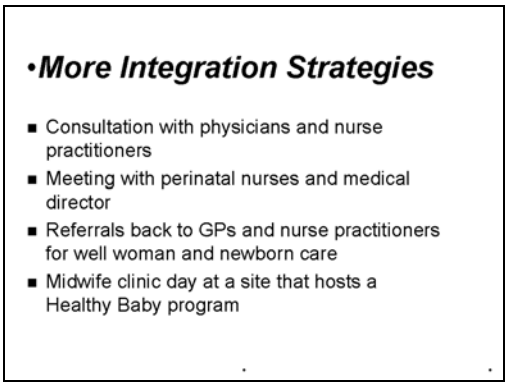

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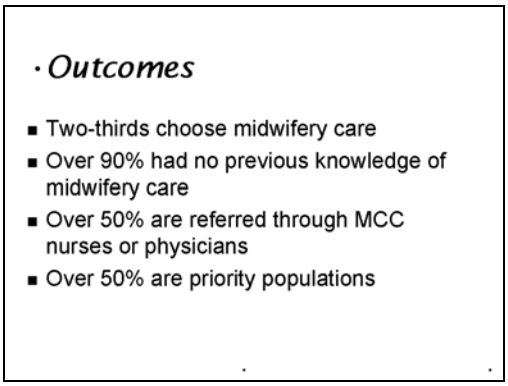

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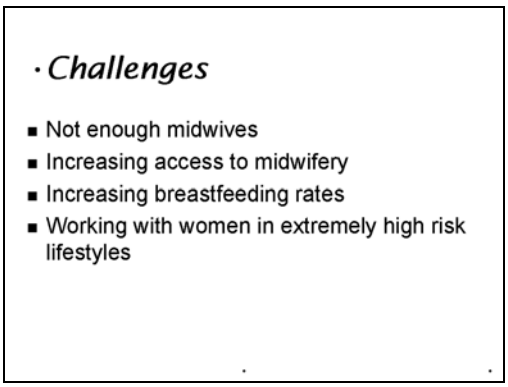

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J.2 COLLABORATION FOR MATERNAL AND NEWBORN HEALTH. AN INTERPROFESSIONAL INITIATIVE

Lee Saxell, Department of Midwifery, Children's and Women's Hospital, Vancouver, British Columbia

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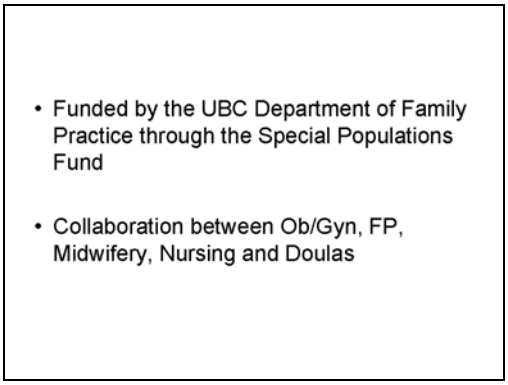

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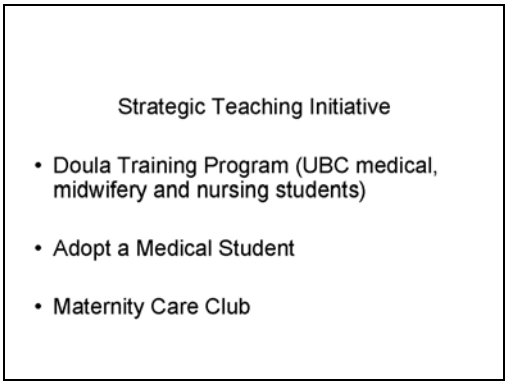

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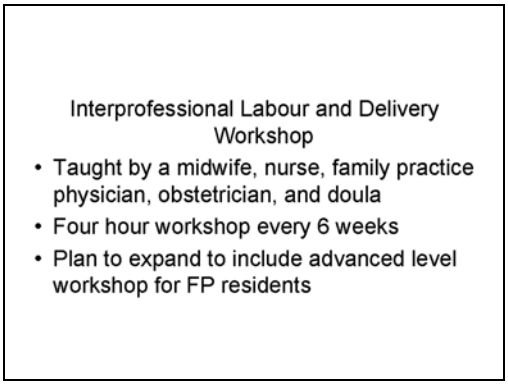

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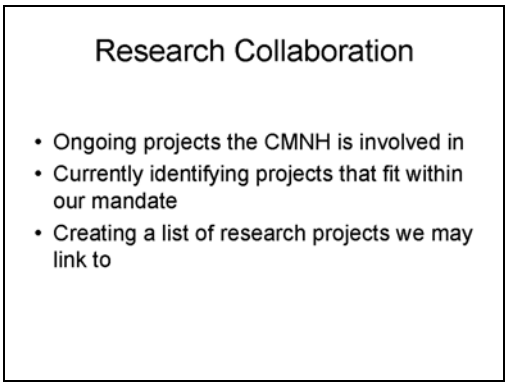

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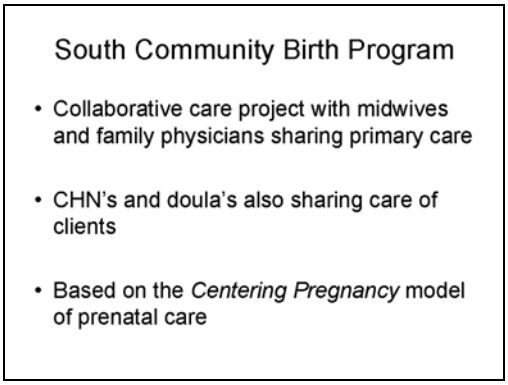

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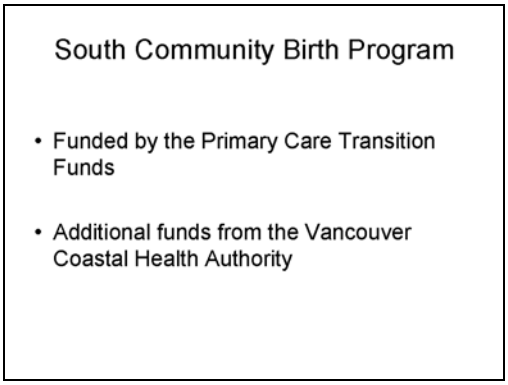

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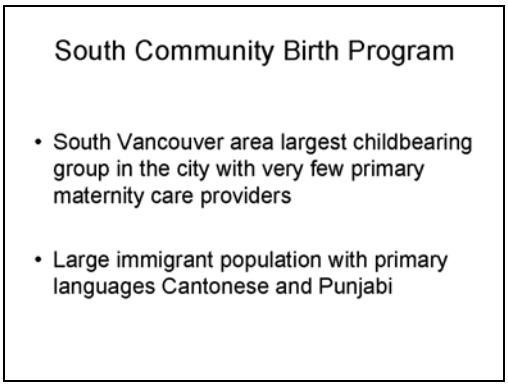

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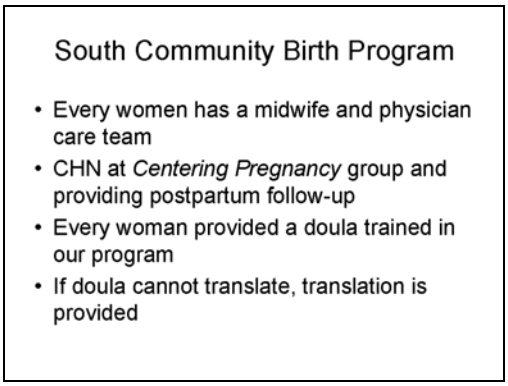

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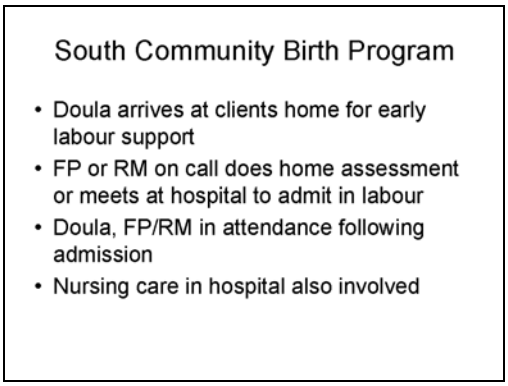

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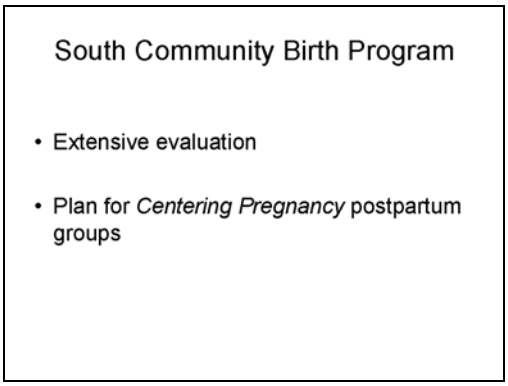

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K. CONCURRENT SESSION

NURSES, DOULAS AND SECOND BIRTH ATTENDANTS: PERSPECTIVES ON INTEGRATED MATERNITY CARE IN CANADA

Midwives regularly work in partnership with other caregivers. The types of partnerships and relationships that exist between midwives and nurses, doulas and second birth attendants is affected by legislation. These relationships will be felt at both the personal and professional levels, and both are explored in this session.

1. *Community-Based Midwives and Hospital-Based Nurses: Seeking the Common Ground for Collegiality*
   Lela Zimmer, Nursing Program, University of Northern British Columbia, Prince George, British Columbia

2. *Second Birth Attendants – A Training Model*
   Lainna Wheatley, British Columbia
   Joanne Przystawka, British Columbia
   Dina Davidson, British Columbia

3. *Envisioning Doulas and Midwives as a Complementary and Collaborative Health Care Team*
   Hilary Marentette, Voulunteer Doula Program, Single Parent Centre, Halifax, Nova Scotia
   Leslee Blatt, Single Parent Resource Centre, Halifax, Nova Scotia

K.1 COMMUNITY-BASED MIDWIVES AND HOSPITAL-BASED NURSES: SEEKING THE COMMON GROUND FOR COLLEGIALITY

Lela Zimmer, Nursing Program, University of Northern British Columbia, Prince George, British Columbia

Problem

I came to this topic initially through my own experiences of medicalized childbearing and as a perinatal nurse working with childbearing women; and through what I have observed of the uncertainty and antipathy toward community-based midwives in some hospital-based nurses. My observations were corroborated by the stories and reports of other nurses and midwives in BC and Alberta. Unfortunately, many in the medical and nursing communities are still angered, confused and worried by the practice of autonomous, community-based midwives (Bourgeault & Fynes, 1996-7; Kornelsen, 2000; Kornelsen, et al., 2000; Lyons & Carty, 1999; McKendry, 1996-7).

So, stated briefly, the problem that this research attempts to address is the tenuous and unpredictable, sometimes hostile, relations between hospital-based nurses and community-based midwives, which may lead to unethical, uncaring, and unsafe situations for childbearing women. This problem has already been described and addressed politically (Bourgeault & Fynes, 1996-7; Kornelsen, Dahinten, & Carty 2000; McKendry, 1996-7; Sharpe, 1997), structurally (Kornelsen, 2000; Lyons & Carty, 1999), and theoretically (Kornelsen, 2000; McKendry, 1996-7). What my research contributes is an examination of the problem through the individual lived experiences of nurses and midwives in caring for childbearing women, and in interacting with one another in the care of midwifery clients in the hospital setting.

Purpose

This study deepens knowledge and understanding of the experience of caring for childbearing women and in so doing has relevance for the practice of midwifery and perinatal nursing, and for the relational ethics discourse as it applies to caregiver-client and inter-professional interactions. There is little existing research that explores the lived experiences of midwives or perinatal nurses in the context of practice.

Research Questions

Certain values, assumptions, expectations, comportment, and modes of relating to patients or clients seem to be common to members of specific professional groups, learned through immersion in the language, theoretical discourse, and context of the professional milieu. Looking beneath these structures, is it possible that in everyday practice essential epistemological similarities and differences between the two groups are revealed? Or, that the practices of each profession and the contexts where practice occurs reflect varied taken-for-granted meanings of childbirth? How does the experience of practitioners reveal the ethos of these professionals? Finally, is there common ground in these practices and meanings? And is this ground a shared space of fertile understanding that is rich and expansive enough to encompass difference in order to facilitate safe and satisfying childbirth experiences for women who choose midwives as primary caregivers but come into medical institutional

contexts? I believe that the answers to these questions are illuminated in the experiences of nurses and midwives with women and with one another. So, the research questions that I have used to elucidate these lived experiences are the following: (1) What are nurses' and community-based midwives' experiences of caring for childbearing women? (2) What are their experiences when they interact in providing this care? (3) What meanings are embedded in these experiences?

Methodology & Method

I used hermeneutic phenomenology as the methodology for this study. This entails using descriptive, textual methods to show experiential phenomena concretely, allowing them to reveal their own substance and significance (van Manen, 1990). The adjective, hermeneutic, means interpretive, elucidating meaning. Therefore, hermeneutic phenomenology seeks to uncover and elucidate the existential meanings in experience showing them as they give significance to every-day life (van Manen, 1990). The purpose of the rich description and interpretation characteristic of this research method is to engage the reader in a dialogic relation with the text and thus with the experiential phenomenon described. Hopefully this intersubjective relation evokes in the reader a deepened understanding resulting in a more perceptive, thoughtful, and tactful awareness of his or her own lived experience with others in the world (Jardine, 1992; van Manen, 1990, 1997).

Data were collected through unstructured interviews with 11 community-based midwives and 10 hospital-based perinatal nurses in British Columbia, following ethical approval of the proposed research by the University of Alberta Health Research Ethics Board, and recruitment via mailings, advertisements, and posters. The interviews were taped, transcribed, and analyzed thematically based on the approach described by van Manen (1990).

Description of the Participants

All of the midwives who participated in this study were registered in the Province of British Columbia. They had a variety of educational and training backgrounds. Three midwives were lay-trained. Two were lay-trained as midwives with nursing backgrounds. Three were formally educated as midwives in Europe and have nursing backgrounds. One was formally educated as a midwife in North America with a nursing background. And one was formally educated in Europe as a midwife. Ten of the midwives were located in urban settings, and one in a rural setting with access to a tertiary centre.

The nurse participants were also all registered in the Province of British Columbia. Three of the nurses had baccalaureate degrees in nursing, and seven had nursing diplomas. All of the nurses were employed in hospitals in urban centres and work in the areas of labour and delivery, antepartum, and postpartum care.

Selected Findings

I would like to present to you some selected findings from this study. First, I will discuss some of the expectations that nurses and midwives expressed about the nurse's role when working with midwifery clients. Then I will describe some experiences of interaction between nurses and midwives, in particular one midwife's story, and suggest what they imply regarding relationships and collegiality. Finally, the description by one nurse of working with midwives points the way to the 'common ground' and where we might go from here.

Expectations

Most of the midwives described their expectations of nurses' role with their clients in the hospital as something that they consider to be straight forward and relatively self-evident. As Judith, a midwife, explains:

> "So, they come in at the time of delivery basically to be our second pair of hands, just the same as when we call a second midwife for a home birth. It's exactly the same role." (JUDITH, RM)

The individual nurse may, however, affect how comfortably these expectations are fulfilled, as these comments from Sheila, another midwife, demonstrate:

> "…[I] take the time, listen to the woman, don't call the nurses in until I absolutely have to…And some of the nurses are great, and they're really very, very helpful. But there are those who seem to be quite oppressed and they take it out… They can be quite snarky." (SHEILA, RM)
> "[S]ometimes nurses think, oh this is a midwifery client, they are going to be hard work. And they make it hard work with their energy that they bring into the room." (SHEILA, RM)

Likewise, for many of the nurses I interviewed, their role when working with midwives is theoretically fairly clear, though there seem to be grey areas and times when an individual nurse will modify the degree of contact with the midwife and her client. Kathleen, a labour and delivery nurse, describes her role:

> "During the second stage or at the time of delivery, the midwife is doing the delivery and I am in my normal role, the role I have if the physician is doing the delivery. I'm helping to receive the baby, or give the baby to the mother, or assess the baby. So I'm in the same role as I usually am at that stage." (KATHLEEN, RN)

However, from her perspective there may be necessary qualifications to the degree to which she may be involved.

> "When I assist a midwife, the things I do besides charting are somewhat dependent on the family and how much they are going to allow me to be involved…There are some families…that choose midwifery care because they have a problem with hospitals. They have a problem with the traditional health care system, and they're very defensive, and very afraid of nurses or doctors, of the medical approach. So, it's hard to break through those differences. Sometimes you just can't." (KATHLEEN, RN)

When there is need for a specialist to be consulted, such as an induction, augmentation, or epidural, the nurse's limited role and interaction with the midwife and her client may become more involved. However, this too may play out differently depending on the individual midwife and her comfort with the interventive technology as these two midwives' quotes illustrate.

> "[M]idwives can run oxytocin if that's something they feel comfortable doing, and it's in their scope of practice. We can't order it; we can run it…Once we have an order for its use we can oversee it. The problem in this hospital is that [the nurses] are spoiled, because they have me. Because a lot of the midwives won't do that [run the induction]." (VAL, RM)

> "We kind of share the nursing care to some degree, and that's a really difficult one. This is one of the nurses' big complaints; they don't like that situation. They actually want us to do our own epidurals and our own augments; but we don't want to do them for two reasons. One is that by the time we get an epidural and an augment, we're usually exhausted and we actually want the help… The other is that as midwives we don't do that many epidurals and augments in a year, and we feel like we will forever be asking, 'How does this pump work? What are we doing now? What's the protocol?'" (DARYA, RM)

Troubling Interactions

These hesitations and sometimes carefully calculated contacts between midwives and nurses are a dance that often betrays a deeper discomfort and uncertainty between the two groups of caregivers. Judith tells a story of her interaction with a nurse while caring for a labouring client with an epidural. Nursing care was required along with all the hospital policies and protocols related to epidurals such as an IV, foley catheter, etc. Judith acquiesced to the insertion of the Foley, though she was not comfortable with this particular intervention. She says,

> "I fought with a few nurses over this stupid catheter issue but I thought, I will let it go, I'll just let it go for now, but when she's fully dilated I'm going to take it out for the pushing."

When her client was fully dilated and feeling pushy, Judith went to remove the catheter but was stopped by the nurse who reminded her that it was part of the unit policy for the catheter to remain in as long as the epidural was in situ. Judith says, "I thought I'm not going to fight in front of [my client]. I should have just said, 'I'm taking the catheter out,' but I didn't." Following delivery her client's vulva was quite edematous and she noticed an abrasion caused by the catheter. She calls the nurse over to show her.

> "I said in a very nice way, an educative way, 'This is why I personally don't like to leave catheters in when women are pushing because, as you can see here, this is going to be very bothersome.'"

The result was the following:

> "And the nurse went unglued, totally unglued! She left the room; she was in tears in Nurse Manager's office saying that she would never ever work with midwives again. .. [She] said I embarrassed her, and blah, blah, blah. And the Nurse Manager tried to get her to talk to me; no she wouldn't talk to me. Absolutely no, no. So… I mean I wouldn't have done it to be intimidating or anything like that."

The apparent circumstances of this situation are that the nurse clung rigidly to a unit policy and the midwife tried to avoid a confrontation in front of her client. However, there is also a backdrop of emotion, ego, and differing loyalties and assumptions that shape the interaction between the Judith and the nurse. Removal of a catheter, particularly in the second stage of labour, seems like a very small issue, something to be played according to the particularity of the situation and the labouring woman. What caused the nurse to be rule-bound in this case? Did she mistrust the midwife's judgment? Perhaps she wanted to assert her authority or the taken-for-granted authority and 'rightness' of the hospital and its policies. And if so, does this imply that she viewed the midwife and her client as outsiders, needing to be brought into conformity? Perhaps the nurse truly believed that it was in the best interests of the labouring woman to leave the catheter in, that her judgment in the situation was superior to the midwife's.

Judith seems to have acted, perhaps against her own conviction, in the interests of preserving a calm and non-confrontational atmosphere for her client. Even when she called attention to the damage done by the catheter, she says that it was done discretely and educatively. She acted assuming that the nurse would receive the information in that way. Clearly the nurse's perception of her words did not fit with this assumption. Throughout this narrative there is indicated, if not hostility and mistrust, at least a resistance to rapport between them. From Judith's point of view this resistance is largely on the part of the nurse. However, it is possible that she herself made a play for dominance couched within her attempt to instruct the nurse. This action, and the proof of the nurse's misjudgment in the visible abrasions, trumped any contribution the nurse made in the situation.

When the midwife pointed out the minor damage done by the catheter, she says that the nurse "went unglued." What does this mean? Did the nurse's identity as a knowledgeable and competent professional momentarily fall away? It seems that the rigidity of the nurse's 'rightness' shattered. The midwife, the outsider, showed her the evidence of her misjudgment that resulted in injury to the woman; and she left the room in tears. Perhaps the nurse heard in the midwife's words the satisfied tone of self-righteousness. Perhaps the rules that bolstered her fragility in the possibly intimidating presence of the midwife seemed thin when viewed across the gap between policies and their application to individual patient care. She followed the rules and yet the person whose welfare her action and the rules are supposed to protect was injured. She seems to have taken the midwife's words as condemnation, leaving the room in a welter of shame, anger and embarrassment.

Later, Judith brought this situation up at a meeting with the charge nurses and head nurse on the unit.

> "And, of course, the Charge Nurses were just black and white: 'Well you're in charge of your client's care. You can order whether the catheter comes out or not. Just order it.' And I go, 'Oh, okay, I'll just treat them like the doctors do and just say it is coming out.' And so I have changed my approach a little bit. And if the nurse gets a little bit snippy, well then I do, I just bark orders at them. And it's a shame because it's not my personality and I don't think that that's what we're… We've intended midwives, you know, to sort of work on an equal basis with nurses. But it made me realize that there is a medical hierarchy and

> that's how nurses respond. And without a doubt, physicians are first and nurses think that they are second and that we are under them. But clearly, because we're primary care providers, we do have authority over the nurses. And that's how nurses respond. That's how they're trained, they're trained to take orders, I guess. And to be clear, to be clear. They believe everybody should have a clear role. But… Maybe it's partly the institutional culture of the hospital. I didn't anticipate this in the beginning, this hierarchy stuff. I thought, you know, 'My communication skills with nurses are good, I sort of know where they're at. This will be all right.' No, I wasn't expecting this at all."

The response of the charge nurses demonstrates Judith's analysis of nurses' ways of working and interacting with midwives. She understands their 'knee-jerk' solution to conflict between midwife and nurse as definition of roles and hierarchy, to give orders and to have them obeyed. Discomfort in the interface between nurses and midwives seems immaterial to solving the problem of who is "in charge". If the roles and hierarchy are clear, then there should be no confrontation.

Judith says that she did not initially intend to relate to nurses with this sort of power dynamic; yet she has succumbed to it as the only way she can see to protect her ability to offer the care she feels her clients should have when in the hospital setting. There is a mixture of retaliation and regret in her words. In order to delineate the clarity that she understands as preferred by the nurses, she is perpetuating circumstances that situate the childbearing woman as a battleground. Unfortunately hierarchy and authority can not make up for a lack of understanding, respect, and relation.

Respectful Interactions

A labour and delivery nurse's account of her work with midwives provides a more positive and hopeful description of these inter-professional relationships and points in the direction that I believe increased respect and understanding can take us.

> "It's wonderful to work with them. It's good working with midwives. Usually I will go in and say 'Hello' to the family the same as I always do, and 'I am your nurse today.' And I work with the midwife to provide care, so we will talk about who will chart, in particular. These things have to be negotiated. The midwife is there, usually continuously, unless she is absolutely exhausted, in which case she might go for a bit of a nap, and leave me. Or, if things are going fine, she might have break and leave me looking after the woman. But I think the expectation of the families is that the midwife will be there caring for them and taking the lead in coaching for birth positions or trying a bath or aromatherapy. It's a wonderful opportunity to work with them and to see that in action – and to be part of the team. And so I get in there as much as I can. If the midwife is fine and the family is fine with having me there, partnering with her, it's usually very pleasant… So, my role as a nurse is quite different because I'm not in charge of the woman's care; but I'm still there to be a support to the family and to the midwife. It's fun, it's wonderful, quite wonderful.

This nurse, Kathleen, clearly enjoys participating in the care of midwifery clients. She is respectful of the family's expectations for care by their midwife, yet delighted if she is called upon to spend time relieving the midwife during a break. She speaks of negotiating duties. This suggests respectful communication and mutual co-operation in order to see that necessities are anticipated and the midwife is freed to focus on her client. She also describes her work with the midwife as "partnering," and as being a "part of the team;" a contrast from the adversarial tone of Judith's story. Yet she is clear that her role is one of support and does not impose her presence in the room unless it is desired and comfortable. Kathleen expresses openness and curiosity regarding what she may learn from the midwife by being included. However, her interest and acceptance is not unthinking or unobservant as the following shows.

> "Sometimes a midwife will have a woman in second stage for a very, very long time. I think if you are working with them, you realize what the family really wants. As long as the baby is okay, and the mother is okay, and you are working with her to do the best you can to have a vaginal birth…That is really where the midwives will go beyond what we would do. They are a little bit more hesitant to say, 'Well, you need some oxytocin because the contractions are just not powerful enough.' So, there may be a delay in intervention. But as long as that is what they want, the baby and mom are all right, everybody is safe and healthy, really, it's no harm done. It will just be a longer labour, but no harm done.

Kathleen is concerned and vigilant for the health and safety of the woman and baby, but is also willing to trust in the woman's command over her own birth and the midwife's judgement. There is a hint of discomfort when she speaks of a long labour, but she seems willing to suspend judgement and to give up authority to the woman and her chosen caregiver. Perhaps what is most striking here is the way in which Kathleen's words indicate the centrality of the woman and family in the event of labour and birth.

Planting the Seeds of Collegiality

The event of birth is moving and transformative, not only for women and their families, but also for those who are privileged to attend them in childbearing. This sense of being a part of, or a witness to, transformation was expressed by all participants in this study. Another primary focus, for nurses and midwives alike, is the baby, the new life whose entrance they facilitate. For midwives, perhaps more that for the nurses, the woman is central. She, as a client, chooses her caregiver, and in choosing midwifery care opts for a model that given her the central decision-making role. Nurses care for physicians' patients, and in that role deliver care based in the medical model. Nevertheless, it is women with whom perinatal nurses spend hours of time providing one-on-one support, particularly during labour and birth. The event of birth and the primary players, mother and baby, are the common ground that nurses and midwives share. All seek positive outcomes.

Kathleen's account demonstrates much that could move nurses and midwives toward more collegial and supportive relationships. First of all she recognizes that the focus is the woman and family, and a happy, safe experience of childbirth. Competing, or asserting rightness, is not her concern. She is confident in her knowledge and skill and in her ability to contribute and adapt these in facilitative ways to the situation at hand. She also engages with the midwife and

family respectfully, assuming the best, and trusting in the woman's choice of caregiver. This willingness to be with the midwife and her client signals alliance in the unique event of birth rather than confrontation. Finally, she is open and curious about the differences between her ways of approaching labour and birth support and those of the midwife. She is willing to engage in exchange and dialogue and to learn.

K.2 SECOND BIRTH ATTENDANTS – A TRAINING MODEL

Lainna Wheatley, Joanne Przystawka and Dina Davidson, all from British Columbia

Abstract
To describe a new training model for second attendants within the Canadian model of midwifery care, to describe the need for second attendants, to describe what second attendants need to know, how they are used, to demonstrate feedback from students who have participated in the training model, and to describe how the training model was created.

Keywords
Second attendant, birth assistant, midwife's assistant, training, doula, labour assistant, home birth, water birth

Second Attendants in a Regulated System

In British Columbia's regulated system of midwifery, a registered midwife and a second attendant must attend every home birth:

> *The ideal assistant to the principal midwife at a [home] birth would be another midwife. However, the second attendant the midwife will choose to assist at a birth will depend on many factors. Some of these will be dictated by the geographic area in which she works, the availability of appropriate professionals in that area, and the midwife's and the woman's preferences.*[1]

Second attendants fill an important role in assisting registered midwives at home births. Further, they help British Columbian women who wish to give birth at home by helping to ensure availability of coverage for home births in underserved areas.

Who Are Second Attendants?

Registered midwives are in limited supply in British Columbia. This constraint is felt keenly in rural areas, where a registered midwife may be practicing solo, with no other registered midwives for many hundreds of kilometers.

The same problems occur in urban areas. Though there is a greater concentration of midwifery practices in larger cities, practices are full, and the midwives are busy. For a midwife to be called to be a second attendant at a home birth often means rearranging clinic schedules or

spending her day off at a birth. This causes stress, not only for the principal midwife (Will she be able to secure a second attendant for the birth? Will she have to transport her client to hospital because no second is available?), but also for the second midwife who may have to give up personal time to attend the birth. One can only imagine the stress a midwifery consumer might feel amidst this uncertainty.

Because of these constraints, the second attendant role can also be filled by:

- Registered nurses
- Respiratory therapists
- Senior student midwives
- Nurse practitioners
- Other experienced individuals[ii]

The second attendant, regardless of education and background, must have the following certification:

- Neonatal resuscitation (NRP)
- Cardiopulmonary resuscitation (CPR) [iii]

The second attendant must be competent in the following assessments:

- Vital signs (blood pressure, pulse, respirations, temperature)
- Uterine tone and position postpartum
- Blood loss postpartum[iv]

The second attendant must have the following basic knowledge:

- Body substance precautions
- Basic knowledge of labour and birth
- Basic knowledge of instruments, supplies, and drugs used by midwives
- Appropriate record-keeping and charting
- Understanding of registered midwifery in British Columbia and the midwife's practice protocols[v]

Duties of a Second Attendant

The second attendant's primary focus is to assist the midwife. The midwife is responsible for the birthing woman and her baby as primary caregiver. As such, the second attendant takes direction from the midwife to ensure the safety and comfort of mother and baby. In the second and third stages of birth, the second attendant may do the following:

- Check layout of supplies for ease of access to equipment and medications
- Check fetal heart tones (FHT)
- Check maternal vitals signs (blood pressure, temperature, pulse, respirations)
- Ensure warmth and safety of the newborn
- Check, report, and record the condition of the newborn
- Assess Apgar scores
- Check maternal fundus and lochia
- Document findings in the health care records[vi]

In an emergency situation, the second attendant may do the following:

- Assist the midwife as needed to help manage shoulder dystocia, undiagnosed breech, non-reassuring fetal heart tones, and so on
- Phone emergency medical services (EMS)
- Assist with NRP
- Assist midwife in setting up intravenous therapy or intramuscular medications for postpartum hemorrhage
- Check maternal vital signs
- Assist with CPR
- Assist in preparation for transport[vii]

In the event of a transfer to hospital for either emergent or non-emergent reasons, the second attendant does not generally accompany the midwife. Rather, she stays behind to pack up supplies and clean up so that the midwife can easily collect her equipment and the family returns to a calm and tidy home.

Where Are Second Attendants Used?

In British Columbia, second attendants are in highest demand outside of urban areas where the concentration of midwives is particularly low. In rural areas, second attendants are regularly used as backup for planned home births.

In urban areas, second attendants are used to cover gaps in areas where midwifery practices are stretched thin by great consumer demand and full caseloads.

Second Attendants at Home: Benefits and Challenges

Second attendants, simply by undertaking the responsibility of the role, must have a sense of commitment to be available for a birth, dedication to maintaining their skills, and a desire to assist in proving the type of setting a woman has chosen for her birthing experience. Knowing that you have assisted a midwife in providing a safe setting where a woman has chosen to birth her baby in the comfort of her home is an accomplishment.

The Birth of a Training Model

Before Sharyne Fraser, RM, moved to Penticton, B.C., there were no other registered midwives in that area. Because Lainna Wheatley had practiced before regulation, she would regularly get calls from women who requested her services. At that time, she was working on a degree in midwifery in preparation for registration and thus referred midwifery enquiries to the midwives in Kelowna, a community one hour north of Penticton.

When Sharyne Fraser set up practice in Penticton, she went through the standard procedure of looking for a second attendant by putting up a poster requesting a second at the local hospital.[viii] With not a single response, she proceeded to apply to the CMBC to have Lainna approved as her second attendant.[ix] Sharyne and Lainna were both continuously on call when someone was due—about 5 weeks for each client from 37–42 weeks. Between Sharyne's excellent guidance, poring over all CMBC documents pertaining to second attendants and the BC model of care, and attending births together with 20 years' experience involving birth, Lainna was able to get a clear understanding of the second birth attendant's role at a delivery.[x]

Further, because Lainna had worked as a primary care midwife before regulation, she knew what she had appreciated in an assistant and was mindful of the needs of the primary midwife.

After about a year of working with Sharyne, Lainna moved to Kelowna and Sharyne had several potential second attendants applying for the position. Following a discussion of how to fill the need for competent, efficient, and trustworthy assistants, Sharyne and Lainna ran a two-day orientation to inform potential second attendants of the ethics surrounding this position, their duties, and the requirements of the second attendant. The training has been refined and changed over time to reflect the general requirements of varying midwifery practices, but the essence of the training is the same and is based on the CMBC guidelines for second attendants.[xi]

The Need for Orientation

Second attendants need to be oriented to the specific duties and responsibilities of working with registered midwives in a home birth setting. Many women applying for this position have worked in a hospital setting with general practitioners and need the knowledge and understanding of the midwifery model of care to bridge the gap.[xii] Others, who are midwifery students or may have lengthy experience attending birth, also need to understand details about the current model of care and the specific needs of a registered midwife at a home birth. Some of these include:

- *Informed choice:* This distinct form of care begins from the first visit with the midwife to the last at six weeks postpartum, and involves the midwife educating and informing couples of the choices they have during pregnancy, birth and postpartum. Each choice for a particular procedure or test has risks and benefits which can help the woman and her partner make the choice that is best for them. The second attendant needs to be mindful and respectful of the woman's choice to refuse or request a certain procedure. The birthing woman's body is her own, and together with her midwife she can explore her choices about her labour, delivery, and postpartum. Most of these decisions are discussed ahead of time, but the principle is applied even in the most basic areas by the second attendant: for example, when asking permission to take heart tones or touch the women's body—this is a way of showing respect and honouring the woman.[xiii]

- *Evidence-based practice:* This goes hand-in-hand with informed choice and is an important aspect of the B.C. model of care. Second attendants should understand current research and be aware of the reasons a woman may choose to have, for example, active management of third stage. She should also know how active management is carried out and be able to competently assist with the procedures involved.[xiv]

- *Home birth as a safe and viable option for low-risk women:* Second attendants need to have a clear understanding of the safety of homebirth for low-risk women with trained, registered midwives as primary caregivers. They need to be oriented to the current research, including the *Home Birth Demonstration Project* conducted in B.C., which offered evidence of the viability of this option for birthing women.[xv]

- *Duties at a home birth:* Second attendants also need to fully understand their role and duties as outlined by CMBC policies for the second attendant and what their specific duties are before, during and after delivery.[xvi]

Table 1: Topics Covered in the Second Attendant Orientation

Introduction: Ethics & obligations	Duties at birth	BCRCP Abbreviations
Teamwork: Philosophy & communication	Assisting the midwife	Grams–pounds conversion table
Confidentiality	Care of the mother	Copies of pertinent policy documents
Availability while on call	Duties at the delivery	Sample of criminal record check form
What to bring to the birth	Postpartum care	Copies of pertinent studies
Locating the client's home	Intermittent auscultation of fetal heart tones	Neonatal resuscitation
Reading requirements	Charting: what to record	Transport procedures
Certificate requirements	Mother's supplies after birth	Cleanup duties
Other requirements: Training & education	Details and demo on how to set up the following birth trays: • Birth setup • Resuscitation setup • IV supplies setup • Suture setup • Newborn exam setup	Emergency procedures: • Shoulder dystocia • Hemorrhage • Undiagnosed breech • Non-reassuring fetal heart tones • Shock
What to do when you first arrive at the birth	Samples of all forms and records	Assisting at a water birth

It is important to note that this training is not affiliated in any way with CMBC or any other regulatory body. Rather, the training is a private service for the midwives, their potential "non-midwife" second birth attendants, and the clients they serve.

Pathways to Training

Potential second attendants can take the Second Attendant Orientation via a number of channels:

- Attend a two-day intensive workshop. This includes a binder full of relevant reading and information. [xvii]
- Take the course Second Attendant (MDWF 144) via distance learning from the Midwives College of Utah. This version includes more detail regarding the B.C. model of midwifery care, evidence-based practice, informed choice, and so on. It also requires evidence of learning through syllabus work and other assignments.[xviii]
- Purchase the 6-hour training video and training binder.[xix]

Who Benefits From This Training?

Midwives: Midwives are very busy with hectic schedules. They are on call for long hours and are often up throughout the night only to have hospital rounds, clinic, or postpartum home visits to complete the next day. Having a pool of non-midwife second attendants allows midwives to have a break from call helping other RMs when they are tired, on call for their

own births, taking maternity leave, or on holidays. This training also assists midwives by allowing potential second attendants to be oriented without a lot of time spent out of their busy schedules. [xx]

Potential second attendants: This training, taken in its various forms, is excellent preparation for anyone planning to assist at home deliveries, whatever their background. If a student comes from a traditional medical environment, this training bridges the gap between these two models. If they come from another background, it helps prepare them to assist an RM appropriately in the Canadian midwifery model.

Consumers of midwifery: Having a large number of trained, oriented, approved second attendants allows women and their families greater access to the option of home birth with a RM.

Feedback from Students

Students have much to say after taking the training:

> *It took it from the theory to the practical, especially listening to the little tips along the way…I can now see—it's real for me now.*
>
> —Jean Elmer,
> Respiratory Therapist, Kelowna, B.C.

> *This is a great starting-off point for me because I am really very new into what's going on with midwives and second attendants.*
>
> —Jodie Petersen,
> Respiratory Therapist, Victoria, B.C.

> *I think the most prominent part of the workshop that really will stand out in my mind is that I came in [to the classroom] with a lot of information but it was extremely fragmented—little bits and pieces from almost every paragraph in the book, but maybe one sentence. But what you were able to do… is put it all together for me so, I really feel now that I got a workbook of information instead of one sentence at a time.*
>
> —Lorraine Coughlan,
> Staff Doula: Stony Plain Birth Centre, Edmonton, AB

> *To be shown the sheer joy of having birth at home with your family, your husband, just seeing that joy and how it should be, how it can be, was wonderful for me.*
>
> —Janine Siddall,
> Licensed Practical Nurse, Kelowna, BC

> *Thank you, because it's so hard—especially coming from a medical setting in the hospital where learning is around a stiff table—people are afraid to admit what they don't know. So I'd just like to thank you for honouring what I do know, but also for honouring what I don't know and sharing those experiences that I don't have much experience with. Just that broad spectrum of what normal birth is; normalizing birth, that to me has meant a lot. Normalizing birth, that it's not always a condition or*

complication, a special issue we have to deal with. It's meant a lot to me to have that support and knowledge given to me. Thank you for facilitating my journey.

—Liz Herman,
Registered Nurse, Kelowna, BC

I appreciate the organization that it takes to take a broad subject like this and try to summarize it into something that can be presented in two days.

—Terra Reindl,
Doula, Kelowna, BC

Because of the Second Attendant Orientation, I was able to anticipate the needs of the midwife and the labouring mum—acting in a timely and efficient manner. Lainna's sessions introduced a standardized role and outlined expectations of the second attendant so that I knew what I needed to know and what was expected of me as a second attendant.

What a pleasure it was for me to participate in a home birth! What an honour it was to share in such an intimate family experience. As I was tidying up after the birth the picture was imprinted in my mind. The five-year-old sister perched up with pillows against the headboard on her parents' bed cuddling her flannel-swathed baby brother. She is smiling so proudly. This is what makes being a second attendant so special.

–Joanne Przystawka (co-author),
Registered Nurse, Kelowna, B.C.

The workshop taught by Lainna Wheatley in Kelowna, BC, for second attendants was extremely helpful for me. The course was very well organized and prepared. Lainna ensured that all important aspects were covered in detail and helped reinforce the skills we learnt with hands-on practice. The binders were a nice way to go home with all the information organized and ready for us to access. This course, along with NRP, has made me feel competent to attend births with the midwives in my community. The atmosphere of the course was especially comfortable and set up in a way that encouraged learning.

—Alyson Jones,
Second Attendant, Naramata, BC

I am a student midwife, mother, doula, and now a second attendant. Although I had already completed my NRP and CPR requirements before taking the Second Attendant Orientation, it wasn't until I completed the program that I began to feel truly confident in my role as second attendant. The biggest "light bulb" that went on for me was shifting from attending births as a doula, where I am there to support the birthing woman, to the realization that as a second attendant, I am there to support the midwife. I am thrilled to be trained to provide this kind of support to my local midwife and contribute to home births in my community while I complete my midwifery studies.

—Dina Davidson (co-author),
Certified Labour Assistant, Port Moody, BC

This course is packed with invaluable information and hands-on experience. It clearly defined for me a second attendant's role, protocols and duties relevant to assisting the

midwife at a home birth. It covers technical training through lifestyle implications, presented in such a way that there is something for everyone, no matter what your background or previous experience.

—Elizabeth Perry
Doula, Vancouver, B.C.

Feedback from Midwives

The content is the foundation of the roles and expectations of second attendants. The individual differences and preferences of the midwifery practice could easily be woven into the content once in an established midwifery practice. A solid foundation of knowledge and understanding will greatly enhance the working relationship between midwife and assistants. It is a gift to midwives to have available a comprehensive introduction to the roles and responsibilities of a 2nd attendant. Assisting at a birth requires knowledge, understanding and a high level of trust. This course will enhance and compliment the training of a second attendant.

—Sharyne Fraser
Registered Midwife, Penticton, BC

When I began training potential second attendants after they had completed Lainna's course, they were primed to move onto the next stage of learning. They came to births poised by having an understanding of the roles and responsibilities of both the second attendant and the primary midwife. The course covered a thorough ground of material that is necessary in the training of second attendants, relieving some of the burden on the midwife for the training. The course's resources are useful for ongoing training, as the material can be reviewed and practiced. The orientation manual is thorough and of exemplary quality. I believe that there is a potential to develop the role of second attendants in the province toward a sustainable system of midwifery and that this course has developed a foundational body.

—Barbara Barta
Registered Midwife, Kelowna, BC

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[i] College of Midwives of British Columbia. "Policy for Second Birth Attendants", *Standards of Practice Policy*, November 1998.
[ii] ibid.
[iii] ibid.
[iv] ibid.
[v] ibid.
[vi] Wheatley, Lainna. *Second Attendant Orientation Manual*, August 2004, pp. 9–14.
[vii] ibid., p. 27.
[viii] College of Midwives of British Columbia. "Policy for Second Birth Attendants", *Standards of Practice Policy*, November 1998.
[ix] ibid.
[x] ibid.
[xi] ibid.
[xii] ibid.
[xiii] College of Midwives of British Columbia, "Informed Choice Policy", *Standards of Practice Policy*, April 1997.
[xiv] College of Midwives of British Columbia, *Model of Midwifery Practice*, April 1997.

[xv] College of Midwives of British Columbia, "Appendix 1: The Home Birth Demonstration Project—A Summary of the Results", *Home Birth Handbook for Midwifery Clients*, pp.17–22.
[xvi] College of Midwives of British Columbia. "Policy for Second Birth Attendants", *Standards of Practice Policy*, November 1998.
[xvii] ibid.
[xviii] Midwives College of Utah: http://www.midwifery.edu
[xix] BirthJoy Consultants: lainna@shaw.ca
[xx] Wheatley, Lainna. "Portrait of a Second Attendant", *Ovarian Connection*, Vol. 2, No. 3, March 2004.

K.3 ENVISIONING DOULAS AND MIDWIVES AS A COMPLEMENTARY AND COLLABORATIVE HEALTH CARE TEAM

Hilary Marentette, Volunteer Doula Program, and Leslee Blatt, both from Single Parent Resource Centre, Halifax, Nova Scotia

It is our hope that this forum will facilitate a discussion about how doulas and midwives can work together for the benefit of the birth mother and her family. As Nova Scotia looks ahead to potential regulation and legislation of midwifery practice, it is an opportune time to look at how complementary care providers, such as doulas, will also fit into the regulatory framework. Our panel has been selected to reflect the range of community members who experience the services both midwives and doulas provide. Present are consumers who have utilized both midwifery and/or doula care, a doctor familiar with the care midwives and doulas provide, doulas who have experience working with midwives, a midwife who has worked with doulas, and a doula who is an aspiring midwife. Our panel members will have the opportunity to express their views on how and why midwives and doulas could work collaboratively together. Following the panel discussion there will be time for questions and discussion with audience members and we encourage your participation as we explore this topic.

We will begin the discussion by distinguishing the unique role of the doula and midwife and follow with a look at the ways in which they are complementary.

The Doula: "The doula is trained and experienced in childbirth, although she may or may not have given birth herself. The doula's role is to provide physical, emotional and informational support to women and their partners during labour and birth. The doula offers help and advice on comfort measures such as breathing, relaxation, movement and positioning. She also assists families to gather information about the course of their labour and their options. Perhaps the most crucial role of the doula is providing continuous emotional reassurance and comfort." [1]

The Midwife: "As primary health providers, midwives are recognized as autonomous professionals who practice as part of *a collaborative and multidisciplinary model of maternal and infant care.* Midwives must be able to give necessary supervision, care and advice to women during pregnancy, labor and the postpartum period, to conduct deliveries on their own responsibility and to care for the newborn infant. This care includes preventative measures, the

detection of abnormal conditions in mother and child, the procurement of medical and non-medical assistance and the execution of emergency measures in the absence of medical help." [2]

While doulas and midwives have differing roles, their practices are complementary:

> -Both strive to offer continuity of care and to present for the entire birth process. While the midwife has the added responsibility of attending to the clinical procedure, the doula remains fully focused on the mothers' needs.
>
> -Both share the goal of helping women have a "a safe and satisfying childbirth as the woman defines it". [3] This involves prenatal education, open communication, informed consent and a belief in allowing the mother to make the choices that are comfortable for her.
>
> -Both doulas and midwives may attend mothers in the birth setting of their choice. Like midwives, doulas are present for the mother and are not accountable to an institution. It has been shown that, "In general, continuous support from a caregiver during labour appears to confer the greatest benefits when the provider is not an employee in that institution".[4]

Before we begin to envision how doulas and midwives can work together in Nova Scotia, it may be helpful to have a brief look at the way in which they are collaborating elsewhere.

Midwife and Doula Services, LLC.

This is a team of complementary health care providers comprised of midwives, a doula and two physicians. They operate in Des Moines, Iowa and offer routine prenatal and labour care.

Midwifery Practice and Doula Service

This program initiated at the University Medical Centre, Stony Brook, NY, trains volunteer doulas. The doula service is made available to women in the community, regardless of their ability to pay. The program was developed by Debra Pscali-Bonaro (CD) who is the president of Motherlove Inc.

Holy Family Birth Centre

This birth centre in Waslaco, Texas provides doula service to all first-time mothers for the two weeks prior to their birth and for follow-up care the two weeks following labour. The staff are direct-entry midwives and certified nurse midwives.

This is only a small sampling of the innovative ways doulas and midwives are working together. They were chosen as they represent independent birth practices and also how hospitals and birth centres may work to integrate doulas and midwives into their care team. These programs strive to make doula and midwifery care available to low-income families and teenaged mothers in an effort to ensure that all women have equal access to quality prenatal care.

Currently in Nova Scotia **The Doula Program** integrates some of these elements by offering a volunteer doula service which includes women who may otherwise be unable to afford a doula. The doula program is equally dedicated to working co-operatively in hospital and with midwives. It has provided volunteer doulas to attend home births and makes referrals to midwives in Nova Scotia. There are currently approximately 50 volunteer doulas in the program. This is a community-based program in partnership with the IWK Health Centre and the Capitol District Health Authority. This is a prime example of what communities can achieve when they work together.

The Cochrane Data Base was used to assess the effects of continuous labour support on mothers and their babies. It is based on the Cochrane Pregnancy and Childbirth Group Trials (30 January 2003) and the Cochrane Central Register of Controlled Trials (The Cochrane Library, Issue 1, 2003). These encompass fifteen trials that included 12 791 women. Analysis of the data included thirty outcomes. For each outcome the data was collected in at least four trials involving at least 1000 women. The following chart compares continuous support versus usual care.

Comparison 1: Continuous Support Versus Usual Care – All trials
Women who had continuous, one-to-one support during labour were less likely to:

1. have regional analgesia/anesthesia
2. have any analgesia/anesthesia
3. have an operative vaginal birth
4. have a cesarean birth
5. report dissatisfaction with or negative rating of the childbirth experience
6. they were more likely to have a spontaneous vaginal birth

Some of the conclusions drawn by those who reviewed the Cochrane Data Base include:

> "-Continuous labour support should be the norm, rather than the exception.
>
> -Continuous support by nurses and midwives may not achieve this goal, in the absence of other changes to policies and routines.
>
> -In most areas of the world at this time, childbearing women have limited access to trained doulas. Where available, costs of doula services are frequently borne by childbearing families and may be a barrier to access"[5]

I would like to conclude this part of the presentation with statements by prominent authors and others in the childbirth field about the role of doulas.

"The evidence in favour of doulas comes from more than eleven carefully designed studies: Quite simply, hiring one cuts in half the odds of having a forceps or vacuum extractor delivery. That's not all! Having a doula shortens labour by greatly reducing stress, pain and anxiety. In a typical birth the doula may be the only person whose sole responsibility is to make you more comfortable and to help you labour as effectively as possible."[6]
Ina May Gaskin

"These women (doulas) are a modern version of the god-sibs whom women in the past could rely on to help them. They do not take the place of a midwife. They provide loving, emotional support and comfort, and in doing so increase a woman's self-confidence and free her so that she can let her body give birth." [7]
Sheila Kitzinger

"An experienced doula becomes respected as an individual who can hear the mother's needs and wishes, and when necessary, interpret them to medial personnel." [8]
Klaus, Kennel and Klaus

"Every woman has the right to choose a midwife or a physician as her maternity care provider."
"Every woman has the right to receive continuous social, emotional and physical support during labour and birth from a caregiver who has been trained in labour support."
From: The Rights of the Childbearing Woman[9]

[1] Simkin, P. DONA Position Paper: The Doula's Contribution to Maternity Care. DONA: 1998.
[2] Interdisciplinary Working Group on Midwifery Regulation. Recommendations for the Regulation of Midwifery in Nova Scotia, Working Group on Midwifery Regulation. Nova Scotia: 1999.
[3] Simkin, P. DONA Position Paper: The Doula's Contribution to Maternity Care. DONA: 1998.
[4] Hodnett, ED. Caregiver support for women during childbirth. In: The Cochrane Library, Issue 2, 2003.
[5] Simkin, P. DONA Position Paper: The Doula's Contribution to Maternity Care. DONA: 1998.
[6] Gaskin, I.M. Ina May's Guide to Childbirth. Bantam Books; 2003.
[7] Kitzinger, S. Rediscovering Birth. New York: Pocket Books; 2003.
[8] Klaus, M. Kennel, J., Klaus, P. The Doula Book. Cambridge, MA: Perseus Publishing; 2002.
[9] Maternity Centre Association. The Rights of the Childbearing Woman; 1999. http://www.maternitywise.org/mw/rights_body.html

L. CONCURRENT SESSION

ROLE OF CONSUMER GROUPS PRE-MIDWIFERY LEGISLATION

It is well documented that consumers have played a critical role in pressuring governments to regulate midwifery. In this session a historical look at the role consumers played in Ontario is examined, as well as with an eye to strategies for consumers in those provinces still seeking regulation of midwifery care. The goal of this interactive session was to develop strategies for moving forward and/or improving maternity care.

1. *Storm Stayed: Sharing Lessons Learned from a Nova Scotia Consumer Group*
   Jan Catano and Katherine Side, Midwifery Coalition of Nova Scotia

2. *The Critical Role Consumers Played in the Struggle for Midwifery in Ontario*
   Ivy Bourgeault, Health Studies Programme & Department of Sociology, McMaster University, Hamilton, Ontario

3. Round Table
   Sylvie Roy, Friends of Midwives, Saskatchewan

4. Round Table
   Susana Rutherford, Birthing Options Research Network, Prince Edward Island

L.1 STORM STAYED: SHARING LESSONS LEARNED FROM A NOVA SCOTIA CONSUMER GROUP

Jan Catano and Katherine Side, Midwifery Coalition of Nova Scotia

Introduction

In the 1970s and early 1980s, Jan was a member of a Nova Scotia group called WHEN – the Women's Health Education Network. WHEN's big event was an annual conference and one year, Cape Breton singer Rita McNeil sang at the conference. She introduced one of the songs as having been written while the band was 'storm stayed' during a Cape Breton tour – that is, stuck in the midst of a journey due to bad weather. We're not native Maritimers, and this was the first time that Jan heard this term, and it's still her favorite local expression.

Despite the presence of practising midwives and the presence of an active consumer group since 1984, midwifery is not recognized in legislation or regulated in Nova Scotia. Since the 1970s, the status of midwives in Nova Scotia has been alegal. That is, there is nothing preventing midwives from practicing, but there is no legal regulation or protection available to them. This ambiguous status has allowed midwives to practise in Nova Scotia and has allowed some women to use the services of a midwife. However, the fragility of this status was highlighted in December 1995, when Nova Scotia undertook to update its Medical Practice Act. Attempts to include the phrase "the management of pregnancy and parturition" in the scope of practice clause were successfully challenged at the Law Amendments Committee by a number of groups including the Midwifery Coalition of Nova Scotia, who were concerned that the inclusion of this clause could be interpreted to make the practise of midwifery illegal, as it could be classified as practising medicine without a license.

The Midwifery Coalition of Nova Scotia, since its formation in February 1984, has been stayed by many storms, of which the challenge to the Medical Practice Act was only one. At this particular moment, the waters appear to be calm and the sky is blue, but we can't know for certain if we're in fact, in the eye of another impending storm.

Riding Out 'Political Storms'

The Midwifery Coalition of Nova Scotia was conceived and born in the midst of an earlier storm surrounding the 1983 prosecution of three local midwives for criminal negligence causing death. The charges were dropped at the preliminary hearing, but this case and its coverage in the local media served as a stark lesson in the vulnerability of midwives working outside of the health system as unregulated practitioners.

Since 1984, members of the Midwifery Coalition of Nova Scotia have worked relentlessly to ensure that community-based midwifery be legalized and incorporated as an insured service in the Nova Scotia health system. We've included a brief chronology of our activities, set in the larger context of some significant milestones in midwifery nationally (see end of this paper). This handout will give you some idea about the scope of our activities as a grassroots consumer advocacy group over the past twenty years. The dates and the events that they mark**,** however, hide the enormous amount of effort, energy and invisible labour by many, many women to sustain (and to finance) this ongoing lobby effort.

Over the past twenty years, the nature of our lobbying efforts has moved in a positive direction. We have moved away, for the most part**,** from explaining midwifery, proving its safety and effectiveness, and defending it from attacks from the medical profession. We are now able to lobby from a position that is based on a shared understanding about the acceptance of the safety and efficacy of midwifery care and our lobby efforts have become concentrated instead on how (and when) midwifery can be incorporated into the health system in Nova Scotia.

During this transition from a defense of midwifery, to negotiating its place in the health system, we have been 'stayed' by a series of political storms. During the initial phases of these storms, the situation appeared to be calm, but became quickly swamped by uncertainty. Two specific examples come to mind. The first was in March 1993, when Nova Scotia's Task Force on Primary Health Care released an interim report recommending that then–Minister of Health, George Moody (Conservative), strike a task force on midwifery. Minister Moody accepted the report. It initially appeared that our lobbying efforts might count, but this same month, a provincial election was called and the Conservative government fell. The new Liberal Minister of Health, Jim Smith, failed, at least initially, to follow through on the Conservative initiative.

Minister Smith subsequently redeemed himself by striking an Interdisciplinary Working Group on Midwifery Regulation in 1998, which included MCNS members**.** The Interdisciplinary Working Group's recommendations—including recognition of midwifery as an autonomous, self-regulated, primary health care profession and its inclusion as an insured service—were accepted by Minister Smith in June, 1999. He instructed Department of Health lawyers to begin drafting the pertinent legislation and announced plans to appoint an Implementation Task Force over the summer of 1999.

And then another storm struck in June 1999. In the midst of plans to appoint the Implementation Task Force, a provincial election was called. The Liberal government was defeated. The new Conservative Minister of Health, Jamie Muir declined altogether to follow up on previous initiatives. Correspondence from Minister Muir to Coalition members suggested that government expenditures related to the recommendation were deemed "prohibitive" and that the development of primary health options would be in "due time" (*Midwifery Now!* Newsletter, April 2000).

In Nova Scotia we have had two subsequent Ministers of Health and another provincial election, resulting in the current government, a minority led by the Conservatives. The provincial government has recently struck a Primary Maternity Care Working Group, to which the Midwifery Coalition of Nova Scotia has been invited to send a representative. The Primary Maternity Care Working Group's purpose is "to develop a regulatory framework for the inclusion of midwives in collaborative teams delivering primary maternity care in Nova Scotia." This group met for the first time in June 2004. Once again, we are optimistic that our goal will finally be realized.

It is important to note that over the course of our struggles in Nova Scotia, midwifery has enjoyed a relatively high profile in some other Canadian provinces, particularly in Ontario, British Columbia and Quebec. While there are other Canadian provinces where midwifery is not yet recognized in legislation and regulated, Nova Scotia appears to be the only province to

have undertaken an investigation of midwifery as primary health care practice, received positive recommendations for its implementation, and then not proceeded with it**.**

Lessons Learned

Over twenty years of lobbying have taught the Coalition many valuable lessons. These lessons are part of our history as a Coalition and are a part of the history of midwifery in Nova Scotia. They may be useful for provinces where midwifery is not yet legislated and where other long-term battles will be fought by women seeking to maintain the quality of midwifery care available to them and their access to this care. Overall, we have learned about the importance of resilience, the importance of taking your issue seriously but not yourselves, and of recognizing small victories. We've learned lessons about the necessity of flexibility and adaptability, and the significance of a policy focus for consumer advocacy groups.

Resilience and staying power are bedrock to our struggle. In 1984, when the Midwifery Coalition of Nova Scotia was formed, members couldn't have imagined that they would still be a part of this struggle twenty years later. But the only way that we can lose at lobbying for policy change is if we stop—and we don't intend to. We have learned to regard lobbying, especially when faced with government change, as a process of two-steps-forward-and-one-step-back. What keeps us going forward is focusing on the fact that we're still one step ahead from where we previously were. While we have a clear goal, we also recognize that along the way to this goal there are many other different kinds of victories. Through lobbying we have acquired new skills and self-confidence. Along the way, we have experienced the pleasures of changing a key person's mind. We have a sense that while we haven't yet achieved our goal of legal midwifery as an insured health service in Nova Scotia, we are closer to it—which leads us to the next point, celebrating the successes along the way, however small.

We've celebrated the success of midwifery in other provinces and the ways that these victories have aided our own efforts. When asked what midwifery might look like, we can point to examples in other provinces; when asked who uses the services of a midwife, we can point to consumers in other provinces. We have enthusiastically celebrated our own successes, even when they've proven fleeting. It is true in any lobbying effort that people will work hard for an issue that they care about, but they will also work hard with **people** they care about. Along the way, it has been important for us as members of the Coalition to get to know one another to, to work together, and to build opportunities to have fun together. We have always tried to take our issue seriously, but not ourselves.

Our accomplishments to date are based on utilizing both the strengths and talents of our individual members, and the collective strength and support of the group. This translates into collective efforts to send various delegates to meetings and committees as a way of keeping members involved and up to date on our activities. When a member has been appointed to represent us on a committee, we've provided support and back up in order for her to be effective. Members have also provided childcare for one another so other members could meet with Ministers. We have taught each other how to write proposals, briefs and letters, and taught each other how to read and use research to support our lobbying positions. We have been fortunate that our efforts have been advanced by the skills and talents of our members. One of our members was a film director and worked with the Coalition to make the video, *What Midwives Do***,** screened in Halifax on International Midwives Day, 2001**.** Another member of

the Coalition who is web-savvy maintains our web site <www.chebucto/ns/ca/Health/Midwifery>. Our members bring a range of skills and talent to the Coalition, from policy analysis and writing skills to the organizational and fund-raising skills that support events such as our annual baby fair.

We have adopted structures that have allowed us to be flexible and adaptable. Most of our meetings are kitchen table meetings. We have never had an office or paid staff. Over the twenty years that the Coalition has existed, our bank account has rarely exceeded three digits. Nevertheless, we maintain a public profile and change how we do this to best suit our goals. For example, we used to regularly publish a print copy newsletter called *Midwifery Now!* The newsletter was mailed to our members and distributed to local venues. While the newsletter served its purposes, it was also labour intensive. It required someone to format it and solicit advertising, and postage was expensive. In the last few years, the Coalition has consciously moved away from the print newsletter and to rely instead on our website as our principle means of communication, although we also still maintain a telephone listing for those without web access. The web site gives us a higher profile. It also provides a contact point for midwifery consumers and for new members. Importantly, politicians can now easily research us, locate us, and contact us. It also provides us with a timely forum to advertise our upcoming events and has serves as a point of contact for other midwifery consumer groups.

Along the way, we have learned about the significance of having a policy focus, although it took us time to realize that what we were dealing with in the Coalition was policy. We came at this work from the position of changing the kinds of maternity care available. In our initial efforts, we didn't understand that what we were asking for required policy changes. That realization dawned gradually as we learned from lobbying experiences. But having a policy focus was important because it meant that we could deal with the issues and not the personalities and it allowed us to adopt the appropriate approach in order to be heard. The formation of a lobbying committee in the Coalition has enabled this further and also allowed us to use the skills and interests of particular members.

Conclusion

All of these have been important lessons, and there are other lessons that we're still learning. One possible way to write the narrative of the Midwifery Coalition of Nova Scotia, over the past twenty years, is as a failure. (And in fact, at least one research paper that we are aware of has done this). While there were allied local groups who were part of this same struggle throughout the 1970s and 1980s, and who were also intent on expanding choices in maternity care, they are mostly inactive now and the struggle to lobby for change appears to be ours alone. It could be argued that the Coalition, based on the fact that we have not achieved the goal that we have been working toward for the past twenty years, has been unsuccessful. Midwifery is not legislated in Nova Scotia and it is not an insured service in our provincial health care.

There is, however, another way to write this narrative. Our efforts could be regarded as ongoing and the narrative of our last twenty years as a Coalition could acknowledge the considerable amount of recognition that we have received. It may be possible to argue that our efforts and commitment have made a substantial contribution to a shift toward the implementation of midwifery in Nova Scotia—but we will not know this for certain. It may

simply be that the tides of health system reform have finally turned in our favour in Nova Scotia. But, twenty years later, largely through the lessons that we have learned, the Midwifery Coalition of Nova Scotia is still around to see it, and we have learned a lot that can be used when the next storm hits.

Midwifery Milestones—National and Nova Scotia

1983 NS Midwifery Trial (Charges dismissed at preliminary hearing level in November)
1984 (Feb 11) Founding meeting of MCNS
1991 Ontario passes the Midwifery Act, legalizing the practice of the profession
1991 (June) Quebec adopts Bill 4. The law authorizing the evaluation of the practise of Midwifery through a pilot project.
1993 (March) Task Force on Primary Health Care (Interim Report) recommends that Conservative Minister of Health (George Moody) strike a Task Force on Midwifery. Minister Moody accepts the report.
1993 (March) Election called. Conservative government falls and Liberal Minister of Health (Jim Smith) doesn't follow up on Conservative initiative.
1994 (January) Midwives begin practising as fully recognized professionals in Ontario.
1994 Quebec midwifery/birth centre pilot projects begin operating at eight sites in the province.
1994 Alberta regulates midwifery through the Health Disciplines Act.
1995 BC includes midwifery in the Health Professions Act.
1995 (December) MCNS and other groups address the Law Amendments Committee. We argue—successfully!—against the inclusion of the phrase the "management of pregnancy and parturition" in the scope of practice. Our concern is that this would make the practise of midwifery illegal, because it would become "practising medicine without a license."
1997 Manitoba passes the Midwifery and Consequential Amendments Act.
1997 (September) Nova Scotia Reproductive Care Program releases report, "The Potential for Midwifery in Nova Scotia." It recommends (among other, far less positive recommendations) that midwifery be implemented as a regulated health profession in NS and that an Implementation Committee be struck to begin process.
1997 (September) MCNS meet with Minister of Health Jim Smith to express dissatisfaction with the process and content of RCP report. Minister agrees to appoint an Implementation committee that will include MCNS and ANSM representatives.
1997 (October) MCNS releases detailed critique of the RCP report.
1998 (January) Midwives begin practicing as fully recognized professionals in BC.
1998 (May) The Interdisciplinary Working Group on Midwifery Regulation begins meeting. Both the MCNS and the ANSM are represented.
1999 (March) MCNS website up and running, leading to increasing visibility for the organization.
1999 (May) The Interdisciplinary Working Group on Midwifery Regulation completes its report: Midwifery in Nova Scotia. Recommends recognition of Midwifery as an autonomous self-regulated primary health care profession and its inclusion in our health system as an insured service.

1999 (June) Minister of Health Jim Smith accepts Working Group recommendations. Tells Department of Health to begin drafting legislation and announces plan to appoint and Implementation Task Force over the summer.

1999 (June) Election is called and Liberal government is defeated. New Conservative Minister of Health (Jamie Muir) fails to follow up on Liberal initiative on midwifery.

1999 Evaluation of Quebec Midwifery Pilot Project completed with positive results. Quebec decides to legalize the practice of Midwifery

2000 (January/February) Correspondence with Minister of Health (Jamie Muir) indicates the government not interested in pursuing midwifery.

2000 (March 1) ANSM meets with Minister of Health. Get commitment that government will "keep talking" about midwifery. Receives excellent press coverage for the issue.

2000 (June 23) MCNS meets with Minister of Health. Very cordial discussion about overall role of Midwives in Primary Health System. Reiterates assurance that midwifery will be included when Primary Health Care Working Group is named.

2000 (June 28) MCNS launches it's video, "What Midwives Do." Mails copies to the Minister of Health and 100 provincial, regional and national recipients including hospitals, bureaucrats, midwifery groups, libraries and District Health Authorities.

2001 (May) Carrie Harlow of the ANSM appointed to Advisory Committee on Primary Healthcare Renewal to represent midwifery issues.

2001 (June) MCNS invited to participate in a Human Resource Study of the Health Sector in Atlantic Canada that will examine the health human resource requirements and the role of education and training in the provision of needed services. Midwives are being considered as part of an evolving system.

2002 Midwife Kerstin Martin participates on the Task Team that was appointed by the Advisory Committee on Primary Healthcare Renewal. Her contribution on midwifery was well received by the other members of the Team.

2003 (June) The Advisory Committee on Primary Health Care Renewal released its report recommending the inclusion of midwifery in the province's primary health care. MCNS issues press release in support of report. Health Minister Jane Purves receives the report. Election called within a short time of the report's release. Conservatives return as a minority government. Minister of Health Jane Purves defeated. Angus MacDonald given Health portfolio.

2003 (Fall): MCNS undertakes systematic lobbing with the Minister of Health (Angus Mac Donald) and the two health critics (Dave Wilson, Liberal Health Critic; Maureen Mac Donald, NDP Health Critic) to follow up on the recommendations of the Primary Health Care Renewal report. All parties support midwifery. Minister of Health says it's no longer a matter of whether midwifery will be implemented, but of how and when.

2003 (November): MCNS initiates a letter writing campaign to raise the level of awareness about midwifery among provincial members of legislative Assembly. New by-laws are adopted by MCNS at its AGM to reflect its increasing focus as a web-based organization.2003 (December): MCNS meets with David Gass, Director Primary Health Care

2003 (December): MCNS invited to participate in a series of meetings at the IWK to discuss potential projects and directions for implementing midwifery in the Capital District.

2004 (March): Department of Health asks for comments on its proposed umbrella legislation for health professions. Plan is to develop legislation for newly regulated health professions initially and later see if it works for already regulated professions.
2004 (March): MCNS invited to send a representative to sit on the Primary Maternity Care Working Group. The purpose of the group is "to develop a regulatory framework for the inclusion of midwives in collaborative teams delivering primary maternity care in Nova Scotia."
2004 (June): First meeting of the Primary Maternity Care Working Group.

Throughout the 1990s midwifery has had an increasingly high profile and has become an increasingly accepted part of mainstream health care in other parts of Canada -- particularly Ontario, BC and Quebec. As of this writing (2004) Nova Scotia is the only province, which having undertaken an investigation of Midwifery and received a positive recommendation, has so far not gone ahead with implementation.

Things seem to be looking up, though, with the appointment of the Primary Maternity Care Working Group to look at a framework for including midwives in the primary care system.
Jane Catano

L.2 THE CRITICAL ROLE CONSUMERS PLAYED IN THE STRUGGLE FOR MIDWIFERY IN ONTARIO

Ivy Bourgeault, Health Studies Programme & Department of Sociology, McMaster University, Hamilton, Ontario

Abstract
Major changes have taken place across Canada in terms of the legitimacy of midwifery care. In several of these cases it has been the call from consumers that has led to this recognition. Consumer organizations have played an important role in garnering media as well as government support. That was particularly clear in the province of Ontario. Specifically, consumers, who were initially members of an amorphous organization that included midwives and other midwifery supporters, organized into a separate consumer support organization called the Midwifery Task Force of Ontario (MTFO). The group solicited supporters from the broader women's movement, often through their own and their midwives' connections. They were well positioned to respond to the various threats against integration that midwifery faced particularly through the 1980s. This included an inquest-turned-public inquiry into midwifery in 1985 and the government appointed Task Force on the Implementation of Midwifery in Ontario in 1986 and 1987. That midwifery was able to overcome these challenges is due in large part to the organized efforts of consumers to reveal that the midwifery community was not a 'lunatic fringe'. But it was not just the strategic actions on the part of midwifery consumer that made them so effective; they were met with a conducive environment within the media, government and bureaucracy. Women in both those establishments singled out midwifery as a key feminist issue that they could sink their teeth into. The outcome was a synergy amongst consumers, reporters, and government Ministers that enabled midwifery integration to proceed to its successful conclusion in that province.

The Critical Role Consumers Played in the Struggle for Midwifery in Ontario

Ivy Lynn Bourgeault
McMaster University

Slide 1

The Problem for Midwifery Consumers?

- How can they be effective lobbyists for the integration of midwifery care?
- To begin to answer this, let's examine what was done in Ontario, what were the outcomes and why …

Slide 2

Early Organization

- *The midwifery community in Ontario as elsewhere began as an amorphous collective*
  - *in the 80s two organizations were developed to pursue integration:*
    - *professional association for midwives*
    - *consumer support organization*

"better to have a consumer group blowing your horn"

Slide 3

Early MTFO Strategies

- Seek support from other feminist organizations
- Become media savvy
  - Create a clear message
  - Stick to it the message
  - Be available
- Create or capitalize on "events"

Slide 4

The Importance of Personal Stories *[aka the power of the anecdote]*

- Easy for media to pick up and sell
- Had an important influence on government-appointed committees
  - Everyone can relate to a birth story
  - Enabled the midwives to focus on the stats (i.e., *"hard evidence"*)
- In turn, easy for government to use in "selling" their legislation

Slide 5

Moving Support from the "Outside" to the "Inside"

- Organized consumers need supporters
  - Inside the media
  - Inside the government
    - Elected officials
    - Bureaucrats
- Consumers need to push for representation on important recommendation and/or decision-making committees
  - need to be easily identifiable

Slide 6

Key points …

- Organization of consumers is critical
- Message needs to be clear and consistent
- Allies in media and government are essential
- Push for a voice

Slide 7

L.3 ROUND TABLE

Sylvie Roy, Friends of Midwives, Saskatchewan

Overview of Midwifery in Saskatchewan (since 1994)

1994: Establishment of the *Midwifery Advisory Committee*

1996: *Midwifery Advisory Committee* recommends the following to the Health Minister

1) Midwifery be a funded, regulated profession
2) Have in-province skills assessment of existing midwives
3) Develop a midwifery education program
4) Have further consultation with northern and Aboriginal populations.

However, midwifery was seen as an enhanced service and the government decided to only regulate midwifery. There would be no in-province assessment, funding for midwifery services, education programs or further consultation with northern and Aboriginal populations.

1997: Establishment of the *Midwifery Implementation Working Group*
Debated as to whether we should refuse to be part of this working group until SaskHealth committed to fund Midwifery Services. After some discussion we decided to take part in the working group. We hoped that with continued lobbying we would convince SaskHealth to fund midwifery.

1999: May 5: ***Midwifery Act*** passed.
However with no funding and no financial help from the government, and with skills assessment done out of province, few midwives were left to practise here. They moved to funded provinces.

2000: May 5: Rally at the Legislature:
"Where have all the midwives gone?"- Discussed the situation of midwives leaving to practise in provinces where they obtained their registration because they could not obtain skills assessment in Saskatchewan and funding was unavailable.
Health Minister Atkinson promised a demonstration project and promised to advertise for a coordinator by December 2000.

2001: January: *Fyke Commission* (Saskatchewan health care commission) established.
There was a freeze on all new projects in Sask Health till the end of the Commission. So the promised demonstration project became part of the freeze.
The consumer movement almost folded at that point. For the next two years there were a few intermittent meetings with discussion on the direction the consumer movement should take.

2003: May: *Friends of the Midwives* incorporated as a not-for–profit organisation.

2003: Fall: *Friends of the Midwives* opens the *Family Room.*
The *Family Room* offers support and information to young families on many subjects relating to family life.

2004: May: Meeting with Health Minister to discuss the Midwifery situation.
Rally held at the Legislature on May 5. Question from the Opposition Party in the Legislature as to why the ***Midwifery Act*** is still not proclaimed.

2004: Summer: In the process of setting up meeting with Primary Care Service to discuss how midwifery could be integrated through their services.

Susana Rutherford, Birthing Options Research Network, Prince Edward Island

I am Susana Rutherford. I'm an artist and a consumer of midwifery services. I've had two homebirths. The first birth was in Ontario under the legislated midwifery system in place there, after moving to PEI and entering into my second pregnancy, I discovered that there are no midwifery services currently in PEI. I chose a homebirth outside the medical system with a midwife from Ontario.

During my experiences with birth, I discovered what a transformative experience birth could be. How pregnancy and birth can be a period in a woman's life where health and healing can occur. I learnt how empowering a good birth experience could be and I wanted to help other women have the best birth experiences possible. I experienced the collaborative care that is part of midwifery and felt how it empowered my partner and me. I became aware of how the health of a mother and her baby can have a ripple effect through their lives, their families lives and be transformative to society as a whole.

After touring the major hospital in Charlottetown during my pregnancy, and discovering that they still operated under a multi transfer system, I made a decision to get involved in improving maternity services in PEI. I began with a petition to the hospital to move to a single room maternity care. Over two hundred women signed in very short order. From this effort the midwives group, comprised of two midwives one retired and one working as a doula joined with a member of the Women's Network and myself to form Birthing Options Research Network (BORN).

Since forming BORN we have built relationships with other women's groups and midwifery groups. With the help of the Atlantic Centre of Excellence for Women's Health we organized a roundtable on Maternity Care in PEI. This brought conventional practioners together with alternative practioners and expanded our BORN members to a steering committee of ten with 100 supporting members. Also, as a result of the roundtable we formed a group with hospital and government workers to promote Family Centred Care within the health care system. BORN attended the AGM for the Nova Scotia Midwifery Coalition and met with other groups from the Atlantic Provinces. Our group is working on Midwifery Legislation with the other Atlantic Provinces. We are designing a Midwifery and Doula education presentation to take to

the public and health care professionals. BORN has plans to create a web site too. We are confident that PEI will be able to offer Midwifery and Doula care in the future to Island women and their families.

M. CLOSING PLENARY SESSION

RE-EXAMINING THE BARRIERS TO REGULATION IN THE NOT-YET-REGULATED PROVINCES

In this session representatives from Saskatchewan explore in-depth the history of midwifery in that province with focus paid to efforts to gain regulation of midwifery care. As well, roundtable participants from several jurisdictions which are working toward regulation gained the opportunity to learn from one another and to strategize for the future of midwifery care in Canada.

1. *Midwifery in Saskatchewan*
   Cathy Ellis, Midwife, Regina, Saskatchewan
   Joanne Havelock, Prairie Women's Health Centre of Excellence, Saskatchewan

2. Roundtable Participant: Pearl Herbert, Association of Midwives of Newfoundland and Labrador

3. Roundtable Participant: Kate Nicholls, Midwives Association of New Brunswick

M.1 MIDWIFERY IN SASKATCHEWAN

Cathy Ellis, Midwife, Regina, Saskatchewan
Joanne Havelock, Prairie Women's Health Centre of Excellence, Saskatchewan

The following article combines the material from two presentations on Saskatchewan midwifery made to *The Midwifery Way* conference in Halifax in July 2004, with the addition of some background information about Saskatchewan.

Introduction to Saskatchewan

Saskatchewan's population of just under one million people is spread over two major cities, several smaller cities, rural farmland and towns in the south and northern communities in the Canadian Shield. Indian reserves and Métis settlements are located throughout the province, with a great concentration in the northern half. Many small communities still reflect the linguistic and cultural heritage of settlers. Rural depopulation has affected the province and the average age in rural areas is older. Almost half of First Nations people live off-reserve and Aboriginal people comprise a significant percentage of the population in larger centres.

In Canada, health services are provided under a number of jurisdictions. Provincial governments have the main responsibility for health services and in Saskatchewan health services are managed by the Department of Health (Saskatchewan Health) and twelve Regional Health Authorities. The federal government's health department, Health Canada, provides some health services to all Canadians, including health education and prevention. Health Canada provides some health services to First Nations on Indian reserves, and some health services are managed directly by some Tribal Councils and Indian Bands.

There are approximately 12,000 births per year in Saskatchewan. There is a strong birth rate among First Nations women. Saskatchewan continues to have a high teen pregnancy rate, the reasons for which are beyond the scope of this paper, but this fact is significant for midwifery practice.

Currently, in 2004, the majority of births take place in hospitals. Northern women may deliver their babies in smaller northern hospitals or fly in to Saskatoon and Prince Albert for their births. Of the small number of home births in the province, most are attended by apprentice-trained midwives and some nurse-midwives. There are about four midwives working in the province assisted by apprentices or doulas. Several nurse-midwives trained outside of Canada work in Saskatchewan in labour and delivery floors in hospitals. The province does not have a large number of obstetricians and the trend to attend fewer deliveries by family physicians continues.

Midwifery History Starting in the 1970s

The early history of midwifery in Saskatchewan is important in setting the stage for the current situation in the province, however in this short paper the focus will be on more recent developments. This account begins with the 1970s. At this time, doctors had the exclusive right to practise midwifery. Trained midwives from Europe and elsewhere who had immigrated to Saskatchewan were working as labour and delivery and postpartum nurses. Apprentice trained midwives were not allowed into hospitals even as "labour coaches". Only husbands or their alternates were allowed to accompany women during hospital births. Women in rural or remote

areas frequently traveled to be near hospitals prior to birth. There were a greater number of hospitals and doctors that provided delivery services at that time. Women in northern communities were flown to larger communities prior to giving birth. However, community nurses were also often called upon to provide delivery and labour support in northern isolated communities.

Saskatchewan women dissatisfied with hospital deliveries in 1970s began to ask other women to help them with their births at home. By the late 1970s several apprentice-trained midwives were attending homebirths in Saskatchewan. Two physicians provided medical back up to the midwives.

By the mid 1980s in Saskatchewan solidarity had developed between apprentice-trained midwives and nurse-midwives. The Midwives Association of Saskatchewan was formed in 1987. The organization continues with all the midwives working well together.

Around this time the Saskatchewan Association for Safe Alternatives in Childbirth (SASAC) was formed by women interested in alternatives to birthing practices. SASAC provided individual counseling on options for childbirth, breastfeeding and other concerns. The organization also provided educational resources and workshops, and actively promoted midwifery. SASAC published its first newsletter in the Spring of 1984 and its activities continued until the late 1980s.

Friends of Midwives was established in 1992. The group continues to provide educational resources on midwifery and birthing. The organization publishes a joint newsletter and carries out joint activities with Midwives Association of Saskatchewan. Friends of Midwives has been focused on lobbying for legalization of midwifery. Through the years a tremendous amount of work has been done including media work, public information sessions, rallies and meetings with a number of organizations such as health districts, health professional organizations, and women's groups.

Lobbying for midwifery was carried out by the Friends of the Midwives and the Midwives Association. Lobbying efforts included letters, petitions and demonstration/celebrations in front of Legislative buildings.

Government Review of Midwifery

The Midwifery Advisory Committee was formed by the Minister of Health in 1994 to study whether there was a need for midwifery. Its work included a needs assessment study. Two midwives and two consumers participated on the Committee. A random sample of women showed little was known about midwifery among the public in the province. The Midwifery Advisory Committee found a "need" for midwifery but First Nations communities did not express a desire for midwifery.

The Midwifery Implementation Committee was announced March 1997. This Committee set up documents to regulate midwifery. Plans were written for training, setting standards and legislative changes needed.

During late 1990's there were only two midwives in Saskatoon, one in Regina, and one in Yorkton. It was difficult to attract midwives to the province because of few births, and because of no plans for implementation of funded midwifery.

Midwifery Act Passed, But…

The Midwifery Act was finally passed in May 1999. Midwifery supporters celebrated with speeches and a gathering in front of the Legislative buildings in Regina. However the Act was not proclaimed at that time. The Department of Health gave no commitment for funding midwifery care; the decision to fund was left up to Health Districts, with no additional funds provided. And other matters needed to be worked out before the Act could be proclaimed.

Midwives and consumer groups held a rally on the International Day of the Midwife, May 5, 2000. Later that spring representatives of Friends of the Midwives and the Midwives Association of Saskatchewan met with Minister of Health Pat Atkinson. An action plan was presented to the Minister. Plans were developed with her for an initial demonstration project of funded midwifery, potentially though a primary health care site. Plans included advertising for a midwifery coordinator by December 2000, whose responsibilities would include selecting a site for the demonstration project and hiring midwives for the demonstration site. Other meetings followed, with good progress toward implementation.

However, the Health department was occupied with other priorities, reviewing and reorganizing health services. The Fyke Commission had been set up by Premier Roy Romanow in June 2000. Much of the Health department's attention went to the Commission. Many decisions were put "on hold", including the plans for a midwifery demonstration project – government officials informed Friends of the Midwives in January of 2001 that there was a freeze and the midwifery project would not be going ahead at that time. In the winter of 2001 the Government of Saskatchewan also announced general spending restraints.

Midwives did make a submission to the Fyke Commission. Fyke's report "Caring for Medicare: Sustaining a Quality System", released in April 2001, mentioned midwifery (once) as a primary health service.

One of the other reasons for the slow progress may have been that in government there was no other strong support in the civil service from departments outside the Department of Health. The Saskatchewan Women's Secretariat had provided a participant for the Midwifery Advisory Committee and included information about the committee's work in newsletters, but plans for an educational pamphlet with midwifery consumers did not materialize. In the Health department, officials continued to view midwifery as an "add-on cost". Midwifery was not seen as a necessary service, but an optional service.

The Saskatchewan Action Plan for Children, a Saskatchewan government inter-sectoral initiative, had been developing proposals concerning services for early childhood development, including prenatal concerns. The resulting program that was announced in April 2001, called KidsFirst, focuses on about one thousand high-risk families in the province, providing postnatal assessments in hospital, home visits by lay workers, and referrals to services. An established midwifery service was not available when the program was established, but in future there might be potential for midwives to link with such a program.

In December 2001 the Health department released the Action Plan for Saskatchewan Health Care, the response to the Fyke Commission. Among other things it recommended a reorganization from 32 health districts to 12 Regional Health Authorities and a Northern Health Authority. Considerable attention was spent on these changes, and dealing with major public concerns about closing hospital beds in rural areas, where elder care was a major issue. The report did include recommendations regarding obstetrics and delivery in health care facilities and recommendations concerning the formation of primary health care teams.

An Action Plan for Midwifery was developed by midwifery supporters in 2001. It covered topics such as: rationale and conditions of practice, hiring a provincial coordinator of midwifery, recruiting midwives, assessing midwives, educating new midwives, serving marginalized women and planning and evaluation of midwifery services. However, there did not seem to be much momentum towards achieving these goals. As of 2001 there were about 3 or 4 practicing midwives remaining in Saskatchewan. Without access to mainstream medical services, midwives had to be resourceful. Consumers and midwives became disillusioned by the lack of progress in implementing midwifery. In June serious discussions were held by Friends of the Midwives concerning the future direction of the organization.

Renewal

Around that time, a small number of new women were attracted to the profession of midwifery in Saskatchewan. Women continued to express interest in having a midwife at their birth. Starting in mid-2001, meetings were held that indicated that interest in midwifery was alive and the support for midwifery was rekindled. Those involved saw the need to promote midwifery as a full service in the province, and also the need to provide information and support to women and their families concerning birth practices. The Family Room was established in Regina in the Fall of 2003, providing a place for families to find information and resources about birthing. Discussions were held amongst midwives and consumers and it was determined that the best arrangement was for the Friends of the Midwives to form two groups, one to oversee the day-to-day work of the Family Room and one to focus on the situation of midwifery in the province. In 2003 Friends of the Midwives renewed their organizational structure by incorporating and moved forward with a renewed purpose of promoting midwifery.

Midwives and Friends of the Midwives met in Regina in the Spring of 2004 and determined to renew efforts to lobby for strong midwifery services in the province.

The Midwives Association and Friends of the Midwives met with the Minister of Health on May 4, the day before the International Day of the Midwife. The government expressed support for midwifery, but wanted a clearer picture of how the midwifery model and structure could be made to fit the Saskatchewan situation. A celebration of midwifery with speakers was held at the Legislature on May 5, with media coverage. The group attended the Legislative Session that afternoon and was formally introduced in the Legislature, by both the Government and Opposition parties. Some meetings followed with the Minister of Health and an advisor on nursing issues.

New Directions Being Considered

One option being looked at by midwifery advocates is to consider how midwives could be part of the Primary Care Action Plan in the province – linking with teams of doctors and nurse-

practitioners. Another option is including midwifery in Community Clinic services, located in urban centres. Some discussions have been held and more discussions are envisioned with First Nations women regarding their experience and thoughts on midwifery.

In the summer of 2004, consumers and Midwives Association began to make the contacts to work with various leaders in health department to see how midwifery fits into current health strategies. Midwifery consumers and midwives also plan to meet with interested health regions and community clinics to see where midwifery is wanted.

What Helped?

What helped to get legislation passed in 1999 was that the Friends of the Midwives worked together with the Midwives Association. There was a lot of educational work and lobbying done by a few key individuals in organizations. Petitions and letters from midwifery supporters kept the Government aware of their interest in midwifery. The Midwifery Advisory Committee report was seen as a reasonable document, and there was support for midwifery among the provincial Cabinet ministers.

Some of the factors that delayed midwifery implementation after 1999 included: a lack of agreement on the funding mechanism, a lack of support by doctors or nurses, a Health department that was in the midst of a major reorganization, and a lack of support from other provincial government departments. After all the efforts in getting the Midwifery Act passed, the midwifery consumer advocates needed a break, and some moved on to other important work, including becoming midwives themselves or doing further work on their midwifery practice. There was some support from women's organizations, but those organizations were undergoing funding cuts, due to provincial cutbacks and a major refocusing of the federal programs providing grants to women's organizations. There was not strong vocal public support from women academics or other women leaders.

Currently, public understanding of midwifery seems to be up among young women; elderly women and men still remember home births and local women or nurses providing labour support with doctors providing medical care. However, there does not seem to be a widespread knowledge of current midwifery. Midwifery is still seen as a "want" but not a "need", especially by MD's who feel they provide good service. There is an ongoing concern by health professionals and the public about the safety of home births. Hospital nurses see only the emergency cases – not the other, more common, successful homebirths. Obstetricians are concerned with the payment they get versus the supposedly high salaries paid to midwives. Health professionals continue to be uncertain about how collaboration on maternity care with midwives would work. However some nurse practitioners in rural areas would welcome the involvement of midwives in a primary care team.

There are several implementation issues that still need to be addressed. There is no midwifery training in Saskatchewan. Currently there are not enough midwives for a College of Midwives. There is a need to determine how midwifery will fit with new health initiatives, such as the new Primary Health Care Strategy. A demonstration project may be needed to demonstrate how collaboration would work – however there is a danger that the process of the project could take awhile. Primary care sites and community clinics have been mentioned at various times as potential sites for such a project. Regional Health Authorities, their administrators and Boards,

need to be informed and consulted about midwifery. A key issue, the method of payment for midwifery still has not been resolved. While the Health department has a very large budget, uncertainties in the farm economy, other economic variations, and continued negotiations with the federal government over health care funding led the provincial government to be short on funding. The question of whether midwifery is a cost-saving measure is still prevalent.

Midwifery implementation could be moved forward by a negative event, such as publicity on concerns about unregulated practice, a problem with a home birth, or concerns regarding unassisted births to women in the North who do not wish to fly out for their birth, as it was in some other regulated provinces. On the positive side, the move to midwifery could be enhanced by more vocal demands for midwifery, indications of how midwifery may be beneficial to First Nations and other Aboriginal women, indications of the benefits for high-risk populations such as teen mothers. At the political level, involvement by women's organizations, women academics, women leaders coupled with direct dialogue with MLA's and Cabinet Ministers, and political pressure by Opposition parties would help provide impetus to action.

Midwifery could be given a stronger impetus if Health Department officials had the mandate and the time to actively support moving the issue forward. It would also be helpful if there were an understanding of how midwifery would fit with major Health initiatives such as Primary Care was well as the Population Health Promotion Strategy, and KidsFirst. Support needs to be built with key actors at Regional Health Authorities and with First Nations health planning and delivery organizations.

The cause of midwifery in Saskatchewan would also be assisted by positive support from other provinces around shared learning assessment, training, and registration. The work of the Canadian Midwifery Regulators Consortium on prior learning assessment will be helpful in ensuring an adequate number of midwives in the province. The work being done by the First Nations and Inuit Health Branch of Health Canada to improve birthing related programs and policies will be important for Saskatchewan. And publicity on successful midwifery practices in other provinces would help its image in Saskatchewan.

Since midwifery is actually very popular in the provinces where it has been regulated and established, government officials should look to other provinces for guidelines on how to set up the profession in the province of Saskatchewan. In Ontario and Manitoba, midwifery is already providing care to women who have special needs, such as women living in poverty and with social problems. The groundwork has been done in Ontario, B.C and Manitoba. Saskatchewan can learn from their experiences and without recreating the wheel and can establish midwifery to benefit many Saskatchewan women and their families.

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M.2 ROUNDTABLE

Pearl Herbert, Association of Midwives of Newfoundland and Labrador

Midwifery in Newfoundland and Labrador has developed in different ways depending on the location.

The Ascent of Midwifery

There were always Aboriginal midwives, and the settlers had their own midwives.

In 1892 Wilfred Grenfell arrived in the colony and in 1893 he had the Battle Harbour Hospital built, the first civilian hospital outside of St. John's. He brought midwife-nurses from Britain to staff the hospital. As more hospitals and nursing stations were constructed in Labrador and Great Northern Peninsula, more nurses who were midwives, from the UK and the USA, were hired to staff them. Eventually the Grenfell Mission (which became the International Grenfell Association) took over the Inuit health care from the Moravian missionaries and the Innu health care from the RC missionaries in Labrador. (The Salvation Army continued to provide health care in Labrador City).

On the Island, Lady Harris, the wife of the Governor of the Colony, was distressed by the maternal and infant mortality rates. (The infant mortality rate was 146.34 per 1,000 live births in St. John's, where most of the doctors were located). She supported midwifery, and in 1920 Midwifery legislation was implemented in Newfoundland. Lady Harris then took a ship to England to recruit nurses who were midwives to work in the outports.

The Government appointed a Midwives Board to examine and provide midwives, who were not nurses, with a license to practise.

The Midwives Club provided a weekly course of instruction for "lay" midwives and prepared them for the examinations set by the Midwives Board. In 1924 the S.A. Grace Maternity Hospital commenced training women in midwifery and pediatric care. (The School of Nursing did not open until 1929 when the hospital became the S.A. Grace General Hospital).

In 1924 the Newfoundland Outport Nursing and Industrial Association (NONIA) was established to assist the outports to pay their midwife nurse and to supply the drugs and equipment, with money obtained from the selling of crafts.

The Descent of Midwifery

Then in 1934 the Commission of Government in Newfoundland resulted in health reforms introduced by Leonard A. Miller. Cottage hospitals were to be built and the government was to be responsible for Outport Nursing (instead of NONIA) and a programme for midwifery education (instead of the Midwives Club and the S.A. Grace General Hospital).

In 1949 Newfoundland joined Canada, a country where midwives were not recognized.

In 1958 the Hospital Insurance Plan gave free hospitalization with a bonus for physicians treating patients in a hospital rather than at home. Women now did not have to pay to give birth in a hospital.

In 1963 the last licence was issued to a midwife.

The Slow Climb Back

Midwifery Programme

In 1979 the first nurses were admitted to the midwifery programme at Memorial University of Newfoundland. (Part of the Outpost Nursing diploma programme but could be taken as an independent diploma programme). But in 1986 the midwifery diploma programme was discontinued as the University was considering larger classes but of necessity the midwifery programme classes were small (10 to 12 students), because without legislation there were limited opportunities to practise skills in the clinical areas.

In 1996 the School of Nursing at Memorial University of Newfoundland, once again considered a midwifery programme at the undergraduate degree level. The development of such a programme was started but then there was a change of directors, and the new director stopped the work on developing the programme.

Supporters of Midwifery

In 1990 the Northern Childbirth Workshop, held in Makkovik, recommended that traditional and southern midwives return to practising in the communities.

In 1991 the Provincial Perinatal Advisory Committee's report on the 1990 conference recommended having midwives and that "there should be good financial incentives to keep General Practitioners and Midwives doing low risk obstetrics, leaving the high risk cases to specialists". "Consumers need to be encouraged to establish lobby groups". An inquiry into having midwives practise was started two years later.

In 1993 the Provincial Advisory Council on the Status of Women recommended that "the provincial government introduce legislation regulating the legal practice and standards of midwifery". They recommended that the public should have direct access to midwives and also recommended that if a midwife has successfully completed a midwifery program, she does not also have to be a nurse.

In 1994 the Working Group on Women's Health recommended that the provincial Government legalize midwifery.

In 1996 the Newfoundland and Labrador Health Care Association resolved to "lobby the Department of Health to begin implementation immediately" of the recommendations of the Advisory Committee.

In December 2002 the Newfoundland and Labrador Public Health Association (NLPHA) requested the Minister to reconsider his decision to postpone midwifery legislation. The reply received in February 2003 was that midwifery legislation could not be passed, as it did not meet the requirements of the government's white paper. The NLPHA requested their representative on the Primary Health Care Advisory Council to promote midwifery which provides primary health care for women. However, it still seems that midwives are not considered to be members of a Primary Health Care Team, partly because they are not regulated and partly because some team members consider that they are "not needed".

Government Actions

In October 1991, MHA Chris Decker, Minister of Health, wrote to the *Evening Telegram* regarding the need for midwives.

In 1993 the provincial Government appointed an Advisory Committee for Midwifery. In May 1994 the Final Report of the Advisory Committee for Midwifery was submitted which stated that "midwifery is safe, cost effective and acceptable to consumers as a means of providing quality care for childbearing women and their families. . . . Midwives emphasize the importance of providing choice of caregiver, control over women's birthing experience, and continuity of care."

In the fall of 1999 the provincial Government appointed a Midwifery Implementation Committee to advise on the development of legislation related to midwifery and to provide recommendations related to the scope and standards of midwifery practice, midwifery education and registration requirements, and eventually a Board. In October 2001 the Midwifery Implementation Committee completed its mandate. Information is unavailable regarding the report to the Minister. The date for legislation was to be the fall of 2001. Then in January 2002 the date for legislation was to be the fall of 2002. By July this had changed. "Although a target date of Fall 2002 was identified for drafting legislation, it is unlikely that other professional groups will be in a position to move forward for some time" to be included in a canopy act, which did not exist in any jurisdiction, and so would have to be made specifically for this province. In October the word was that "It has been decided that self-regulation of the midwifery profession will be temporarily postponed". Apparently the definition of "temporarily" is "indefinitely". "In the meantime, I [the Minister] would encourage the Association of Midwives of Newfoundland and Labrador to continue with its efforts of advocacy and education in the area of midwifery". The Government also says that there are too few midwives in the province, although there are more here than were in other provinces when legislation was implemented.

In April 2003 the AMNL made a complaint to the Office of the Citizen's Representative for the Province of Newfoundland and Labrador on behalf of the members who were appointed to the provincial Midwifery Implementation Committee. The main points were that "Members of the AMNL were misled regarding midwifery legislation" (when told that legislation was imminent), "Members of the AMNL wasted much time preparing materials for the MIC" (estimated for some at about 400 hours each), "Members of the AMNL question what information was given to the Minister" (as no final report was ever given to the MIC members)".

Lobbying and Promoting

The Association of Midwives was formed in 1983 following the fading away of the Atlantic Nurse Midwives Association. The consumer/advocate group, Friends of Midwifery, was formed in June 1994. Over the years there has been much promotion of midwifery by the midwife members and the advocates, sometimes combined and sometimes separately. The promotion has included: letters to officials and newspapers; briefs; posters; being interviewed on radio and television programs; speaking at workshops, conferences, to specific small groups and classes; having a midwifery promotion table in a shopping mall (when permission has been given). However, there are still many government officers and health professionals who do not consider that midwives are needed. (These physicians are often those who have authority but do not provide maternity care). Most recently the birth scenes of the coordinator of Friends of Midwifery having a home birth attended by a midwife were viewed on CBC, and later the mother, midwife and baby were interviewed on the Community TV Program.

Current Situation

We now have a provincial government which is practising financial constraints. When Unions negotiate contracts, the results have been that personnel are not receiving pay raises and there is a cutting back on concessions. Some professional unions are not applying to negotiate but hoping to continue their current contracts for another year. Therefore, the AMNL is not actively pushing for funded midwifery legislation at this time. (Although, if the Government offered legislation we would accept it.) We do not want to get legislation without funding and end up like the midwives in Saskatchewan who have been fighting against implementation without funding. Or, be like Alberta with implemented midwifery legislation without funding.

It has been suggested that midwives have private practices in the community. This way, people in the province will experience midwifery and be more able to support midwifery when the Government considers midwives provide primary health care (similar to physicians and nurses) and is willing to fund midwifery practice. The Midwifery Implementation Committee developed standards and guidelines, based on national standards, and these could be used.

Without legislation midwives cannot practice in hospitals, except in St. Anthony and Happy Valley Goose Bay, where nurses who are midwives are employed in these hospitals, are permitted to deliver babies but are unable to provide the whole scope of midwifery practice. These midwives are also expected to provide general nursing care when there are no women in labour. We do have a midwife in private practice in St. John’s.

Twenty years ago there were home births in the St. John’s area, attended by physicians and midwives. The physicians ignored the Medical Board when it threatened to suspend the physicians, and it was all words and no action. The Association of Registered Nurses of Newfoundland and Labrador’s (ARNNL) current standards for nursing practice state that “The professional relationship between a nurse and those receiving the services of a nurse . . . is based on a recognition that people are able to make decisions about their own lives and are, therefore, partners in the decision-making process. Clients' decisions may include the rejection of the professional opinion or advice of the nurse and **such decisions must be respected** [emphasis added]”. As a result of the history of midwifery in this province, the majority of midwives are registered nurses.

Another problem we have in this province is that the number of midwives is decreasing. Some are moving to other locations in Canada or overseas. Others have reached retirement age, and those near to retirement do not want to risk losing their pensions, but would probably consider practising midwifery if it were funded and they could keep their benefits. Other midwives say that they have now reached an age where they feel that they could not adapt to being on call 24 hours a day. On the brighter side, there are some new midwives arriving. So far we have not had any midwives who are registered in Canada. Our midwives mainly come from overseas, or have been overseas or the USA, to obtain their midwifery education before returning to Canada.

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Primary Goal of MANB

– legislated, regulated, publicly funded midwifery services accessible to all women

Progress in Last 12 months

- Legal Report funded by the Advisory Council for the Status of Women (ACSW) and shared with other not-yet regulated provinces, travel to Halifax funded by ACSW
- Receptive Environment – time is right , eight press interviews in 6 months
- Community focus in the reorganization of health care
- Health Department looking for savings and midwifery cost-effective
- Support from ACSW, Women's Issues Branch of provincial government
- Support from Minister responsible for the Status of Women
- Support from Minister of Health and NDP leader
- Support from Atlantic Centre of Excellence for Women's Health
- Cautiously open to Concept of Midwifery – Nurses Association of NB & NB College of Physicians and Surgeons & NB Medical Association

MANB Assets

- Midwifery information leaflet, website, information sessions provincially
- Charter of Rights developed

Summary

- Have political will; Need popular demand

Barriers

- Lack of an active consumer group as in other provinces
- Lack of funding and people to provide education and awareness building, with Professionals, health and wellness reps, the general public
- Lack of a significant midwifery presence in NB, only 4 midwives, 2 practicing
- Logistics of communication and meetings amongst busy young parent members
- Lack of professional infrastructure to support midwives in this province [suggest Atlantic College of Midwives to deal with regulatory concerns in Atlantic Provinces]

From the perspective of Kate Nicholl, President of M.A.N.B , July 2004

III. APPENDICES

PRESENTER BIOGRAPHIES

Marion Alex has 25 years of nursing experience in an urban remote and rural maternal/child and pediatric settings. After receiving her Bachelor of Science in Nursing from St. Francis Xavier and a Master's in Nursing from Dalhousie University, she later pursued her midwifery education in the United States from 1998 until 2002, at the Frontier School of Midwifery and Family Nursing in Kentucky. She completed a training practicum with Women's Health and Midwifery Associates, Cooperstown NY, which is a rural practice involving collaborative practice between OB/GYNs, certified midwives, and nurse practitioners. Marion Alex now teaches Nursing at St. Francis Xavier University in Antigonish, Nova Scotia, specializing in courses involving maternal/child, women's health, and health promotion courses.

Judith Andrade is a Registered Nurse who approaches health care through a holistic and inclusive framework. She has been involved in Maternal and Child health, as a primary health care nurse, bereavement counselor, prenatal educator, and lactation consultant for the past 25 years. Her work includes both community based care and hospital settings as well as private practice.

Gisela Becker graduated from midwifery school in Berlin, Germany in 1986. Since then she has practised in a variety of settings including hospitals, birth centres and homebirth practices in Germany, Canada, and the Cayman Islands. She is a registered midwife in Alberta and the current president of the Midwives Association of the NWT and Nunavut. Gisela moved to Fort Smith, NWT in the fall of 2000.

Darlene Birch is an independently practising community midwife of Aboriginal descent. She has practiced for twenty-three years in rural, northern and urban Manitoba. She currently lives in Winnipeg and is actively involved in her core area neighbourhood. She is a mother to four grown children and grandmother of three.

Leslee Blatt has been a doula both privately and as a volunteer for the past three years. As a doula she has attended over 25 births in hospital and with midwives. She has been the prenatal educator at the Single Parent Centre for two years. Leslee Blatt chose midwifery care for the birth of both her sons and has experienced legislated midwifery in Ontario and non-legislated midwifery in Nova Scotia. She is a member of the Midwifery Coalition of Nova Scotia and co-founder of the Nova Scotia Doula Association.

Janis Wood Catano, is a Health Education Consultant with 20 years experience in developing health education materials for people with low literacy skills. She was a founding member of the Prepared Childbirth Association of Nova Scotia and the Midwifery Coalition of the Nova Scotia (MCNS) and is currently a member of the Coalition's Board of Directors. She has represented the MCNS on the Interdisciplinary Working Group on Midwifery Regulation and is currently the Coalition's representative on the Working Group on Primary Maternity Care.

Ivy Lynn Bourgeault is an Associate Professor in Health Studies and Sociology at McMaster University, Canada. She also holds a Canada Research Chair (Tier II) in Comparative Health Labour Policy at McMaster. Ivy has published extensively in national and international journals on midwifery in Canada and elsewhere. She has contributed to two chapters in the international edited volume *Birth By Design* (Routledge, 2001). *Reconceiving Midwifery* a book which she co-edits with Cecilia Benoit and Robbie Davis-Floyd has just been published with McGill-Queen's University Press. Ivy lives in Woodstock with her partner and three children – all born with the assistance of a midwife.

Kirsty Bourret is currently a midwifery student entering her third year in the Ontario Midwifery Education Programme. Prior to Kirsty's enrollment, her academic focus was women's health and women's studies at the University of Wisconsin Madison. In addition, she spent a great deal of time as a doula which included running a non-profit doula organization providing care non-exclusively to young women, women with addictions and incarcerated women. As a birth activist, much of her understanding of midwifery is rooted in the discourse of legislation within the United States and now much more recently, Canada. As a research assistant for Philippa Spoel in her joint research collaboration with Susan James, Kirsty explores the intersects of midwifery philosophy, policy and practice in Canada and hopes to continue with post-academic work in these areas.

Nadya Burton completed her PhD in Sociology and Equity Studies in Education at the University of Toronto in 1999. She is currently the Social Science Coordinator for the Ontario Midwifery Education Consortium (Ryerson, McMaster and Laurentian Universities), and sessional faculty at Ryerson University where she teaches social science courses to students from both Ryerson and McMaster Universities. She sits on the Midwifery Education Programme Curriculum Committee, and has produced several reports about the social sciences for the MEP. In the past she worked as the Community Director at the National Network on Environments and Women's Health (Centre for Excellence in Women's Health, York University), and as the Prior Learning Assessment Coordinator at the College of Midwives in Toronto.

Dina Davidson, CLA, is a mother of four, labour assistant (doula), second attendant, and midwifery student. After more than a decade of working as a professional writer and editor, Dina is currently completing the first year of a four-year BSc in Midwifery and plans to practice in British Columbia when her training is complete.

Robbie Davis-Floyd PhD, a Research Fellow in the Department of Anthropology, University of Texas Austin, is an internationally known cultural anthropologist specializing in medical, ritual, and gender studies and the anthropology of reproduction. She is author of numerous articles and of *Birth as an American Rite of Passage* (1992); coauthor of *From Doctor to*

Healer: The Transformative Journey, and *The Power of Ritual* (forthcoming), and coeditor of eight collections, including Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives (1997); Cyborg Babies: From Techno-Sex to Techno-Tots (1998); Reconceiving Midwifery: The New Canadian Model of Care (2002); and Midwives in Mexico: Continuity, Controversy, and Change (2002). Funded by the Wenner-Gren Foundation for Anthropological Research, she has recently completed a major research project on the development of direct-entry midwifery in the U.S., the results of which will appear in Mainstreaming Midwives: The Politics of Change. Her research on midwives in Mexico and on global trends and transformations in midwifery is ongoing. Website: http://www.davis-floyd.com/

Betty-Anne Daviss was recently awarded the Women of Distinction award for her work of 28 years on informed choice, grassroots education, midwifery legislation in Canada, and international work on five continents. Betty Ann is currently a Chair of the International Bureau of the Canadian Association of Midwives and the Midwives Alliance of North America Data Base. She is published in social science anthologies and medical journals and concentrates at this conference on fears of being connected with "the left" among midwives in Canada.

Kelly Ebbett graduated from the University of New Brunswick with her BN in 1997. She worked in the Maritimes as a maternity nurse and childbirth educator. She moved to Bermuda in 1999 and certified with Doulas of North America and the International Childbirth Educators Association. She has attended births in Bermuda, Ottawa, and Toronto. Upon her return to Canada in 2002, she received the position of Childbirth Educator at Mount Sinai Hospital, Toronto, Ontario where she continues to teach. In August 2004, she will assume the position of Clinical Case Coordinator – Prenatal Education with Mount Sinai's Maternal Infant Program.

Cathy Ellis has been practicing midwifery since 1977 in Mexico, Nicaragua, Honduras, Kosovo and Canada. She became a registered nurse, achieved a Masters of Science in Community Health and Epidemiology, and became a Registered Midwife in British Columbia (2002). Recently, she has worked with Canadian Public Health Association (and Canadian Nurses Association) in Kosovo as Coordinator of Maternity Training from 2001 to 2004 and as a community midwife in Vancouver carrying out locums. She will begin a new position as Clinical Instructor at UBC in the fall of 2004.

Joyce England, a registered nurse, certified midwife and currently PEI's representative to the Canadian Association of Midwives, has a wide range of experience working as a Community Health Nurse in Manitoba and Rankin Inlet; as well as working as a midwife on PEI, Goose Bay Labrador and Rankin Inlet. Indeed, she coordinated the Rankin Inlet Birthing Project. She also served as a Nursing Consultant with the Association of Nurses of Prince Edward Island and has been assisting with the facilitation of the Family Health Centres with the P.E.I. Dept. of Health & Social Services. She spoke on the topic of Midwifery: Status and Opportunity in Canada.

David Gass is a Professor in Family Medicine at Dalhousie University. His academic interests include Health Care of the Elderly and Narrative Ethics. He has acted in a number of administrative roles including Director of Long Term Care and Clinical Chief at Camp Hill

Hospital and Professor and Chair of Family Medicine at Dalhousie University in Halifax, NS. He has been Chair of the Council on Medical Education for the Canadian Medical Association, The Assessment and Evaluation Committee and currently the Committee on Ethics of the College of Family Physicians of Canada. He is presently on secondment to the Nova Scotia Department of Health where he is the Director of Primary Health Care for Nova Scotia and the Chair of the Primary Maternity Care Working Group.

Sinclair Harris was trained in England. She has been in Canada since 1970 and has extensive experience among birthing women, both in the hospital and community settings. Since 1994 she has been involved with the implementation of midwifery practice in Quebec. As a member of The Regroupement Les Sages-femmes du Quebec, she is also a member of the Canadian Association of Midwives. She is a preceptor for the midwifery education program at the University of Quebec at Trois-Rivières, and is currently employed as a midwife at a community birthing centre in Montreal with a busy practice.

Joanne Havelock is a Policy Analyst with Prairie Women's Health Centre of Excellence. Originally from Winnipeg, she has a BA in Sociology from the University of Manitoba, and a Masters in Health Administration from the University of Ottawa. She has had over 20 years experience in government, in health, environment and status of women portfolios. Her background includes work with community groups and community involvement on a wide range of issues.

Pearl Herbert completed general nursing and midwifery training in England prior to coming to Canada in 1962, and then obtained a Public Health Nursing diploma, Bachelor of Nursing degree, Bachelor of Education degree, and Masters of Science degree (in health education). An initial surprise on arriving in Canada was to find that there was no midwifery. After working in Ontario and British Columbia she went to the Northwest Territories in 1964 and stayed for 12 years, working in various communities and delivering a few hundred babies. In the summer of 1979 she moved to St. John's, NL, and worked in the case room at the S.A. Grace General Hospital. In September she started at Memorial University of Newfoundland where she taught and then also coordinated the midwifery diploma program. But, with University cut backs this program ceased in 1986. She then taught mainly basic undergraduate students. In 1996 the University offered a retirement incentive "package", which Pearl took. Pearl has been involved with the Association of Midwives in Newfoundland (AMNL formerly NLMA) since its formation in 1983. (The Atlantic Nurse Midwives Association, formed in 1974, had lost most of the Maritime midwives by 1980). Pearl was the Coordinator of the Canadian Confederation of Midwives (CCM) from 1993 to 1997. (The CCM later became the Canadian Association of Midwives (CAM) as midwifery legislation started to be implemented in Canadian provinces). Although Pearl is retired from paid employment, she is still endeavouring to keep her knowledge current and to promote midwifery as a good experience for childbearing women and their babies.

Formerly a practicing midwife in Edmonton, AB (both pre- and post-regulation), **Susan James** is now the director of the Midwifery Education Program at Laurentian University. Her doctoral research was a phenomenological study of relations between women and their midwives. In addition to this study, her current research is in the area of relational ethics, focusing on relations among health care providers and on interdisciplinary health issues in northern, rural and remote Canada.

Jane Kilthei is currently registrar of the CMBC, and was co-registrar of the College of Midwives of Ontario prior to moving to BC. She practiced as a midwife in Ontario for 15 years both before and after midwifery was regulated; Jane has a certificate in midwifery from the Michener Institute of Applied Health Sciences in Toronto. Involved in the movement to bring midwifery into the regulated health

care system in Ontario, Jane was president of the Association of Ontario Midwives when they negotiated the first funding contract and sat of the Midwives Liaison Committee to the Interim Regulatory Council, and the Committee Reviewing Ontario's Public Hospitals Act.

Michelle Kryzanauskas, RM, has been an active member on the Collaborative Maternity Care Committee of the SOGC, which secured Federal funding for a national multi-disciplinary (DR RM NP RN) model project. Michelle also sits on the Ontario Coroner's Obstetric Review Committee, where all maternal, fetal and neonatal loss is reviewed by a group of multi-disciplinary professionals.

Louise MacDonald was one of the last people to be apprentice-trained with the Association of Ontario Midwives (1986-1987). Lousie graduated from the Prior Learning Assessment program offered by the College of Midwives of Ontario in 2000, and has been practising midwifery in the Atlantic provinces for 17 years, primarily in Nova Scotia. Lousie has 4 sons- all born at home- and an incredibly patient husband!

Ami McKay is a writer of fiction, essays, musical theater, radio documentaries and dramas. Ami is a dedicated artist who brings creativity and passion to her work. With over fifteen years of experience in musical theater she has scored several productions including, *The Clouds, Mother Courage, A Midsummer Night's Dream* and *The Tempest.* She believes that the power and magic of a good story can only come through the strength of the characters, plot and place. Her work has been described as "a balance of stories, humour and thick grief, observation and internal musings, matter of factness and fancy." Her radio documentary for the CBC, *Daughter of Family G* won an Excellence in Journalism Award at the 2003 Atlantic Journalism Awards and her novel manuscript, The *Birth House* was awarded second place in the 2003 Atlantic Writing Competition. Born in Indiana, Ami has lived in California, Chicago and Nova Scotia. She currently lives in an old farmhouse in Scots Bay, the inspiration and setting for her first novel. She's an avid blogger and is an active member of Harping for Harmony as well as PEN Canada.

Heather Mains has been a doula, attending birth for 9 years and advocating on behalf of improved maternity services for over a decade in Canada. Her post-graduate Masters studies (York University 2003) included investigations into how women create ritual in order to birth their children in comfort and security. She incorporates the disciplines of Visual Arts with Anthropology, Religious Studies and Women's Studies. She writes, photo-documents, lectures and researches women's health issues, particularly maternal and newborn issues. She hears, and tells, many birth stories.

Lorna McRae, RM, BSc, MSW, is a full-time midwife in Hamilton Ontario. She worked as a social worker for 12 years in Toronto. She is moving to Vancouver Island where she plans to continue midwifery.

In addition to her current work with the Brown Birthing Network, **Nadine Mondestin** is also involved with The Village, a collective seeking to establish the social justice focused child care center in Montreal. Committed to women's rights, social justice and diversity, Nadine Mondestin will start a degree in Community Economic Development at Concordia University's School of Community and Public Affairs.

Kate Nicholl is Canadian, originally from Quebec. Kate completed her nursing training in Edinburgh, Scotland, and her midwifery training in Yorkshire, England. She then practiced on the west coast of Scotland in the 80's, where she was the first midwife to support women in the use of alternative birthing positions, and also organized a water birth, which in 1989 was one of the first in Scotland. Since coming to NB, she has been involved in studying health promotion, working for a housing project for pregnant and parenting teens, and advocating for community support for breastfeeding mothers. She has

recently worked as coordinator for the Prenatal Benefit Program in Saint John. Kate is the parent of a seventeen year-old daughter, and lives in Saint John.

Lisa Nussey, of Fredericton New Brunswick, has recently completed her second year of the Midwifery Education Programme at McMaster University. Her interest in the practice stems from a passion for women's health issues, particularly those surrounding reproduction. As a student at St. Thomas University in Fredericton, she was co-host of a weekly women's radio program, "F words and misconceptions". Upon completion of the MEP, or shortly thereafter, she hopes to return to her home province of New Brunswick to practice midwifery.

Joanne Przystawka RN, MScN, is a freelance community health researcher and registered nurse. Joanne has worked as a community health nurse in northern B.C. and in Ontario for two First Nations Community Health Centres as a primary health care nurse practitioner. Joanne attended the Second Attendant Orientation in the spring of 2004 and has recently filled a locum position as RN (EC) at Shkagamik-Kwe Health Centre in Sudbury. Joanne hopes that nurses, nurse practitioners, and midwives, among other health care professionals, can engage together to provide women with dynamic reproductive health care.

Karen Robb is Registered Midwife and Nurse (UK) who just moved to Halifax after practicing as an independent midwife for 1 1/2 years in St. John's, NL.

Judy Rogers' early work as a midwife was in the Annapolis Valley, Nova Scotia from 1973-1975. She then pursued formal midwifery education in England and graduated in 1978. She was a founding member of the Association of Radical Midwives in 1976, and practiced midwifery in hospital and community settings in England until returning to Canada in 1990. She is a partner in Midwifery Care - North Don River Valley and holds privileges at North York General Hospital and York Central Hospital. She is also an Associate Professor and Director of the Midwifery Education Program at Ryerson University. Judy's research interest is maternity care in rural and remote communities. She has also worked in Inukjuak, Quebec and Alert Bay, B.C. She was a participant in the successful SOGC application to the Health Canada Primary Health Care Transition Fund for the Collaborative Primary Maternity Care Project.

Susana Rutherford, coordinator and one of the founders of BORN, has spent many hours of volunteer time working on maternity care issues. She also had the most recent home birth in PEI. She is also an accomplished professional artist - a painter of wild and domestic animals. She outlined the Guidelines for Family Centered Maternity and Newborn Care (2000).

Christine Saulnier, PhD has been Senior Research Officer at the Atlantic Centre of Excellence for Women's Health (ACEWH) since July 2003. She returned to the Maritimes and joined ACEWH just after completing her doctorate in Political Science from York University. She is also Adjunct Professor in the Faculty of Health Professions at Dalhousie University and has created and coordinates the Midwifery and Women's Reproductive Health Programme at ACEWH. The broad objective of this programme is to support activities in the Atlantic region that will improve women's reproductive health. Its current focus is on improving maternity and newborn care services for women and specifically access to publicly-funded services of midwives. This work has to date focussed on forming partnerships in the region with groups and individuals are interested in working toward a health system where midwives would provide complete care during pregnancy, birth and postpartum for women in the Atlantic region. She currently sits on the Primary Maternity Care Working Group for the province of Nova Scotia, which has a mandate to make recommendations for the regulation of midwifery.

Lee Saxell - not available

Mary Sharpe is a registered midwife in Ontario. Over the last 30 years, Mary has worked as a teacher, childbirth educator, lactation consultant and midwife. She began attending home births in 1976 and since 1979 has been a practicing midwife in Ontario. In April 2004 she received her Ph.D. from the University of Toronto; her thesis is entitled *Intimate Business: Woman-Midwife Relationships in Ontario, Canada*. She is a faculty member in the Midwifery Education Programme at Ryerson University in Toronto. Mary Sharpe has six children and has had the privilege of being the midwife for five of her six grandchildren.

Katherine Side, Ph. D. is an Assistant Professor in the Department of Women's Studies, Mount Saint Vincent University, Halifax, Nova Scotia. Her areas of research include women's reproductive rights and rural community sustainability. She has experience in curriculum development and distance education instruction in the Midwifery Education Programme, Ontario. Katherine Side has been a member of the Midwifery Coalition of Nova Scotia for four years and has served on the Coalition's Board of Directors.

Amanda Sorbara is currently a midwifery student at Ryerson University. She has a background in Health Education and has worked in the area of midwifery advocacy in Nova Scotia.

Philippa Spoel is an Associate Professor in the Department of English at Laurentian University. She teaches and researches in the field of rhetorical studies. Currently, she is collaborating with Susan James on a SSHRC-funded research project entitled "The Textual Regulation of a Healthcare Profession: A Rhetorical Analysis of the Regulatory Documents Governing Ontario's Midwifery Profession." She is also the mother of two children born with the support of midwives.

Lainna Wheatley, BScM, MScM, has been involved in midwifery, both as a consumer and then, as a midwife, since 1980. She is currently a faculty member of the midwifery distance-learning program from the Midwives College of Utah and teaches midwifery clients childbirth education classes. She has been facilitating Second Attendant Orientations since August 2003 and working as a second attendant in the Okanagan area of British Columbia since July 2002. Lainna has enjoyed her work in underdeveloped countries such as Mexico and Jamaica involving birth and "well woman/family care" projects.

Beckie Wood is a Registered Midwife who practices full time at an inner city community health clinic in Winnipeg, Manitoba. She is on the Board of the Directors of the Midwives Association of Manitoba.

Heather Wood, RM, BA, BSc, is a full-time midwife in Hamilton Ontario. She worked pre-legislation as an apprentice midwife in Saskatchewan and as a public representative on the Government of Saskatchewan Midwifery Advisory Committee. She is currently the managing editor of the Canadian Journal of Midwifery Research and Practice.

Lela Zimmer – not available.

CONFERENCE PROGRAM

Thursday, July 22, 2004

8:00
Registration
McInnes Room
2nd Floor, SUB

8:30-9:00
McInnes Room

Welcome and Opening Remarks

David Gass, Chair, Primary Maternity Care Working Group & Director, Primary Health Care, Nova Scotia Department of Health

Welcome from the Prairie Women's Health Centre of Excellence

Many Women Still 'Have-Not': Moving the Midwifery Agenda Forward for All Women in Canada
Christine Saulnier, Conference Coordinator, Atlantic Centre of Excellence for Women's Health

9:00-10:30
Keynote Address
Midwifery: Global Trends and Transformations
Robbie Davis Floyd, Department of Anthropology, University of Texas

10:30-11:00
Nutritional Break
McInnes Room

11:00-1:00
Plenary Session
McInnes Room

Canadian Midwifery Implementation: Reflections on the Last Decade

Co-Chairs and Opening Remarks:
Christine Saulnier, Atlantic Centre of Excellence for Women's Health
Jane Kilthei, Canadian Midwifery Regulators Consortium

The Challenges of Midwifery Implementation in the Northwest Territories
Gisela Becker, Midwives Association of the NWT and Nunavut

Integrated into the System: Manitoba Midwives Speak Out
Beckie Wood, Midwives Association of Manitoba

Birthing Centres in Quebec: Ten Years of Community Midwifery,
Sinclair Harris, Maison de Naissance Lac-St-Louis, Pointe Claire, QC

1:00-2:00
McInnes Room
Lunch (Provided)

2:00-3:30
Concurrent Sessions

Concurrent Session 1
Room 307

Collaborative Primary Maternity Care Models for Rural and Remote Populations
Facilitator: Judy Rogers

Opening Talks
Judy Rogers, Midwifery Education Program, Ryerson University
Registered Midwife, Midwifery Care-North Don River Valley, Toronto, Ontario
Marion Alex, School of Nursing, St. Francis Xavier University

Small Group Work
Goal: *Identifying Essential Principles for Successful Collaborative Care Models*

Concurrent Session 2
Room 303

Critical Reflections on Regulation and the Changing Nature of Midwifery in Canada
Chair: Michelle Kryzanauskas

Legislated Midwifery in Canada: a Brand New Tradition
Lisa Nussey, Midwifery Education Program, McMaster University

From Calling to Career: Reconsidering the Essence of Social Activism in Midwifery
Betty-Anne Daviss, Registered Midwife, Ontario

A Comparative Examination of Regulated Midwifery Practice in Canada
Amanda Sorbara, Midwifery Education Program, Ryerson University

Concurrent Session 3
McInnes Room

Exploring Informed Choice: Multiple Perspectives
Chair: Jan Catano

Exploring Informed Choice from a Consumerist Perspective
Philippa Spoel, Department of English, Laurentian University

Exploring Informed Choice from a Student Perspective
Kirsty Bourret, Ontario Midwifery Education Program, Laurentian University

Exploring Informed Choice from a Midwife Perspective
Susan James, Midwifery Education Program, Laurentian University

3:30-3:45
McInnes Room
Nutritional Break

3:45 - 4:45
Concurrent Sessions

Concurrent Session 1
Room 303
What Evidence Counts? Whose Evidence Counts?
Chair: Shelly Martin

Measured to Death: Birth Beyond Randomized Control Trials (RCTs)
Heather Mains, Doula, Toronto, Ontario

Quality Assurance Practice Audits: The Fear Factor
Michelle Kryzanauskas, RM, Ontario

Concurrent Session 2
Room 307
Midwifery Education and Legislation in Ontario
Chair: Judy Rogers

Redefining the Clinical: Social Science Learning in Clinical Education
Nadya Burton, Midwifery Education Program, Ryerson University

Exploring Legislated Midwifery: Texts and Rulings
Mary Sharpe, Midwifery Education Program, Ryerson University

5:00-7:00
Free Time

7:00-7:30
McInnes Room
Ami McKay, The Midwife House (Open to the Public)

7:30 - 9:00
McInnes Room
Atlantic Premiere of "Singing the Bones"
Open to the public

Friday July 23, 2004
8:45 - 9:45
McInnes Room
Keynote Address
Aboriginal Midwifery in Canada: Reflections from a Manitoba Midwife
Darlene Birch, RM, Full Moon Lodge Midwifery Services, Winnipeg, Manitoba;
Member, College of Midwives of Manitoba
Member of **Kagike Danikobidan** - the Standing Committee to Advise the College on Issues Related to Midwifery Care to Aboriginal Women

9:45 - 10:00
Nutritional Snack
McInnes Room

Plenary Session
10:00 - 12:00
McInnes Room

Midwifery and Diversity: Building an Inclusive Midwifery Framework
Chair: Yvonne Atwell

Conflicting Demands: The Challenges to 'Accessible' Midwifery
Heather L. Wood, The Hamilton Midwives, & Lorna J. McRae, Community Midwives of Hamilton

Developing a National Assessment Strategy for Bringing Foreign-Trained Midwives into Registration in Canada
Jane Kilthei, Canadian Midwifery Regulators Consortium

Nadine Mondestin, Brown Birthing Network

12:00- 1:00
McInnes Room
Book Launch
Reconceiving Midwifery, Edited by Ivy Lynn Bourgeault, Cecilia Benoit and Robbie Davis-Floyd
(Published by McGill-Queen's Press)
Welcome and Introductions of Book Editors and Contributors
Lunch (Provided)

1:00 - 2:30
Concurrent Sessions

Concurrent Session 1
Room 307

Providing Collaborative Maternity Care for Marginalized Women
Chair: Mary Sharpe

Midwives Reaching Women in Priority Populations: An Inner-City Winnipeg Experience
Beckie Wood, Mount Carmel Clinic, Manitoba

South End Community Birth Program, Vancouver, BC
Lee Saxell, Department of Midwifery, Children's and Women's Hospital, Vancouver, BC

PrenataLink- Providing Collaborative Primary Care in Canada-a Comprehensive Pre and Post Natal Program for Immigrant Women, Women of Colour and Black Women from the Caribbean, Latin America, and Africa
Judith Andrade, Women's Health in Women's Hands, Toronto, Ontario

Concurrent Session 2
Room 303

Nurses, Doulas and Second Birth Attendants: Perspectives on Integrated Maternity Care in Canada
Chair: Betty-Anne Daviss

Community-Based Midwives and Hospital-Based Nurses: Seeking the Common Ground for Collegiality
Lela Zimmer, Nursing Program, UNBC

A Complement to Care: Midwives and Doulas Together - a Personal Perspective
Kelly Ebbett, Mount Sinai Hospital - Maternal Infant Program

Second Birth Attendants - A Training Model
Lainna Wheatley, British Columbia

Envisioning Doulas and Midwives as a Complementary and Collaborative Health Care Team
Hilary Marentette, Volunteer Doula Program, Single Parent Centre, Halifax, Nova Scotia
Leslee Blatt, Single Parent Resource Centre, Halifax, Nova Scotia.

Concurrent Session 3
McInnes Room

Role of Consumer Groups Pre-Midwifery Legislation
Chair: Cathy Ellis

Opening Talks

Storm Stayed: Sharing Lessons Learned from a Nova Scotia Consumer Group
Jan Catano & Katherine Side, Midwifery Coalition of Nova Scotia

The Critical Role Consumers Played in the Struggle for Midwifery in Ontario
Ivy Bourgeault, Health Studies Programme & Department of Sociology,
McMaster University

Confirmed Roundtable Participants:*
Sylvie Roy, Friends of Midwives, Saskatchewan
Sonia Lavictoire, Birth Roots Doula Collective & Manitoba Association of Student Midwives
Susana Rutherford, Birthing Options Research Network, Prince Edward Island

Goal: *Develop Strategies for Moving Forward and/or Improving Maternity Care Broadly*
*Other participants are welcome to join the roundtable

2:30 - 3:00
Nutritional Break
McInnes Room

3:00 - 4:30
Closing Plenary Session
McInnes Room

<u>Examining the Barriers to Regulation in the Not-Yet-Regulated Provinces</u>
Chair: Katherine Side

Opening Talk:
Cathy Ellis, Midwife, Regina, Saskatchewan
Joanne Havelock, Prairie Women's Health Centre of Excellence, Regina, Saskatchewan

Confirmed Roundtable Participants:*
Pearl Herbert, Association of Midwives of Newfoundland and Labrador
Joyce England, Prince Edward Island Midwives Association
Kate Nicholls, Midwives Association of New Brunswick
Louise MacDonald, Association of Nova Scotia Midwives

*other participants are welcome to join the roundtable.

Closing Remarks