Midwifery Policy in Ontario

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Executive Summary

> ***The practice of Midwifery is the assessment and monitoring of women during pregnancy, labour and the post-partum period and of their newborn babies, the provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries.*** (Midwifery Act, 1991--Section 3)

In November 1991, Ontario became the first province in Canada to grant legal status to midwifery. Proclamation of **Bill 56**, the **Midwifery Act (1991)**, was the culmination of a legislative process that had begun in 1982 with the creation of the **Health Professions Legislation Review** by the Ontario Minister of Health. The Review's mandate was to prepare draft legislation with respect to:

- which health professions should be regulated
- updating and reforming the Health Disciplines Act
- devising a new structure for all legislation concerning the health professions

In 1986, the Minister of Health announced that 24 health professions, including midwifery, would be granted self-regulation. The Review recognized that midwifery's questionable legal status had prevented it from evolving naturally; unlike the other professions that would be newly regulated, it functioned primarily outside the official health care system. Critical issues relating to the very nature of the profession and its role in the health care system would require resolution. The MOH adopted the Review's recommendation that a Task Force be created to investigate these issues. The **Task Force on the Implementation of Midwifery in Ontario** reported to the MOH in November 1987; the most significant of its 70 recommendations was that midwifery be regulated by a separate governing body.

The social, economic and political circumstances that allowed **Bill 56** to survive unscathed through eight ministers of Health and four governments constitute the main theme of this review. Issues and controversies surrounding the implementation of the **Midwifery Act** are discussed at some length.

Until 50 years ago, maternal mortality rates in Canada and the U.S.A. were close to those observed in the Third world today ~ 400-500/100,000 births. The dramatic decrease in mortality rates that occurred during the 1940s was attributed to antibiotics and blood banking, and the medical profession took full credit for these outcomes. In post-war North America, faith in technology was almost absolute: pregnant women were cared for by specialists, had no recollection of their heavily medicated hospital births, and they bottle-fed their newborn. Midwives had long since disappeared from urban areas; the few that remained had little formal training and attended the home births of those who could not afford medical care. In the early 1900s, the medical profession had waged a successful campaign against legalized midwifery: midwives were uneducated, provided a sub-standard level of care, and competed economically with doctors.

Renewed interest in midwifery surfaced with the social upheaval of the 1960s. Large numbers of middle-class youth explored alternate lifestyles. Self-help books proclaimed a client-centered holistic approach to health which clashed with the authoritarian, male-dominated medical model. The inflexibility of hospital policies led to planned home births and a consequent demand for trained birth attendants who sympathized with the aspirations of their clients. The latter were no longer the poor and disfranchised: they were mainstream, the sons and daughters of the solid middle class---the then-hippie, now-yuppie generation.

Midwifery advocates began to organize in Ontario during the 1970s. In 1973, the **Ontario Nurse-Midwives' Association** was formed within the **Registered Nurses' Association of Ontario (RNAO)**. The **Ontario Association of Midwives** was created in 1979 as a professional organization for midwives practising outside the legal system.

These two groups officially merged in 1984 under the name **Association of Ontario Midwives**. A parallel support group---the **Midwifery Task Force**[1]---emerged at the same time; organized into local chapters, it lobbied for official recognition of midwifery, raised funds, and published a newsletter.

Among the major stakeholders, medical organizations were opposed to the creation of a new, self-regulating profession. As late as 1987, the **Canadian Medical Association** believed that the demand for legalized midwifery was generated by a small number of very vocal supporters with media access. The **CMA** felt that consumer demands could be addressed by introducing more flexibility into the existing system. Nursing associations were supportive of midwifery, but wanted its practitioners to be nurses with additional training at the master's level, and regulated by the **College of Nurses of Ontario.** Midwifery advocates, including the **Ontario Association of Registered Nursing Assistants**, lobbied hard for self-regulation. They also favoured direct entry into a training program independent of the nursing and medical professions, as well as a *fast-track* for licensing existing midwives.

Politically, midwives found allies among feminist groups and the **NDP**. A Private Member's Bill to establish midwifery as a self-governing health profession was introduced in 1984 by **NDP** MPP Dave Cooke, but did not make it to second reading. The Progressive Conservative government was well-connected with the medical establishment and would not support this initiative. Ironically, the cause of midwifery was furthered by two well-publicized coroners' inquests---in 1982 and 1985---into the deaths of newborns following midwife-attended home deliveries. Both juries recommended that midwifery be regulated and integrated into the health system to protect the public. The surprise election of a Liberal-**NDP** coalition in the mid-1980s marked the ascendancy of the yuppie generation to political power, and finally gave the **NDP** agenda some political clout. Subsequent health ministers in the Peterson Liberal government were favourably disposed towards midwifery and the election of a majority **NDP** government in 1990 guaranteed the swift passage of **Bill 56** through the provincial legislature.

[1] Despite the similarity in names, this is NOT the Task Force on The Implementation of Midwifery in Ontario.

The **Midwifery Act (1991)** does not come into force until the **Interim Regulatory Council on Midwifery (IRCM)** has developed standards of practice and established criteria for the registration of existing midwives. Newly-registered midwives will elect a **Council of the College of Midwives**. The College will then take over responsibility for registration and regulation from the **IRCM**, and will have one year to set up a patient-relations program and three years to create a quality assurance program.

One or more universities in Ontario will develop an undergraduate program in midwifery. This will require the cooperation of faculties of Medicine and Nursing, both to ensure access to patients and to foster harmonious inter-professional relationships. The **Public Hospitals Act** needs to be amended for midwives to have admitting privileges, and individual hospitals will have to establish protocols governing the conditions under which midwives will operate within their jurisdiction. While it has been accepted that the cost of midwifery services will be covered by provincial government funding, neither the details nor the necessary legislation have been worked out. The presumed greater cost-effectiveness of midwifery remains to be demonstrated. Planned home birth, medico-legal liability and consumer choice remain among the controversial issues related to the implementation of midwifery.

Will recognition change midwifery? Once the first generation of midwives is replaced by new graduates, midwifery will assume the characteristics of any other profession. Its recruits will see it as a career rather than a vocation, and its members will practise a more standardized type of obstetrics. As midwives replace GPs and obstetricians and attend ever more babies, they will face the same time and place constraints: hallowed precepts of midwifery such as continuity of care will give way to call groups and shift work. *Plus ça change...*

The Midwifery Act (1991)

The government of Ontario policy on Midwifery is detailed in **Bill 56,** the **Midwifery Act (1991)**. This is a subset of **Bill 43,** the **Regulated Health Professions Act (1991)**. Both bills passed quickly through the Legislature, first reading on April 2nd, 1991 and Royal Assent on November 25, 1991. **Bill 43** lists 21 self-governing health professions and the regulations that are common to all. Each profession has its own Act that specifies the scope of practice and the *authorized acts* that can be performed by members of that profession. **Schedule 2** of **Bill 43**, the **Health Professions Procedural Code**, is part of each health profession Act; its 95 paragraphs spell out the composition and duties of the College that governs each profession. (See Appendix 1- Summary of Bill 56)

The Midwifery Act as Policy

A policy has several characteristics:

- it is proclaimed by an authoritative agency
- it deals with a specific subject
- it specifies rules of behaviour and provides guidelines for action
- there are enforcement clauses
- a formal assessment / evaluation mechanism exists

This legislation defines government policy on midwifery. It is both permissive and enabling, but does not specify the details of implementation. The transitional council (the **Interim Regulatory Council on Midwifery**) and the Ministry of Health have broad powers to *do anything that may be necessary or advisable for the coming into force of this Act.* The integration of Midwifery into the existing health system will require discussions with other jurisdictions: hospitals, universities and other health professionals.

Current Implementation of Midwifery

The Interim Regulatory Council on Midwifery was created in May 1989 by the Ontario government to advise the **MOH** on such matters as the development of standards of practice and the establishment of criteria for registration of midwives in Ontario. The **IRCM** became the official transitional council when **Bill 56** received Royal Assent on November 25, 1991. (Section 12).

Bill 56 will come into force once an initial group of midwives has been registered and a Council of the College of Midwives of Ontario (**CMO**) is elected. (Bill 56, Section 6) The Council will be the board of directors of the **CMO** and ensure that the College carries out its mandate as set out in Sections 3 and 4 of the Health Professions Procedural Code. (Bill 43, Schedule 2) The College will then assume responsibility for registration and regulation and the **IRCM** will be dissolved.

The **IRCM** has been guided in its work by the recommendations of the Task Force on the Implementation of Midwifery in Ontario.[2] Its final guidelines, however, are subject to approval by the Minister of Health, who has broad powers to enforce the spirit and letter of Bills 43 and 56.

Philosophy Statement

One of the first steps taken by the Interim Regulatory Council was to develop a philosophy statement embodying the spirit of midwifery care. (see Appendix 2)

[2] Hereinafter referred to as the **Task Force**

Licensing existing midwives: *grand mothering*

A key demand by midwifery advocates during their years of lobbying for recognition was the integration of practising midwives into the health system without having to undergo the full training program required for new entrants to the profession. The Norpark survey (Task Force, Appendix 3) estimated that at least 40 midwives planned to seek licensure after the legalization of midwifery. The Task Force recommended the creation of a Midwifery Integration Program.

Pre-registration Program for Experienced Midwives:

The Mitchener Institute for Applied Health Sciences (Toronto) offers a Pre-registration Program for experienced midwives currently practising in Ontario. This on-time-only educational opportunity is designed to ensure that practising midwives can meet the new provincial standard prior to certification and integration into the health-care system.

The program will reflect the list of required competencies in midwifery approved by the **Interim Regulatory Council on Midwifery** and the content and approach recommended by the Midwifery Curriculum Design Committee and the Midwifery Integration Planning Project.

Program faculty and evaluators will be drawn from midwives experienced in teaching and practice from other countries, and as appropriate, physicians, nurses and other health professionals from Ontario.

To provide an effective link between the program planners, faculty, the Interim Regulatory Council, an Advisory Council will be formed to assist the Mitchener Institute at each stage of program development and implementation. Membership will include consumer representatives, members of the Interim Regulatory Council, interdisciplinary representatives of relevant health professions in Ontario and representatives of the Association of Ontario Midwives.

Training of New Midwives

One or more universities in Ontario will develop an undergraduate program in midwifery. The Curriculum Design Committee has recommended that midwives obtain an undergraduate degree as a condition of registration. It is likely, however, that nurses holding a BScN would get advanced standing. A rationale for this educational requirement is to ensure greater status for midwives in the health care hierarchy. Even before the first Ontario midwife has been licensed, there is grumbling in nursing circles that RNs will not readily take orders from midwives. (Monk-Vanwyk, 1992)

Since there are no Canadian-trained academic midwives, the first teachers will necessarily be foreign-trained. The **Task Force** report does not specifically mention the roles that Faculties of Medicine and Nursing might play in the education of midwives, but the inference is clear that these faculties would not be directly involved in the educational programs.

COFM (Council of Faculties of Medicine) recommended that faculties of Medicine should have a direct involvement in the educational programs without the overall responsibility. Furthermore, **COFM** believes that faculty members should be selected from a broad disciplinary base and, in the case of clinical training, that faculty should be fully accredited in the country in which they received their training.

The **Task Force** report recommends that community hospitals with Level 1 and Level II obstetrical services, community health centres and physicians' offices be used to provide clinical placement sites. **COFM** supports this view, provided there is an opportunity for collaboration during the clinical training process with interns and/or residents, as well as family physicians and obstetricians. This position reflects the view that clinical instruction for midwives cannot take place in total isolation from the training provided to other members of the health care team, and sets the stage for effective collaboration among these groups in their later careers.

Hospital Privileges

The **Task Force** recommended that the **Public Hospitals Act** and regulations be amended to empower hospitals to appoint midwives to the hospital staff. Planned home births have been criticized by the medical and nursing establishments. It is likely that many such births could be avoided if patients could deliver in a hospital or birthing centre attended by the care provider of their choice. Hence a rationale for giving midwives full access to hospital facilities.

Such privileges would not be automatic. Individual hospitals will maintain the right to decide what services they will offer to the public. An application for privileges at a hospital with a midwifery ward would be subject to an *impact analysis*. Physicians currently undergo this process, which aims to assess the impact of a new doctor on hospital resources.

There will initially be turf wars and concerns about overlapping medico-legal liability on the part of doctors, nurses and administrators. Over time, as midwives demonstrate their competence and cultivate good interpersonal relations with allied professionals, they will assume their place in the health care system.

Why Midwifery Now?

Any major policy initiative prompts the question: why now? Who was pushing for change, and how were they able to achieve their goals at this particular time? The answer is as convoluted as the process: a concatenation of social, economic and political circumstances that, in the end, made midwifery in Ontario seem like *an idea whose time has come*.

The Current System of Reproductive Care

99.6% of pregnant women in Ontario deliver in a hospital (McCourt, 1986), attended at birth by a physician. In large cities, this doctor is likely to be a male specialist Obstetrician / Gynaecologist who follows over 20 patients a month, delivers 15-25% of them by caesarean section and another 10-20% using forceps or the vacuum extractor. After 2-5 days in hospital, the new mother goes home. Two weeks later she brings her new-born to the Paediatrician and, at six weeks, returns to her Obstetrician for follow-up and contraceptive advice. In smaller centres, a Family Physician is more likely to offer continuity of care through pregnancy, birth and the puerperium.

Routine ante natal care typically consists of 10-12 visits to the doctor. Most first time parents attend prenatal classes organized by local health units, hospitals or private childbirth education groups. Virtually all fathers are now present during labour and delivery.

Although the midwifery profession has not had legal recognition in Ontario for more than a century, midwives have continued to exist and approximately 50 are currently practising outside the health care system (Task Force, 1987). Whereas parents who sought midwives in the early 1970s belonged to the counterculture, the current clientele is mostly mainstream. The most frequently cited reason for seeking out a midwife, and perhaps also a home birth, is an unsatisfying previous birth experience.

Without medical insurance (current fees for midwifery care are in the $800+ range) or institutional backing, midwifery care remains a preferred option for only those who are willing, able and equipped to search out solutions for their personal needs. The current midwifery clientele has above average education, a middle-class income, and the time and inclination for both parents to get involved in a pregnancy and birth (Barrington,1985).

Consumer (dis)satisfaction

The writings of midwifery advocates are highly critical of North American birthing practices. The most gruesome and dehumanizing hospital births are paraded, and contrasted with the almost mystical experience of natural childbirth at home. Given the close links between the revival of midwifery in North America and the feminist movement, it is hardly surprising that most books and articles on ' natural childbirth 'bear an unmistakable anti-male/establishment bias.

Fifty years ago, pregnant mothers were frighteningly aware of the hazards of pregnancy, because maternal deaths were common (4-8/1000 in Ontario). Thus, former generations of mothers were content to survive pregnancy in good health, and seemed less occupied with emotional satisfaction. Obstetricians might have expected some credit for the enormous reduction in maternal and perinatal mortality rates. As it turns out, they find themselves discredited by international comparison, and often blamed for destroying the emotional satisfaction of mothers, and their sense of achievement in the normal delivery of a live baby. (Beazley and Lobb, 1983)

CMA Report

Obstetrics '87, a Report of the Canadian Medical Association on Obstetrical Care in Canada, summarized the criticisms directed at the existing system of birthing care:

There appears to be a common perception among the public that the current system of obstetrical services does not provide women with the quality of care they want and need. This perceived dissatisfaction has been well aired by vocal minorities, lobbying groups and the media, all of which has had a major impact on public opinion and politicians. This dissatisfaction is manifested principally in the following beliefs and concerns:

1. **That there is excessive medical intervention in hospital-based reproductive care.**
2. **That many hospital facilities provide a sterile and rule-encrusted environment for childbirth.**
3. **That there is not enough emphasis on the psycho social aspects of the birth experience, and few choices are available regarding alternative approaches to childbirth.**
4. **That obstetrical patients do not participate fully in decision-making about childbirth.**
5. **That little has been done in recent years to allay these concerns.**

Despite these concerns, no women of reproductive age in Ontario had been surveyed to determine their opinions on midwives and home births. Even the Task Force conceded that *how satisfied women are with the current system of reproductive care is very difficult to gauge.*

To answer the question of patient satisfaction, the CMA commissioned a survey of 2006 women who had delivered in the previous 24 months.

Conclusions:

- only 21 (1%) had sought the care of a nurse-midwife or lay midwife
- 95.7% were satisfied with their prenatal care
- 91.5% " " " " labour & delivery
- 89.3 % " " " " postnatal care
- the present structure and organization of obstetric care in Canada are achieving desirable and excellent results
- Canadian women have a high level of satisfaction with their obstetric care
- the present system of obstetric care in Canada has demonstrated the capacity to adapt to the changing needs of Canadian families

Philosophy of Childbirth

The midwifery debate is, in essence, a clash of value systems. How birth is treated in any society is a product of its culture, ideology, norms and expectations. The more childbirth is seen as a healthy event in the natural cycle of life, the more are midwives valued as birth attendants. It is perhaps not surprising that midwifery has been devalued most in North America, where the faith in medical science and technology is perhaps strongest.

What in northern industrialized cultures are considered 'alternative' forms of care in childbirth are the norm in most countries of the world. In contemporary Western society...birth is a medical crisis, the termination of a disease called 'pregnancy'. In Western culture, birth is perceived primarily in terms of the activity of the uterus and the acts of the attendants, rather than of a woman giving birth. She is the object of care and the essential action can proceed without her cooperation, and even despite her. If we view birth in other societies exclusively in terms of perinatal mortality statistics it is impossible to understand the dynamics of human behaviour in childbirth. (Kitzinger, 1989)

Midwifery advocates tend to have a different perspective on:

Perception of Risk

While the existence of risk to mother or baby is acknowledged, it is perceived to be very small compared to the benefits of a midwifery approach to childbirth. Advocates mistrust technology, believing that the new hazards resulting from increased intervention in the birth process are at least as serious as those occurring naturally. They are more likely to accept bad outcomes with resignation. This is discussed further in the context of home birth. (page 32)

Process vs. Goal Orientation

Many women, probably the large majority in North America, view childbirth with apprehension and see it as a process to be endured, a means to an end. Natural childbirth advocates are more akin to triathletes: they view labour as a challenge to be met, a triumph of mind over matter. In the more zealous, this belief in spirit over body is bolstered by an unwavering, quasi-religious faith that, given time, Nature will always do the right thing. "Successful" parturition confers spiritual benefits that go far beyond the mere birth of a child. Conversely, inability to complete the process without analgesia or other medical intervention after such a large investment of ego energy, can lead to profound loss of self-esteem, guilt and the attribution of blame to partners and care givers.

Historical and Social Factors

From the earliest times, women have helped each other during childbirth. In all cultures, certain individuals were recognized as possessing special skills and experience in the matter of parturition. *The midwife orchestrated the events of labour and delivery, and the woman's neighbours and relatives comforted and shared advice with the parturient* (Leavett & Numbers, 1985). *Nature, however, is not always a reliable ally, and the natural course of spontaneous labour may vary considerably, not infrequently proving to be quite dangerous to both mother and the baby* (Beazley & Lobb, 1983). *The prospect of a difficult birth led women to seek out practitioners whose obstetric armamentarium included drugs and instruments* (Leavett & Numbers, 1985). *The invention of the forceps is generally acknowledged as the crucial factor in the rise of men to dominance as caregivers at birth* (De Vries, 1989). By the 19th century, the *man-midwife* was well-established in Europe and the U.S.A. as a consultant in difficult childbirth, and was the usual attendant at the labours of the well-to-do. As physicians became the preferred attendants of the upper classes, midwives came to be associated more and more with the lower classes.

In Canada, an 1865 Statute of the Province of Canada placed midwifery under the jurisdiction of licensed medical practitioners. By 1897, physicians attended 84% of the registered births in Ontario and midwives disappeared from urban Ontario around the turn of the century (Oppenheimer, 1983). American physicians rejected the European idea of upgrading midwifery through education and actively campaigned for the elimination of midwives: on the grounds that they provided an inferior type of care, and because they competed economically with physicians. (Ziegler, 1913) As physicians replaced midwives as the pre-eminent caregivers at birth, the place of birth shifted from home to hospital. Advances in anaesthesia, blood banking and the discovery of antibiotics led to a 25-fold decrease in maternal mortality during the 1940s and 1950s. Faith in medicine was never as great, and doctors enjoyed an unprecedented amount of public confidence during this era.

This idyllic state was shattered in the 1960s: this was the decade of disillusionment with authority in general, and medicine in particular. Middle-class youth experimented with alternate life styles. A vanguard of young parents began seeking a more fulfilling experience of birth than the medical system could offer. The first ' new midwives ' emerged from among these questioning parents.(Barrington, 1985) Many were helped with their births by a small number of nurse practitioners/midwives who has gained firsthand experience caring for expectant and labouring women while working in federally funded community health programs for the ' medically under-served ' These lay and professional birth practitioners were joined after 1968 by returning Peace Corps members who had acquired experience with birth in Third World countries. Midwifery got its foothold in most communities because hospital policies clashed with parents' wishes. (Barrington,1985) By the mid-1970s, the diverse branches of the patients' movement were united on several points. They agreed that obstetric interventions were often unnecessary, dangerous, and poorly investigated prior to widespread use. They also agreed that parents should have the right to select the place of birth and should be free to choose among different types of care and caregivers; that parents should be offered full disclosure of the unknowns, and the risks, benefits, and alternatives to any perinatal care proposal. (Shearer, 1989)

Economic and Medical Manpower Factors

Whether to license para-professionals is sometimes not thought of as political since most of the people who argue against midwifery do so on medical grounds. Yet the licensing of midwives is an economic and political question for it will affect the remuneration of doctors and the bargaining power of those doctors in determining future fee schedules and capital purchases for hospitals, etc. (McCready DJ, 1987)

Cost Effectiveness of Midwifery Care

Supporters of midwifery claim that midwifery care is more cost-effective than physician care. This is said to be so because midwifery education will be less costly than medical education, because midwives will be paid less than physicians, because midwives rely less heavily on expensive electronic monitoring, tests, medication, and because midwives' clients remain in hospital for shorter periods of time after giving birth. (Task Force, 1987)

A 1983 Quebec study calculated that each birth attended by a midwife would cost $270 less than an MD-attended birth. This estimate was based, however, on the assumption that midwives would be paid the same as nurses, and would attend two births a week.

The Task Force recommended that, to provide the intensive antenatal and intrapartum continuity of care that are the hallmarks of midwifery, it would be difficult for midwives to attend more than 70 deliveries per year. At current OHIP rates, an MD receives approximately $650 for total obstetric care of a low-risk gravida. A midwife paid at this rate on a fee-for-service basis would earn $45,500 annually, which is in the range of what experienced RNs and teachers earn, but without any benefits such as holidays, sick leave, pension plan etc. Midwives currently charge clients over $800 for their services, and have very little overhead compared to MDs. The average obstetrician, usually sharing call with other MDs, will attend > 250 births annually. Thus, it would take at least three to four midwives to provide the same volume of service as one MD.

If midwives are salaried, hospitals or other health care organizations must provide them with clinic space, equipment and personnel. Such expenses, in addition to the start-up and maintenance costs of the College of Midwives and university training programs, must be factored into any calculations on the presumed economic advantages of midwifery.

It is thus premature to predict that cost savings will result from the integration of midwifery in Ontario. (Task Force, 1987)

Medical Man(Person)power Factors

Observed trends in medical manpower provide support for the legalization of midwifery. Issues of lifestyle, remuneration and litigation have precipitated the exodus of obstetricians and family physicians willing to care for pregnant women. Midwives are being permitted "in" as the traditionally male-dominated system breaks down. (Monk-Vanwyk, 1992)

Women now make up approximately 50% of new medical graduates. They are less willing to sacrifice family for career than female physicians of previous generations. Most marry other physicians or professionals, work fewer hours than their male counterparts and, if they are family practitioners, find it difficult to reconcile the demands of a young family and their regular office practice with those of an obstetric practice.

In urban areas, family practitioners---male and female---are rapidly abandoning obstetrics. They may continue to provide some antenatal care, but transfer most of their patients to obstetricians for delivery. However, the average age of practising obstetricians is increasing. In Windsor, for example, the three youngest and busiest obstetricians are leaving for the U.S. in response to the salary cap imposed last year. All ten remaining obstetricians are over 50. It is also well-known that, with age, obstetricians do more gynaecology and less obstetrics.

The number of applications to Obstetric training programs is declining; furthermore, a large majority of applicants to Ob/Gyn training programs are now women. Most plan to marry and have a family and the majority are interested in sub-specialty practice in a University centre. This means fewer specialists who do high volume obstetrics. Midwives are needed to fill the gap.

Political Factors

Theory

In a modern pluralistic society, heretics are no longer burned at the stake or thrown to the lions. In the health field, *professional bodies have the right to, and routinely do, forbid private individuals from entering into mutually acceptable contracts, if they judge that such contracts involve professional practice by unlicensed individuals, or improper practice by licensed ones. And they have the power to call in the police and the full coercive apparatus of the state to enforce their decisions. To suggest that such power is not political, is either naive or dishonest. Such powers are, of course, delegated by statute, and may equally be modified or removed by statute. But some spokesmen for professional associations appear to claim that professional bodies have a special right to be consulted, and to advise, on the statutes themselves, and that passage or revision of a statute without their approval is somehow illegitimate....de facto political realities have given professionals a remarkable degree of influence over the regulatory process, particularly as it touches their own professional and economic interests. The politicisation of health care represents competition by other interests for some share of this influence, and professionals are as hostile to political competition as to economic.* (Evans R G, 1987). Thus, counter-culture groups may be threatened with legal action by the establishment, but the publicity only serves to disseminate their views and attract new converts. Formal advocacy groups are formed when a critical mass of true believers is achieved. The next steps are media access, which in turn puts pressure on politicians. Implementation becomes inevitable once supporters include cabinet ministers.

Ontario Politics

Chronology

1970s-early 1980s: The Progressive Conservative government of Ontario, had strong ties to the medical establishment: Senior ministers Dr. Betty Stephenson (former president OMA), Dr. Robert Elgie (a neurosurgeon) and Roy MacMurtry (brother of an influential Toronto Orthopaedic surgeon).

1973: Nurse-Midwives Association of Ontario formed within the Registered Nurses' Association of Ontario. These nurses had obtained formal midwifery education outside Canada, mainly in Britain. The Association lobbied within the RNAO to achieve recognition for midwifery, consciously focusing its efforts on other nurses rather than on the public and government.

1979: A group of midwives formed the Ontario Association of Midwives. Most its members had learned their profession by a combination of self-teaching, apprenticing to other midwives, and accompanying physicians to home births.

1982: An inquest was conducted into the death in Kitchener, Ontario, of an infant whose birth involved a midwife. The OAM retained a prominent lawyer to represent it at the inquest. The jury recommended that the College of Physicians and Surgeons and the College of Nurses set up standards for midwives and establish a program of study in midwifery leading to licensing in Ontario. The inquest rallied and politicized the midwives, who realized that they needed to articulate standards of practice and education for themselves and become more sophisticated in their dealings with the public.

1983: The College of Physicians and Surgeons of Ontario issued a statement to its members expressing strong disapproval of home births. Thus, most of the physicians in Ontario who had been attending home births stopped doing so and patterns of midwifery changed accordingly.

1984: The Ontario Nurse-Midwives' Association and the Association of Ontario Midwives officially merged under the name Association of Ontario Midwives. The work the associations did for the Health Professions Review paved the way for the merger. Because it was felt that the AOM, as the midwives' professional association, should not have consumers in its membership, the Midwifery Task Force was formed at the same time. Organized into local chapters across Ontario, it serves as a support group for midwives, lobbying for official recognition of midwifery, raising funds, and publishing a newsletter.

The midwives pressed their case for recognition with members of the Ontario legislature. Partly because of their efforts, Dave Cooke, an NDP MPP, introduced a private member's bill to establish midwifery as a self-governing health profession under the Health Disciplines Act. In November 1984, Mr. Cooke moved a 2nd reading of the bill. Some members of the legislature opposed the bill and no vote was taken on it.

1985: Publication of *Midwifery is Catching*, a popular book by journalist Eleanor Barrington about midwifery and its status in Canada. This book sold well and spread the midwifery message to the public.

In October 1984, a baby boy died 2 days after his birth at home, attended by midwives. An inquest was held in Toronto and the jury recommended that midwifery be legalized and incorporated into the health care system, to protect the public.

1985-1990: After years in opposition, the surprise election of a Liberal-**NDP** coalition marked the ascendancy of the yuppie generation to political power, and finally gave the **NDP** agenda some political clout. Health ministers in the subsequent majority Liberal government were favourably disposed towards midwifery and the election of a majority **NDP** government in 1990 guarantied the swift passage of **Bill 56** through the provincial legislature

The Major Stakeholders and their Views

Ontario Hospital Association

86 Ontario hospitals responded to an OHA survey on midwifery in preparation for its submission to the Task Force. Most agreed that midwives, practising in cooperation with physicians in hospitals, would play a positive role in the further development of a family-centred approach to maternity care. 97% of hospitals expressed a preference for midwives with a nursing prerequisite. However, they were flexible regarding the level and form of education of midwives if they were competently trained. Most hospitals recommended that midwives be regulated through the College of Nurses. The **WHO** definition of midwifery (Appendix 3) was acceptable to most of the hospitals. The **OHA** believes that hospital boards must be free to make decisions on the feasibility of introducing midwifery practice and how the service should be provided. Hospitals were more receptive to birthing centres than home births as an alternative to hospital birth. Liability insurance for midwives was a major issue. **OHA** believed that in the long run midwifery could prove to be cost effective: *the turn towards family centred maternity care, the use of midwives and less dependence on medical intervention could reduce costs in the long term.*

Medical Associations

College of Family Physicians (Ontario)

Rejected the WHO definition of midwife, or any other definition which extended the midwife's role into the field of gynaecology, family planning and child care.

Canadian Medical Association

1987 Policy: *The CMA does not support the establishment of midwives as an autonomous health care profession. A detailed study of obstetric care by the association indicates that the present system contains all the resources and personnel required to provide the highest quality of obstetric care to Canadian women.*

The CMA recognizes the major contributions of obstetric nurses and believes nurses could be trained to assume more obstetric care responsibilities

under the direction of physicians. The possibility of licensing midwives is being studied in some jurisdictions in response to political pressure from a small vocal minority. It is estimated that fewer than 2% of women in Canada who have given birth have sought the services of midwives.

The CMA feels that without close medical supervision, problems beyond the scope of midwives' training could go unrecognized or that unexpected medical emergencies, which may develop during labour and delivery, would not receive appropriate attention. Moreover, to fulfil their mandate to protect themselves from litigation, hospital boards would likely require that a midwife have immediate medical back-up, which would pose an increased financial burden on the system.

Ontario Medical Association

1984 position statement

1. Needs of pregnant women throughout the course of pregnancy are changing. These needs could be addressed by hospital and office-based services through strong OMA advocacy:

    - of effective measures to maintain and enhance the GPs role in providing family-centred reproductive care
    - of family-centred maternity care in all hospital obstetric units
    - to maintain and improve the safety record of hospital births for both mother and child
    - of a more active role for nurses
    - in providing continuity of care during pregnancy, including labour
    - by enhancing their supporting, caring skills
    - in performing medical procedures and deliveries

2. Alternatively, the government may attempt to meet these needs by introducing midwives as a new health care worker and by allowing an alternative system to develop. If this is the government's decision, the OMA recommends:

    - high standards of training and practice
    - integration with the present health care system and its providers
    - evaluation, including cost effectiveness
    - women continue to have a choice of medical providers for their reproductive care

3. Whether government chooses the route of a new, alternative system or seeks to change the existing approach,

- midwifery should be defined in legislation
- the result will be increased expenditure
- the details of legal responsibility, the litigation process and malpractice insurance must be addressed

Nursing Associations

The nursing profession, although supportive of the introduction of midwifery in Ontario, was divided on the issue of necessity of a nursing prerequisite for midwifery and the issue of whether midwifery should have a separate regulatory body.

College of Nurses of Ontario

Midwifery should be recognized as a specialty of nursing under the **CON**. The College felt that midwifery should be regulated to protect the public. The **CON** felt that preparation should be at the Masters' level.

Registered Nurses Association of Ontario (RNAO)
Ontario Nurses' Association (ONA)

Both supported the view that midwifery is a subspecialty of nursing and that midwives should be trained in nursing and regulated by the **CON**.

The minimum entry requirement into the practice of midwifery should be basic registered nursing education with advanced preparation in midwifery.

RNAO *supports midwifery but does not support planned home birth. While the midwife is often the birthing attendant of choice for low-risk women, it is preferable that birth occur in a hospital or facility equipped to handle obstetrical emergencies. Midwives must be given the opportunity and privilege to work in such settings.*

ONA and **RNAO** saw midwives as practising only in hospitals and community settings. They did not endorse independent practice.

Midwife Associations

Association of Ontario Midwives

The midwives view birth as a normal process. Although they state that they are committed to a scientific evaluation of obstetrical and midwifery practices, they reject much of the medical model of maternity care and the injudicious use of technology. They submit that the midwifery model is based on a holistic approach of care which includes emphasis on continuity of care, informed choice, educational counselling and the appropriate use of technology. The midwifery model incorporates both a different philosophy and different practices from those of the medical and nursing professions.

AOM recommended a 4-year university degree. Many midwives felt that it was essential that midwifery be taught largely by midwives rather than by academics or members of other professions. Almost all midwives indicated that currently practising midwives must be integrated into the system without having to do a full midwifery course. **AOM** recommended that midwifery be structured as a self-regulating profession. All endorsed the **WHO** definition of midwife. Most midwives were supportive of planned home birth as a consumer choice. They wished to have a choice of practice location, including the right to independent practice. Most felt that fees should be paid by **OHIP**.

Educational Institutions

Council of Ontario Faculties of Medicine (COFM)

The views of **COFM** were summarized on page 10 of this review.

Consumer and Women's Groups

Consumers' Association of Canada (Ontario)
Association of Concerned Citizens for Preventative Medicine
Midwifery Task Force (9 Ontario chapters)
Ontario Coalition for Abortion Clinics
R.E.A.L. Women of Canada

All these groups were supportive of an independent profession of midwifery, and all took the position that the birth experience should be the choice of the informed mother. They endorsed the **AOM** positions.

Problems and Controversies of Implementation

Consumer Choice

Canadian health policy has always maintained the patient's right to choose his/her physician. The **Regulated Health Professions Act (Bill 43,1991)** enshrines this principle in Section 3: ***It is the duty of the minister to ensure that...individuals have access to services provided by the health professions of their choice.***

Given the choice, a large majority of patients in Ontario will elect to see an obstetrician/gynaecologist or a paediatrician rather than a family practitioner. (personal observation) Market factors dictate the pattern in different locations: where there are few specialists, the latter will accept patients only on referral by a GP, because consultations are both more lucrative and clinically more interesting. In large cities, with a glut of specialists, the latter do a lot of primary care and patients have a choice of practitioner.

It is well recognized that many of the tasks currently done by GPs and specialists could be performed just as well by less trained (*ergo* cheaper) personnel. On economic grounds, it is not inconceivable that future governments will institute a hierarchical system of access to the health care system.

It would be ironic if midwives---who lobbied hard for the consumer rights of a small minority---became the gatekeepers of a system that prevented large numbers of clients from having the "high-tech" birth of their choice.

Framework of Practice and Remuneration

The Task Force recommended that no midwife be permitted to practise except in a practice, service, agency or other health facility approved by the Ministry of Health. The Ministry of Health was advised to provide funding based on global program-based budgets to approved institutional and community-based midwifery practices and services, including those proposed by individual midwives, groups of midwives, multi-disciplinary groups, boards of health, community agencies, physicians and hospitals.

Midwives would be prohibited from seeking or obtaining payment directly or indirectly from clients. They would be permitted, however, to charge fees for childbirth education classes.

The role of the solo independent midwife is not made clear. Any salaried or global budget approach to funding would necessarily be linked to performance or productivity criteria which may not be appropriate for a given practitioner. Fee-for-service may be a better choice in these cases.

Home birth

There are at least 6 major hazards which can occur in 'low risk' labours. All of them are acute obstetric emergencies, which are both unpredictable and extremely hazardous. Each hazard assumes its greatest proportions where medical aid and hospital facilities are limited, or not available:

Apnoea in the new-born
Foetal Distress
Post-partum haemorrhage
Prolapsed umbilical cord
Retained placenta
Shoulder dystocia

These emergencies are recognized by even the strongest advocates of home confinement. Barry (1980) admits that three maternal deaths at home, due to postpartum haemorrhage, had no contraindication to home confinement!

> ***Obstetricians are advised to organize randomized, controlled studies to evaluate the relative risks of selected home confinement versus hospital confinement. One may as well question whether such a trial was ever organized to evaluate the parachute. Surely, there is no need for more maternal deaths from postpartum haemorrhage to demonstrate but one of the serious risks of home confinement. The continued existence of the Obstetric Flying Squad is evidence of the unexpected and serious nature of obstetric emergencies. Moreover, the existence of the Obstetric Flying Squad should not be viewed as a safety net for home confinement. It is an attempt to rescue the unforeseen emergency. The obstetrician take the view that unforeseen deaths are not the same as unavoidable deaths.*** (Beasley & Lobb, 1983)

Clearly, we are dealing here with a philosophical problem: one of perceived risk. If the incidence of a serious complication in low-risk births is, for example, 1/1000, then a midwife attending 50 births a year would see the problem only once every 20 years. In her eyes this is indeed rare! Such "bean counting" is valuable for actuaries, debaters and health care planners, but offers meagre consolation to the next-of-kin.

Physician and nursing organizations are strongly opposed to home births by either midwives or physicians, except when hospital-based care is unavailable. The **C.M.A** believes that home births do not allow for optimal maternal and foetal health care. Planned home births expose neonates and mothers to unnecessarily high risks, and the **C.M.A** considers the practice both retrogressive and irresponsible. The **O.M.A** Committee on Reproductive Care (1985) believes that the responsible reply to those advocating planned home birth is to offer a uniformly safe and satisfying birth experience in Ontario hospitals or birthing centres.

The **IRCM** in its Philosophy of Midwifery Care statement (Appendix 1) states that *midwives are willing to attend births in a variety of settings, including birth at home.* The Task Force recommended that the College of Midwives prepare a home birth protocol covering assessment of risk and contraindications to home birth. It also opposed the creation of a *flying squad network* in Ontario and suggested that parents and caregivers take responsibility for ensuring that transportation be available during labour if necessary.

Liability Insurance

Modern medicine's success in diagnosing and treating a wide variety of conditions has led to a societal expectation of a guarantied perfect outcome in obstetric care, regardless of the known risks of any particular medical intervention. The reward system gives few points for avoiding unnecessary intervention but applies heavy sanctions for missing rare, but serious problems. (Klein, 1986)

The Task Force recommended that liability insurance be mandatory for practising midwives. This is based on three considerations:

1. Midwives practise autonomously within their scope of practice. While they will collaborate with physicians, they will not be supervised by them. They will be primarily responsible if something goes wrong. Accountability is concomitant with responsibility.

2. Unless midwives are insured, some physicians will not feel free to consult with them or accept referrals from them, for fear their own liability will be increased.

3. Hospitals, which require the physicians who practise in them to have insurance, are unlikely to grant privileges to uninsured midwives.

Ideally, the obstetrician and the midwife should maintain very clear lines of responsibility. If the midwife is sued together with the obstetrician, and if it can be shown that they are both at fault, the doctrine of joint and several liability may apply. For example, if a court were to find that the midwife was 90% at fault and the obstetrician was 10% at fault, the doctrine of joint and several liability would require that the obstetrician satisfy 100% of the judgment if the midwife, either personally or through her insurer was unable to pay the midwife's proportionate share of the judgment. Clearly, the 'shared care ' situation is to be avoided. (Colangelo, 1986)

Most physicians belong to the Canadian Medical Protective Association (**CMPA**). This non-profit organization is run by physicians on their behalf and offers both advice and legal counsel in cases of real or potential medico-legal liability. Annual premiums are based on risk category as determined by actuarial considerations, and are adjusted to maintain the organization's solvency. This is obviously less expensive than relying on private carriers for coverage. Also, all physicians in good standing with their college are eligible.

The **CMPA** provides a good model for midwives, but is unlikely to be feasible until many midwives are registered and practising in Ontario. Because of their style of practice, and the low-risk nature of their clientele, it is expected that midwives are less likely to be sued than MDs. However, until real data are available, it is questionable whether private insurance companies will want to insure members of a new profession. Midwives employed by hospitals or other health care organizations may well be insured under their employer's policy. This, however, may compromise midwives' status as independent professionals.

Role of Family Practitioners in Obstetrics

In 1976-77, 46.9% of deliveries in Ontario were attended by family practitioners; by 1982-83, the percentage had dropped to 36.9%. and the decline has continued ever since. Some causes of this downward trend have been identified: (OMA, 1984).

- **lack of role models during training**
- **interference with home or family**
- **inadequate fee structures**
- **high malpractice premiums**

This trend places more pressure on obstetricians and supports the need for midwives.

The College of Family Practitioners is concerned that midwives will effectively remove family doctors from obstetric and newborn care and get involved in routine gynaecology.

Role of Nurses in Obstetrics

Nurses provide care to patients in labour and postpartum under the direction of a physician. They do not deliver babies except in an emergency. They are bound by many hospital protocols.

Nursing associations lobbied hard for midwifery to be under the *aegis* of the College of Nurses. However, legislators felt that midwives *who are nurses would be too accepting of the hierarchical way in which hospitals are run. [They] ...would not have the flexibility of independent professionals*. (Task Force, 1987)

The Association of Ontario Midwives states that, for the midwife's client, nurses would be present during the second and third stages of labour to assist in monitoring foetal heart tones, maintaining records and assisting with newborn care. (**AOM** Newsletter #3, 1990)

This sets the stage for confrontations between midwives and case room nurses: *It seems midwifery has staked out its turf and expects nursing to respect the boundaries. While the midwife is there to serve and care for her client, nurses might wonder if their role won't be to serve and care for the midwife.* (Monk-Vanwyk, 1992)

Scope of practice

The Task Force recommended that Ontario enact a Midwives Act in which the midwife's scope of practice was consistent with the international definition of midwife. The **WHO** definition of midwifery includes "the work...extends to certain areas of gynaecology, family planning and child care."

Section 3 of The Midwifery Act does not include these areas in the scope of practice of Ontario midwives. **Section 4(4)** authorizes instrumentation during the post-partum period, and presumably could be interpreted as allowing midwives to insert IUDs or fit diaphragms. **Section 4(7)** gives the authority to prescribe drugs designated in the regulations; the College of Midwives could presumably allow midwives to prescribe the BCP, antibiotics, analgesics, although the latter would require changes in the Food and Drugs Act. It is also unclear whether midwives would receive sufficient training in these areas.

Any extensive activity in the areas of gynaecology, family planning and child care would bring midwives into conflict with family practitioners and gynaecologists.

The Task Force suggested that the standards of practice for midwives incorporate a minimum of two mandatory medical visits during pregnancy, as well as criteria for consultations with and referrals to physicians. The standards should clearly differentiate between consultations for advice, consultations for advice and treatment, and transfers of care. If midwives are adequately trained, the obligatory medical visits will be redundant and increase utilization costs. In locations where inter-professional relations are adversarial, the client may receive suboptimal care. The College of Midwives and the College of Physicians should create a joint committee to address complaints from patients, midwives or physicians.

Conclusions

Midwifery has finally arrived. Whether physicians like it or not is now irrelevant. The smooth integration of midwives into the health care system will require an uncommon degree of cooperation between the various professional bodies concerned. In the clinical setting, there are bound to be frictions between professional groups competing for status or patients, and individuals who put ideology ahead of good health care. Where patient welfare is compromised by intransigence, the Minister of Health may have to intervene on an *ad hoc* basis and propose such amendments to the Regulated Health Professions Act as may be indicated.

Will official recognition change midwifery? Once the first generation of midwives is replaced by new graduates, midwifery will assume the characteristics of any other profession. Its recruits will see it as a career rather than a vocation, and its members will practise a more standardized type of obstetrics. As midwives replace GPs and obstetricians and attend ever more babies, they will face the same time and place constraints. Hallowed precepts of midwifery such as continuity of care will give way to call groups and shift work. *Plus ça change...*

References

Barrington E, *Midwifery is Catching*, NC Press Limited, Toronto 1985

Barry J, Roy. Coll. of Gen. Pract 30:102-107,1980

Beazley JM and Lobb MO, *Aspects of Care in Labour*, 1983, Churchill Livingstone

Buckley S, in Essays in the History of Canadian Medicine, McClelland & Stewart 1988, p. 156, Toronto

Clarke J N, *Health, Illness and Medicine in Canada*, McClelland & Stewart, Toronto, 1990

Colangelo J, Counsel for McCarthy & McCarthy, letter to Mr. John Krauser, Associate Director Health Services OMA, 1986)

Council of Ontario Faculties of Medicine (COFM) - Commentary of COFM Task Force on Midwifery Education to the Report of the Provincial Task Force on the Implementation of Midwifery, November 1987

DeVries RG in *Effective Care in Pregnancy and Childbirth* Vol. 1 p. 143-161 Ed. by I. Chalmers, M. Enkin, M. Keirse, Oxford Univ. Press 1989

Evans R G, in Health *Care in Canada: Looking Ahead,*

Gaskin IM, *Spiritual Midwifery*, 1978, The Book Publishing Company, Summertown, Tennessee

George J, in Health *Care in Canada: Looking Ahead,*

Kaufman K, The Implementation of Midwifery in Ontario, Ontario Medical Review, p.9-12, Nov 1991

Kinch RAH, Midwifery and Home Births. CMAJ 135(1986)280-281

Kitzinger S Childbirth and Society in *Effective Care in Pregnancy and Childbirth* Vol. 1 p. 99- 109 Ed. by I. Chalmers, M. Enkin, M. Keirse, Oxford Univ. Press 1989

Klein MC, Can Fam Physician 32:533-540,1986

Leavitt J W, Numbers R L: Editors; *Sickness & Health in America* (1985) Chapter 6, U. Wisconsin Press

Madeleine H. Shearer in Maternity patients' movements in the United States 1820-1985 in *Effective Care in Pregnancy and Childbirth* Vol. 1 p. 110-130 Ed. by I. Chalmers, M. Enkin, M. Keirse, Oxford Univ. Press 1989

McCourt C Legalization of midwifery and the issue of home births. CMAJ,135(1986) 285-288

McCready D J, in Health *Care in Canada: Looking Ahead,*

Monk-Vanwyk D, The Canadian Nurse, February 1992, p. 15-18

Oakley A, *The Captured Womb*, Basil Blackwell 1984

Ontario Medical Association:

1. Discussion Paper on Directions in Health Care: Issues Relating to Childbirth---April 1984
2. Issues in the Implementation of Midwifery, 1988. Subcommittee on the Implementation of Midwifery

Ontario MOH Advisory Committee on Reproductive Care in a paper entitled 'Strategy for Dealing with Changing Trends in the Delivery of Reproductive Care', June 1984,

Oppenheimer J, *Childbirth in Ontario: The Transition from Home to Hospital in the Early Twentieth Century*, Ontario History 75 (1983) 36-60.

Report of the *Task Force on the Implementation of Midwifery in Ontario*, 1987

Ziegler CE, The Elimination of the Midwife, J.Am.Med.Assoc., 60 (1913) 32-38

Appendix 1

Summary of the Midwifery Act (1991)

Section 3 (Scope of Practice):

The practice of Midwifery is the assessment and monitoring of women during pregnancy, labour and the post-partum period and of their newborn babies, the provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries.

Section 4 (Authorized Acts):

In the course of engaging in the practice of midwifery, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

1. **Managing labour and conducting spontaneous normal vaginal deliveries.**
2. **Performing episiotomies and amniotomies and repairing episiotomies and lacerations, not involving the anus, anal sphincter, rectum, urethra and periurethral area.**
3. **Administering, by injection or inhalation, a substance designated in the regulations.**
4. **Putting an instrument, hand or finger beyond the labia majora during pregnancy, labour and the post-partum period.**
5. **Taking blood samples from newborns by skin pricking or from women from veins or by skin pricking.**
6. **Inserting urinary catheters into women.**
7. **Prescribing drugs designated in the regulations.**

Section 5:

The College of Midwives of Ontario is established (**COMO**).

Section 8:

The title *Midwife* is reserved for members of the **COMO**. The practice of midwifery is restricted to members of the **COMO**.

Section 10:

Specifies a fine up to $10,000 for breach of section 8.

Section 12:

Creation of a transitional Council responsible for ensuring that the intent of the Act and the Regulated Health Professions Act comes into force. The Minister of Health is given broad powers to enforce the Act, including authority over the Council.

Section 13:

After the Act comes into force, the transitional Council will become the Council of the **COMO**.

Section 14:

The Act comes into force, except section 12, on a day to named by proclamation of the Lieutenant Governor

Appendix 2

Philosophy of Midwifery in Ontario

- Midwifery care is based on a respect for pregnancy as a state of health and childbirth as a normal physiological process.

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

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

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

- Midwives respect the woman's right to choice of caregiver and place of birth in accordance with the Standards of Practice of the College of Midwives. Midwives are willing to attend birth in a variety of settings, including birth at home.

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

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

- Midwives promote decision-making as a shared responsibility, between the woman, her family (as defined by the woman) and her caregivers. The mother is recognized as the primary decision maker.

- Fundamental to midwifery care is the understanding that a woman's

caregivers respect and support her so that she may give birth safely, with power and dignity.

Appendix 3

International Definition of Midwifery

A midwife is a person who, having been regularly admitted to a midwifery education 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.

Sphere of practice: She (*sic*) must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the patients but also within the family and community. The work should involve antenatal education and preparation for parenthood, and extends to certain areas of gynaecology, family planning and child care.

She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service.