STAKEHOLDER PERCEPTIONS OF MIDWIFERY INTEGRATION INTO THE HEALTH CARE SYSTEM IN MANITOBA

By

Meta J. Kreiner

A Thesis submitted to
the Faculty of Graduate Studies
In Partial Fulfillment of the Requirements for the Degree of

MASTER OF SCIENCE

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Abstract

Midwives have practiced as regulated professionals in Manitoba since June 2000. This study looks at how four topics central to the implementation of midwifery were dealt with in Manitoba: (1) The midwifery model of care; (2) Issues in access to midwifery care; (3) The integration of midwifery into the health care system; and (4) Issues in access to the midwifery profession. The three objectives of this project are to describe: (1) how issues within these four topics were defined and negotiated; (2) how agreement on these issues was translated into the regulations and structure of midwifery care; and (3) how these issues are now seen by stakeholders from the midwifery implementation process. This study used a qualitative, case study approach. A review of documentary sources was combined with in-depth interviews. The 26 participants who were interviewed were selected to represent five identified stakeholder groups: midwives, women as maternity care consumers, health care professionals, provincial representatives, and midwifery implementation and professional bodies. This study documented the midwifery implementation and integration processes in Manitoba, and highlighted Manitoba midwifery initiatives. Both successes and challenges were identified with the changes made to the assessment process to make it more inclusive. Funding through RHA employment was found to ease midwifery integration, but also standardize the model of practice and limit autonomy. Prioritizing disadvantaged women for the service was determined to increase the diversity of midwifery clients. It was also found that meaningful inclusion of Aboriginal midwifery revitalization within regulated midwifery is possible. Geographic accessibility remains a challenge. Implementing provincial education programs was identified as crucial to the future of the profession.

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Abbreviations

AMEP	Aboriginal Midwifery Education Program
CMM	College of Midwives of Manitoba
CPSM	College of Physicians and Surgeons of Manitoba
EMS	Emergency Medical Services
MAM	Manitoba Association of Midwives
MARN/CRNM	Manitoba Association of Registered Nurses (became the College of Registered Nurses of Manitoba in 2001)
MEPA	Midwifery Education Programs Approval
MIC	Midwifery Implementation Council (1995-1998)
MMA	Manitoba Medical Association
NARM	North American Registry of Midwives
NMAM/AMM	Nurse Midwives Association of Manitoba (became the Association of Manitoba Midwives in 1992)
PLEA	Prior Learning and Experience Assessment
RHA	Regional Health Authority
Working Group	Manitoba Working Group on Midwifery (1991-1993)
WRHA	Winnipeg Regional Health Authority

Chapter One: Introduction

1.0 Introduction

Midwifery in Canada is in transition between being a marginal service whose practitioners were at risk for legal sanctions, to being a publicly funded profession with rights and responsibilities that overlap with those of physicians. During the last fifteen years, seven provinces and territories have written legislation that regulates the profession of midwifery: Ontario (1991), Alberta (1994), British Columbia (1995), Manitoba (1997), Quebec (1999), Saskatchewan (1999) and the Northwest Territories (2003) (Scurfield 2002; Carroll and Benoit 2004). All of these provinces and territories have recognized midwifery as a direct-entry autonomous profession, but there are significant differences in how each defined the specifics of midwifery care, which then had implications for the ways in which each province shaped the legislation and regulations that were to govern the profession (Scurfield 2002; Bourgeault and Fynes 1997a; McKendry and Langford 2001; Page 2000; Vadeboncoeur *et al* 1997). The impact of these legal decisions on the actual implementation of midwifery care is becoming increasingly evident as each province proceeds in the integration of midwifery into their health care system.

This project looks at the case of the implementation of midwifery in Manitoba. It focuses on the historical factors which shaped its development and the unique initiatives which distinguish midwifery in Manitoba from the other provinces. It also looks at how midwifery has continued to evolve during its integration into the health care system. Research for this project used a qualitative, case study approach. Policy documents and reports were combined with in-depth interviews with many of the people who were directly involved in the process. Participants were recruited from one of five stakeholder

groups: midwives, women as maternity care consumers, other health care providers including physicians and nurses, the provincial government, and members of midwifery implementation and professional bodies. The in-depth interviews were designed to explore how midwifery implementation and integration is now seen by those who were involved as individuals, but also as members of the five stakeholder groups.

1.1 Research Objectives

This project focuses on four topics which have been identified as central to the implementation of midwifery care within the Canadian midwifery literature. It looks at how these four topics were dealt with during the midwifery implementation process in Manitoba:

- The Midwifery Model of Care
- Issues in Access to Midwifery Care
- The Integration of Midwifery into the Existing Health Care System
- Issues in Access to the Midwifery Profession

Each of these topics went through a long process of negotiation, definition, translation into a legal and regulatory framework and finally, implementation.

The three objectives of this project are:

1. To describe how the issues within the four topics of the midwifery model of care, access to care, the integration of midwifery care, and access to the profession were defined and negotiated within and between each of the five stakeholder groups;

2. Based on a review of reports, newsletters and policy documents, to describe how agreement on these issues was translated into the legal and regulatory framework and the structure of midwifery care;
3. To describe how these issues are now seen by members in the different stakeholder groups including what they see as having worked well, as partly successful or in need of major revision.

1.2 The Five Stakeholder Groups

In many ways, the five stakeholder groups have been identified, reinforced and refined through midwifery implementation across Canada. Midwives represent the most obvious stakeholder group for the profession, but they are not a homogenous group. Midwives in Manitoba can be subdivided into those who trained in midwifery as a specialization of nursing, those who trained in direct entry midwifery programs, and community midwives[1] who were trained primarily through less formal means. The midwives in these groups are diverse in terms of their country of origin, philosophies of midwifery care, scopes of practice, and academic qualifications which ranged from Canadian university degrees, to international vocational programs recognized only by a local institution, to apprenticeship and self study (Kaufert and Robinson 2004; Nestel 1996/7).

Women as maternity care consumers make up a second stakeholder group. Midwifery has distinguished itself as a profession whose regulation was largely driven by consumer demand and advocacy (Bourgeault 1996; James 1997). Organized midwifery

[1] While there are many terms for the midwives who practiced in North America outside of regulation, the terms 'community midwifery' and 'community midwife' will be used because they can encapsulate the many philosophies and types of training held by these women, and only refer to the fact that they were practicing outside of health care institutions.

consumers were a small but very active set of supporters who were united by shared ideas about the philosophy of midwifery care and a focus on midwives as home birth practitioners. This small but vocal group was linked with a larger group of women's health activists and women from the general population who were supportive of reform of the existing maternity care system (Bourgeault and Fynes 1997a; Bourgeault 1996). Peripheral to these organized movements, whose members are often predominantly urban, middle class, white and highly educated, are rural and northern women, immigrant women, low income women, and Aboriginal women. While more difficult to hear from because they are often not well represented by mainstream midwifery and childbirth consumer groups, women from these groups have an equal stake in the introduction of midwifery services as maternity care consumers (Nestel 1995; 2000).

Health care professionals make up the third stakeholder group. The two health professions with the greatest overlap in scope of practice with midwives, and who will interact most with midwives in the care of childbearing women, are physicians and nurses (Kornelsen and Carty 2004). They are not homogenous groups either though. Practicing obstetricians and general practitioners will have different responses to the introduction of midwifery services. Their issues will also be different from the individuals who participated as representatives of medical organizations, since these individuals are often elites within the profession (Coburn *et al* 1997). Similarly, practicing registered nurses and representatives of nursing organizations will also have different views of the process (Coburn 1988; Glazer 1991). Health professionals who have worked more closely with midwives' practices will also view the service differently than those who have had little contact with the program (Lyons and Carty 1999).

The provincial government makes up the fourth stakeholder group. The regulation and introduction of a new health profession falls within the jurisdiction of policymakers, administrators and Provincial Ministers primarily from the health department (Manitoba Health), but also the departments of finance, labour and education. Individuals in these roles have different perspectives on midwifery which are further diversified by changes in the Ministers and the governing parties (Bourgeault 1996; James and Bourgeault 2004). Further, with the regionalization of the health care system throughout many provinces in Canada, including Manitoba, government management of the health care system now occurs at two levels, at the provincial departments of health and at the regional level. Regional Health Authority (RHA) administrators thus become another key player in the integration of the new profession (Manitoba Health, Undated; Church and Barker 1998).

Finally, individuals from the first four stakeholder groups have made up the majority of the individuals in the fifth stakeholder group, midwifery implementation and professional bodies. As members of the midwifery implementation and professional bodies, individuals from the first four stakeholder groups are given greater control over the processes that are occurring and play a larger role in shaping the new profession. These individuals must look at the issues not only from the perspective of their stakeholder position, but also more broadly in terms of the interests of the new profession and the wider health care system of which it is becoming a part. In Manitoba, the primary bodies in this process have been the Manitoba Working Group on Midwifery, the Midwifery Implementation Council (MIC), and the College of Midwives of Manitoba (CMM).

1.3 Research Topics

The introduction of midwives as a completely new professional into the health care system brings with it many challenges as midwives must find a way to fit into a system which has developed its philosophy of care and hierarchy of occupations without midwifery input. On the other hand, it also means that the Canadian midwifery movement has had the opportunity to create a new midwifery profession based on its own principles. A review of the Canadian midwifery implementation literature identifies four major themes which will be the focus of this case study: the model of care, who has access to being a midwifery client, how midwives integrate into the health care system, and who can register as a midwife. The following section will define and discuss the principles which make up these four research topics. These principles will then be used as the basis for evaluating the Manitoba case of midwifery implementation.

1.3.1 The Model of Care

Five facets of the midwifery model of care can be seen to be interdependent, forming a complete package. These are autonomy, an expanded scope of practice, continuity of care, informed choice, and choice of birth place. Central to the model of care is the midwife's autonomy because its differences from the medical model would be diluted if midwives were reporting to medicine. This autonomy requires an expanded scope of practice for midwives, including prescription and hospital admitting privileges, so that she[2] has all of the tools and supports she needs to act as a primary caregiver. Continuity of care is also central to the midwifery model because it offers the time

[2] The use of the pronouns "she" and "her" and the use of the term "woman" to describe midwives throughout this thesis are used in acknowledgement of the fact that the vast majority of midwives throughout the world (including all of the registered midwives in Manitoba) are women (Manitoba Government 1993; College of Midwives of Manitoba 2004d).

necessary for health education and informed choice. From this extra time and the trusting relationship it allows to develop comes care which is individualized and directed by the needs of the woman, including allowing her to choose her place of birth.

In the Canadian midwifery literature, acquiring professional autonomy is sometimes closely associated with achieving self regulation through a college structure and a lack of direct supervision by other health professionals (Bourgeault 1996; Van Wagner 2004; Kornelsen and Carty 2004). While this protects a certain level of professional autonomy, a more detailed definition of autonomy allows a more complex understanding of the areas of practice which can be either sites of professional control or a lack thereof. In their discussion of medical dominance, Coburn *et al* (1997) discuss four attributes of social, cultural and professional autonomy for a health profession. The first is the content of care, which includes clinical decision making and the philosophy of care. The second is control over clients, including both control over who the professional is serving and control over the care that the client accepts. The third is control over the relationship with other health professions. The last attribute is control over the context of care, which includes the health care policy that regulates both the profession specifically and the wider health policy that shapes the health care system within which care is being offered. Benoit (1996/7) also points out that control over the location of practice and the practice group a health professional is in are attributes of professional autonomy.

To facilitate midwives as autonomous primary caregivers with full responsibility for the prenatal, intrapartum and six weeks postpartum care of the mother and newborn, their scope of practice was expanded across Canada beyond what many had offered before, to include prescription privileges, hospital admitting privileges, ordering routine

prenatal laboratory tests, and offering well woman care (Sharpe 1997; Shroff 1997; Bourgeault 1996). This extended scope of practice allows midwifery care to be more continuous because midwives do not have to rely on other health professionals for certain aspects of care. It also places more responsibility on the midwife than she may have experienced before (Sharpe 1997; Van Wagner 2004). In a study of newly regulated midwives in Ontario, Sharpe (1997: 222) found that offering this extended scope also creates distinctions between those midwives who are more familiar with the protocols and policies of the health care system, and those for whom integrating into this system is more stressful: "Midwives felt that their new situation of working in hospital was very stressful and that they were on a steep learning curve...Excepting those who had previous nursing experience, most had found this overwhelming at first but with time were somewhat able to adapt."

Within their model of care, midwives across Canada have also been required to offer continuity of care which all provinces with regulated midwifery have defined as a midwife or small group of midwives offering the majority of the preconception, pregnancy, labour and birth, and postpartum care to a woman over the childbearing year (College of Midwives of Ontario 1994; College of Midwives of British Columbia 1997; Midwifery Regulation Advisory Committee, Undated). Continuity of care has been protected should a client need to be transferred to the care of a physician through a policy on supportive care, which recommends that the midwife remain in a supportive role to the woman following the transfer. This facilitates a return of primary care to the midwife if things return to normal (Ontario Hospital Association 1994; College of Midwives of Manitoba 2003b; Shroff 1997). It has also been protected by the funding structures used

for midwifery services which limit the possibility for fragmentation of care between practitioners (Shroff 1997). The idea of a small number of midwives offering shared continuity of care tries to balance the desire of the woman for continuity and the quality of life of the midwife, but it does continue to be associated with issues of burnout (Sharpe 1997; Benoit and Heitlinger 1998).

Like continuity of care, "An informed choice model of decision-making...is often identified as the hallmark of Canadian midwifery" (James 1997: 183). Informed choice developed in response to women expressing unhappiness about being required to have routine interventions in hospital which some felt introduced unnecessary risks when labour was progressing normally. Informed choice involves ensuring that health professionals provide birthing women with comprehensive information about their care so that the woman can be the primary decision maker during the course of care (Tyson 2002; James 1997; Shroff 1997; Scurfield 2002). With informed choice, professionals are expected to follow the decisions of clients once they believe that the client has all the information they need to make the decision. Informed choice is often described as a more egalitarian and woman centred method of decision making about care. It largely developed within community midwifery where midwifery clients were a small self selected group who often shared a focus on preventative care and a desire for as few interventions as possible with the midwife they chose. As midwifery becomes integrated into the public health care system, clients are more likely to come from the mainstream and make decisions which more closely match the medical philosophy of care, or which are not evidence-based or particularly healthy. Midwives who are more interested in practicing a certain model of midwifery rather than informed choice will then find it more

challenging to follow the course of care decisions made by their clients (Shroff 1997; Sharpe 1997).

Choice of birth place is a facet of informed choice, and in theory, choice of birth location means that a woman can choose to give birth in her home, a birth centre, nursing station or hospital. While agreement that midwives need to be able to attend hospital births as autonomous caregivers has been easier to reach because this is the location where the majority of women are likely to choose to give birth, preserving home birth has been one of the most contentious aspects of regulating the new profession (Rice 1997; Kaufert and Robinson 2004). It is a defining feature which often divides the community midwifery and the nurse midwifery models, and it is the facet of the profession which is most opposed by the medical profession (Rice 1997; Lyons and Carty 1999; Kornelsen 2000; Kornelsen and Carty 2004). For community midwives, home birth is often viewed as important to preserve a connection with a wider range of normal birthing experiences than would be seen within an institution with interventionist policies. For women with positive home environments, the home can also be a location which facilitates non medical methods of alleviating labour pain, and where women can feel more assertive to make decisions about how they will birth (Shroff 1997; Mason 1990). However, when discussing home birth it is also important to ensure that practice guidelines recognize that a woman or a community's socio-economic status should not be used to deny choice of birth place (Sharpe 1997; Ford and Van Wagner 2004). Practice guidelines should also recognize that the home is not always a positive environment: "For women who face violence, abuse and other forms of oppression in their homes, hospital births may provide an alternative to the site of their abuse" (Shroff 1997: 22; Kaufert and Robinson 2004).

1.3.2 Access to Midwifery Care

The introduction of midwifery as a new regulated profession offers an opportunity to implement the profession in such a way that it can address the accessibility issues which have been identified both in mainstream maternity care and in midwifery services pre-regulation (Shroff 1997; Manitoba Government 1993; Rice 1997; James 1997; Bourgeault 1996; Benoit 1997). Provincial funding, a sustainable number of midwives available throughout the province, and public education and outreach are all essential to remove financial and geographic barriers, and barriers of information (Bourgeault 1996; Patel and Al-Jazairi 1997; Rice 1997). Flexible practice standards which allow the midwife to spend more time with clients also lay the foundation for midwives to be able to work in different practice arrangements to target different populations, and individualize care to a woman's social, economic, and cultural needs and values. While individualized care has been constructed as a mechanism for offering culturally appropriate care to most women, this excludes a sense of community as an important attribute of culture. Aboriginal groups are the only ones in the Canadian midwifery literature where it is recognized that culturally appropriate care may need to be more than individualized care, and instead be community led since introducing midwifery services can be a part of Aboriginal cultural and community revitalization movements (Ford and Van Wagner 2004).

Rice (1997: 149) defines a number of requirements for access to midwifery care including: "...publicly funded midwifery services, culturally relevant and sensitive care, and an adequate number of midwives throughout the province." Public funding is essential to make midwifery care a real choice for women regardless of income level. It

also means that midwives benefit from the increased legitimacy of being a part of the public health care system in Canada, and are not competing with insured physician services while midwifery clients have to pay out of pocket (Bourgeault 1996; James 1997; James and Bourgeault 2004; Rice 1997). Because of the small numbers of midwives available to practice and register initially, without a concerted effort to geographically distribute midwives, midwives will cluster in a few regions leaving large areas without services (Rice 1997). A strategy for distributing midwifery practices throughout the province is therefore necessary to overcome this geographic barrier (Benoit 1996/7). Public education and outreach are also essential so that women who may be peripheral to midwifery and childbirth consumer groups know that regulated midwifery care has become available and what it constitutes. In their study of whether women of colour were interested in having midwife-assisted births in Ontario following regulation, Patel and Al-Jazairi (1997: 70) conclude: "Our research indicates that lack of information is one of the main barriers for women of colour in accessing midwives in Toronto. The majority of participants did not know: that midwives are available here; that midwifery is legal; or that it is covered by OHIP."

In Canada, creating a midwifery service which is culturally appropriate to a majority of birthing women is also seen as an important aspect of making the service accessible. As part of trying to reach this goal, consultations with representatives from multiple minority groups were held in most provinces to understand their maternity care issues and their vision for midwifery services (Ford and Van Wagner 2004; Rice 1997). Based on some awareness of these issues and expectations, the primary method of attempting culturally appropriate care has then been through support for individualized

care (Tyson 2002). To facilitate this individualized care model, the standards of midwifery practice need to be flexible enough to accommodate the needs of women who fall outside the mainstream. This includes ensuring that standards of practice and regulations are written in a way that is applicable for rural, urban and remote practice locations (Rice 1997), and in a way that allows midwives to use different practice models as part of targeting different populations. A public funding structure which is not directly tied to the number of clients seen per year allows midwives to work with clients who may require increased time for education, outreach and client care (Ford and Van Wagner 2004). Alternate practice arrangements can allow midwives to work with a second birth attendant who can assist with addressing needs relating to language, ability, or culture (Israel 1997; Ford and Van Wagner 2004). It is also important that the standards on who is an appropriate midwifery client are not written in such a way that a woman's social and economic status, age, or other non-clinical characteristics are used to define her as an unsuitable candidate for midwifery care (Ford and Van Wagner 2004, Rice 1997).

There is one group in Canada where this individualized care model is not seen as sufficient, and the possibility for a community directed and initiated midwifery service, which may differ substantially from regulated midwifery, is seen as an important option. This is for Aboriginal women, particularly those living in remote First Nations communities (Ford and Van Wagner 2004; Carroll and Benoit 2004). The revitalization of Aboriginal midwifery traditions has often taken place within attempts to heal from and resist the colonial legacy and a movement towards more autonomous, self-sufficient communities (Couchie and Nabigon 1997). Returning midwifery to these communities is partly about reforming the maternity care that women receive, but it is also about

reforging generational links through the traditions, rituals and experience of childbirth, links which have been severed by the past removal of children into residential schools and foster care, the suppression of language and culture, and the removal of women for childbirth (Hiebert 2003). It has also been pointed out that this revitalization of Aboriginal midwifery traditions has needed to occur outside of the mainstream midwifery movement in some communities where trust has seriously eroded between the Aboriginal community and the First Nations and Inuit Health Branch of Health Canada, and where this trust must be rebuilt before people will be comfortable working with new government programs (Shroff 1997; Carroll and Benoit 2004).

1.3.3 Integration into the Existing Health Care System

Comprehensive integration with the health care system and good working relationships with other health professionals are essential to ensure that midwifery clients receive timely medical attention when needed. They are also important to facilitate a working environment for midwives which is not marred by routine hostility and harassment from other professionals. Research into midwifery integration in other provinces illustrates the hostility midwives have faced from physicians as they have begun practicing, but also points to the possibility that clear protocols for consultations and opportunities for non clinical interactions can improve these relationships and build mutual trust. Similarly, research into integration with nurses concludes that greater exposure to regulated midwifery leads to greater respect and cooperation between the professions. The greater government involvement in health care also means that midwives will have to accommodate more directly provincial and Regional Health

Authority administrators' new control over the health care system and thus, the midwives' practice models.

Coburn *et al* (1997) argue that the influence of the provincial government on the work of health professions has increased recently due to greater state interference into the management of the health care system to rationalize health care costs. This interference appears to partly explain how midwifery was able to gain legitimacy without direct support from medicine (Scurfield 2002). It also indicates that with midwifery integration into the public health care system, midwifery as a profession will have to struggle with tensions both between midwives, physicians and nurses as they interact in the care of patients, and between midwives and the state as midwives must now, like the other professions, accommodate more directly the interests of the government, especially their focus on cost containment (Coburn *et al* 1997).

While there has been little research on the way midwifery practices have had to accommodate provincial health administrators, studies confirm the importance of the quality of the interactions between midwives and other health professionals for midwives' work experiences and the care offered their clients (Page 2000; Vadeboncoeur 2004). A study of midwifery integration in Quebec found that the midwives practicing during the midwifery pilot projects (1990-1998) were poorly integrated into the health care system which created a situation which was detrimental to their clients because they had difficulty accessing consultants, lab tests, technology and medications, and were met with delays and hostility when attempting to transfer women to hospitals and medical care. This study identified four barriers to midwifery integration: lack of knowledge on the part of other health care providers about the practice of midwifery, midwives working

in settings which offered no contact with other health care providers except during negative situations, physician fears that midwives were challenging their professional territory, and the different conceptions of risk and professional responsibility in the client-provider relationship held by physicians and midwives. The provincial health department also did not play a role in assisting in the development of the necessary protocols for medical consultations and transfers (Collin *et al* 2000). Based on the findings of this study, Collin *et al* (2000: I-19) stated:

> "The results of this study suggest that to favour the integration of midwives in the health care system, it would be necessary to undertake the following: develop consultation and reference mechanisms that clearly state the limits of responsibility of each professional;...ensure that these mechanisms are defined through dialogue among professionals who have to cooperate rather than through administrative rules imposed from outside; keep consultation and reference mechanisms flexible and leave room for clinical exchange between the professionals involved; favour contact between professionals to develop mutual trust and real cooperation; increase the visibility of midwives in the perinatal system; and reach a standardization in midwifery practice, notably through the establishment of standard training and shared ethics, in order to reduce the uncertainty felt by midwives' collaborators toward their practice."

Studies of physician responses to midwives in British Columbia also describe an environment of hostility. In a observational study done during the first year of integration, Lyons and Carty (1999) found that physicians felt threatened by the introduction of midwifery and resisted integration in a number of ways. Issues which were primary for physicians were midwives' training in newborn care, and fears of liability and responsibility if there was a poor birth outcome after a consultation (Vadeboncoeur *et al* 1997; Lyons and Carty 1999). Physicians were particularly resistant to being required to collaborate with midwives doing home births while their Colleges and Associations still firmly opposed home births as unsafe. Some physicians chose to resist midwifery integration in a number of ways including condemning midwifery to

clients who asked for more information about it, discharging patients who chose midwifery or home birth, reluctantly accepting or refusing to accept client transfers from midwives, lobbying hospital boards to refuse admitting privileges to midwives, and refusing to accept obstetrical patients at all (Kornelsen 2000).

A study of perinatal nurses in British Columbia was also done in the first months of midwifery integration. The study found that nurses' initial perceptions of midwifery were generally shaped by their previous experience with midwives; if these were hospital based nurse midwives the view was generally positive, if it was home based community midwives during a hospital transport the view was generally more negative. As well, more than 15% of the perinatal nurses had midwifery training themselves. These nurses saw themselves as having a similar scope of practice with midwives, and many viewed the midwives with envy for gaining greater autonomy and a wider scope of practice (Lyons and Carty 1999). Some nurses were also afraid that with integration a relationship of subordination like the one they have with doctors would be repeated with midwives (Kornelsen *et al* 2000). Probably for many of these reasons, Kornelsen *et al* (2003) found that initially midwives and nurses did not work cooperatively in hospitals. However, they found that nurses who observed the actualization of the midwifery model of care or worked collaboratively with midwives in patient care came to have a more positive attitude towards midwives. This seems to indicate that more interaction and greater exposure to midwifery care leads to cooperation and greater respect for the midwifery philosophy of care. It also indicates that midwives who practiced within the community pre-regulation are often seen as distinct from their hospital based counterparts and held up to more rigorous standards.

1.3.4 Access to Midwifery as a Profession

Equity principles should not just be applied to who can be a midwifery client, but also to who can be a midwife. It is the attributes of the assessment and registration guidelines which create barriers to the profession or facilitate a more inclusive midwifery service which includes midwives from multiple training backgrounds. Whether the assessment and registration guidelines are inclusive or exclusionary also affects the internal cohesion of midwives within the profession, and research indicates that the level of internal cohesion plays a central role in the further development of the profession. Midwifery education programs are important for the continued growth of the profession, and the particular education model(s) which are implemented can both continue a commitment to access to the profession or be exclusionary, and can work to either strengthen internal cohesion or foster more divisiveness.

In Canada, the women interested in practicing midwifery have been trained in programs throughout the world within different educational models, and been taught different philosophies of care and scopes of practice. When determining which midwives would be eligible to register here, one area of debate was whether midwives would be required to have formal midwifery education, or whether apprenticeship education would also be acceptable. Formal education programs have more standardization and would be recognized more readily by other health professionals, while apprenticeship programs can allow for more time spent training in the midwifery model of care. Without formal midwifery schools in Canada, for many aspiring midwives, apprenticeship training was also the only option available (Benoit and Davis-Floyd 2004; James 1997; Kornelsen and Carty 2004; Bourgeault 1996). Because of the strengths and limitations seen in the

different educational backgrounds, it was determined that an assessment process which allowed multiple routes of entry was most appropriate across Canada. This assessment process would be based on an individual candidate's educational background, level of experience, and competence rather than a general assessment of the equivalency of educational programs and registration requirements in other jurisdictions (Ford and Van Wagner 2004; Bourgeault 1996; McKendry 1997; Kornelsen 2001).

Studies of how this was put in place in Ontario however, have identified some attributes of the process which created barriers for some women who wished to register as midwives. In Ontario, the practice history assessment required practicing in the province as a midwife prior to registration (when it was illegal), which meant that nurses who had trained and practiced as midwives in other countries, but never practiced as primary caregivers in Canada, were made ineligible. It also rejected immigrant women with direct entry training from other countries who did not practice here because they feared deportation for practicing midwifery outside the law (Nestel 1996/7). The financial cost of the assessment and upgrading has also been identified as a barrier (Shroff *et al* 1997; Nestel 2000). These studies offer insights into some of the barriers that need to be addressed if an inclusive assessment and upgrading process is a goal.

Following the assessment and upgrading, the women who register as midwives then make up the new profession, and creating unity among women from such varied backgrounds can be quite a challenge. Research in other provinces has indicated that the degree of internal cohesion among midwives has been a factor which influenced the development of the midwifery profession and the pace of the regulation process (Vadeboncoeur *et al* 1997). According to Hatem-Asmar and Blais (1997: 325) internal

cohesion is the ability of midwives with different training backgrounds and practice models "...to develop a unified practice that transcends their differences". Internal cohesion is important during the integration of a new profession for creating a unified definition of midwifery and appointing a single set of representatives to speak for the profession during negotiations with the state and other health care providers (Hatem-Asmar and Blais 1997; Kornelsen *et al* 2003; Vadeboncoeur *et al* 1997). Focusing on the benefits of internal cohesion alone however, can lead to the use of exclusionary tactics to protect it, creating a loss of diversity in experience, philosophy, training, and socio-economic background within midwifery (Nestel 2000). Thus, a more inclusive assessment process may make for a larger and more unified midwifery profession to shape the future of midwifery, or it may find itself held back by internal disputes and mistrust. On the other hand, a more exclusionary assessment process may create a midwifery profession which is more united, but has to deal with more external challenges to its legitimacy by those who have been left out of the process (Rice 1997).

Following these issues in the initial implementation of the profession, it is the midwifery education program(s) which are developed which will shape the future trajectory of the profession (Rice 1997; Bourgeault 1996). How this education is implemented also effects whether it facilitates a unified profession of midwives who have all been educated in the same model and philosophy of care, or supports multiple routes to midwifery and a diversity of educational models. There are three educational models that are discussed when Canadian provinces are considering starting midwifery training programs: apprenticeship, vocational training, and baccalaureate programs.

Apprenticeship education combines self study with a student working closely with a single midwife. It offers the advantages of being self directed and community based. Apprenticeship training generally allows for extensive experience with normal births which builds trust in the process, and means that experience is gained within a continuity of care model (Rice 1997; James 1997). On the other hand, apprenticeship training requires strongly self motivated students and graduates students slowly. It can also be compromised because of personal issues in the student-mentor relationship, and it rarely gives students an opportunity to see a range of birth complications without being supplemented by another form of education. Finally, it is not an education model which is acceptable to other health professions (Benoit and Davis-Floyd 2004).

Like apprenticeship, vocational training usually closely combines practical and academic training, but it is often carried out within an institution which is preparing midwives to work within the protocols and guidelines of that institution. It is often the shortest educational pathway, and can be one of the most accessible because it is available at many locations, can accept many students, and is lower cost. However, it is not generally viewed as an educational program which prepares students to work autonomously in the community. It is also an educational model which can be viewed as 'second rate' in comparison to university education, which would make it challenging for midwives to be accepted by other health professionals as colleagues (Benoit and Davis-Floyd 2004).

Baccalaureate education programs can improve acceptance by other health professionals, and can also allow for cross training with students in other health professions when the programs are offered in the same institutions (Kornelsen and Carty

2004; Benoit and Davis-Floyd 2004). Baccalaureate education offers access to large teaching hospitals where students are exposed to a wide range of clients, birth complications, and the styles of many different health professionals. Yet, baccalaureate education can be critiqued for divorcing academic and clinical training, with extra focus placed on academic preparation. Midwifery programs in institutions which carry out medical training can also be pressured to incorporate medicalized approaches to birth. Finally, Baccalaureate training is the most expensive, the least accessible, and is available in the fewest locations (Benoit and Davis-Floyd 2004; Rice 1997; James 1997).

1.4 Organization of the Dissertation

The organization of the rest of the thesis is the following: *chapter two* provides the theoretical perspective that guides the study. It also details the research design and methods used in this project. *Chapter three* reviews the history of midwifery in Canada to conceptually identify the four groups of midwives which now have an interest in shaping and practicing midwifery. It also outlines the conceptual framework used in the project to explain both how midwifery was able to be suppressed in Canada for so long, and current trends in the health care system which have recently allowed for the regulation and incorporation of midwifery. *Chapter four* offers a detailed and chronological documentation of midwifery implementation in Manitoba situated within the wider Canadian context. This chapter identifies the Manitoba initiatives which differentiate it from the other provinces with regulated midwifery, and which are the focus of the rest of the thesis. Each subsequent chapter will look at these distinct features from the perspective of the four research topics to delve deeper into the issues they were designed to address, the challenges that were faced in implementing them, and whether or

not they have accomplished what they were intended to do. *Chapter five* discusses the negotiations which were a part of implementing the model of care, and the factors which have affected registered midwives' ability to offer that model since they began practicing. *Chapter six* traces the development of the initiatives to increase access to midwifery services for all Manitoba women regardless of cultural background, socio-economic status or geography, and looks at how these initiatives appear to have worked in practice. *Chapter seven* examines the strategies which were used to ease the integration of the midwifery service into the existing health care system, and discusses whether or not participants felt that these strategies worked. *Chapter eight* explores how regulating midwifery is creating midwives as a new professional group in Manitoba. It looks at three attributes of this process: the attempt to create a more inclusive profession by making changes to the initial midwifery assessment and upgrading, the development of internal cohesion among the registered midwives, and the midwifery education options which are under consideration. *Chapter nine* offers a summary of the research and discusses its implications. This concluding chapter brings together the insights garnered from looking at the Manitoba initiatives through the lens of each research topic to produce an holistic evaluation of these features. In addition, this chapter suggests recommendations both for other provinces considering implementing regulated midwifery services, and for Manitoba as it makes decisions about the future development of midwifery here.

Chapter Two: Theoretical Methodology and Research Design

2.1 Theoretical Methodology

2.1.1 Critical Methodology

A critical theoretical methodology guided this study. Critical methodology involves using research as a form of social criticism based on an assessment that our society is inequitably structured, and that information is suppressed about why society has taken the shape it has and what can be done to change it. According to Thomas (1993), critical methodology involves giving research a political purpose by choosing topics which identify and illustrate processes of cultural repression, and by generating knowledge which can be used for social change by suggesting ways to resist. Critical methodology also attempts to critique the limits put on research frameworks which make it difficult to accept certain viewpoints as valid and to come up with new solutions to the problems in society.

2.1.2 Feminist Theory and Methodology

A subset within critical methodology is feminist theory which focuses on repression based on sex and gender, and resistance and transformation within this realm (Nelson and Robinson 1999). The midwifery regulation movement can be viewed as a feminist movement (Sharpe 2004). In North America over the last century, physicians have exercised a near monopoly over the provision of care to pregnant and birthing women and have done so within a medical model which regards birth as an inherently pathological process. Feminists have long argued that many standard obstetrical procedures are inhumane, clinically ineffectual, and a method of controlling women and their bodies. Despite these reform efforts, these practices have been slow to disappear

(Benoit 2000). One response has been the revival of community midwifery which in many ways falls within the realm of radical feminism. Radical feminism, the celebration of facets of femininity as a source of power for women (one of the most potent symbols of that power being women's ability to give birth), was central to the reclamation of birth and birth attendance as a woman's event and profession. These feminist attributes became joined with liberal feminist movements with the progression towards the regulation of midwifery. Liberal feminism generally defines women's movements which work toward improving women's equality through interventions of the state to improve the status of women, promote equality between the sexes, and incorporate feminist principles into pre-existing social, political, and economic institutions (Nelson and Robinson 1999; Benoit 1997). The midwifery regulation project likely would not have been successful without the efforts of women working from within the state towards these emancipatory goals (James and Bourgeault 2004).

As a critical feminist research project, midwifery was chosen as a research topic to explore how social change movements transform inequitable aspects of society. This project is also an attempt to help ensure further integration of this profession which offers important alternatives for Manitoba women. Towards this goal, this thesis will focus on the unique aspects of midwifery services in Manitoba, and explore whether participants believe these innovations have created solutions to the challenges of introducing midwifery which they were designed to address. It will analyze the opportunities and barriers to full integration of midwifery services in the province, and will make policy recommendations. This study is thus meant to be a possible tool for the province of Manitoba to draw on while making decisions about the development of midwifery here.

It is also meant to serve as a resource for provinces considering implementing midwifery services, allowing them to build on the innovations and problems identified by the Manitoba experience, just as Manitoba did from the provinces which came before it.

However, as a regulated profession, midwifery is now becoming an institutionalized locus of power in society, and it will also be viewed with a critical lens to understand how power works. As women through the feminist movement have gained greater status, they have increasingly become a part of the elite power structures of society. The participants in this study were for the most part highly educated, middle class, white professionals who had become media savvy and sophisticated and influential speakers through their professional work or their work in the movement for midwifery implementation. They more closely resembled elites than a marginalized population.

2.1.3 Studying Elites

Critical and feminist methodologies in health research are usually used to study and give voice to marginalized populations because their interests are not addressed in mainstream research or service provision. Some critical researchers have argued that this approach should not be used solely to study marginalized populations but should study elites and powerful institutions as well to understand the hidden ways that power works in society. Elites are rarely studied though, and elite case studies are underrepresented in the social science literature (Bradshaw 2001). Within critical methodology, elite interviews are employed to try to understand the hidden, personal ways that power works and relate these to macro analyses of power (Kezar 2003).

Elite research is often done differently from research with marginalized populations. Interview protocols for studying elites are characterized by the fact that the

interviewee is known to have participated in a certain situation, and the researcher can review information written by the individual or their organization (because the views of elites are accessible in the public record) before the interview and use this as the base for the production of the interview guide. Interviews are usually open ended because there is more of a focus on the interviewee's definition of the situation than the researcher's. The researcher further assumes that elites will not listen to or be impacted by the researcher's view of the topic. The interview usually aims to elicit subjective perceptions, and retrospection is used to encourage the interviewees to recall immediate reactions. Deviations in interpretation of events by different participants are seen as valuable, and generalization to a wider population is uncommon (Kezar 2003).

2.1.4 Interlocking Methodology

To identify midwives and their supporters as elites is something which could only occur in the very recent past in Canada. Women remain underrepresented in government and health care institutions, and midwifery as a profession continues to play a minimal role in the Canadian healthcare system (Benoit 2000). Thus, a more complex theoretical framework of repression needs to be employed than one which identifies individuals and groups as either elite or marginalized. This theoretical complexity in midwifery implementation research in Canada was explored in depth by Nestel (1996/7 and 2000). She employs a concept of interlocking oppressions which will also be used to understand power within this thesis.

Diversity within feminism is often described with an additive model which sees gender as the foundation of social identity and repression, which is then doubly or triply burdened by other sources of repression such as racism, heterosexism or classism.

However, this additive model has shortcomings in that it creates an imperative for ranking and ordering social categories, it cannot allow for a conception of individuals occupying a multiplicity of social positions (both subordinate and dominant), and it fails to capture the way that oppressive systems operate in and through one another (Nestel 2000).

Nestel (2000) explores how race, class and gender are not additive, but interlocking discourses of oppression which rely on and reinforce each other. She maintains that "...Western feminist projects of the last three decades which have claimed to seek gains for all women...have, in fact, produced economic and socio-political rewards primarily for white women" (Nestel 2000: 4). Within the wider women's movement, she argues that the cheap domestic labour from recently immigrated women of color was central to the ability of white middle class women to enter the labour force without overly threatening male privilege. In midwifery, Nestel (2000) points to a practice she coins 'midwifery tourism', the frequent traveling of Canadian midwives to Third World countries for their training, as an example of the use of women of color by white women for their own emancipatory ends. She argues that white Ontario women who traveled to Third World countries for their midwifery training and birth experience relied on their white skin and Canadian citizenship to cross international boundaries unmolested, and relied on the desperation of Third World women for health care providers to accept them without formal training. At the same time, the same training held by women of color from these countries was not deemed fit for registration in Ontario because of added requirements. Nestel (2000) thus argues that any consideration

of successful women's movements must take into consideration the cost of the racial and class privileges which may have been essential for this transformation.

However, the midwifery movements in Manitoba had some awareness of the interconnections of gender, class, and race in reproduction, and the possibilities for the midwifery movement to be oppressive to marginalized women. The midwifery implementation bodies were also cognizant of Nestel's critiques of the midwifery movement in Ontario, and the increased visibility of immigrant midwives that this produced (Kaufert and Robinson 2004). This thesis will thus use an interlocking methodology to understand how systems of oppression rely on one another, and allow an individual or a political movement to play both a dominating and subordinate role in society. It will also explore the consequences of the midwifery movement in Manitoba which tried to take into consideration the interconnections of gender, race and class, and tried to regulate midwifery without using exclusionary tactics.

2.2 Research Design

2.2.1 Qualitative Research

Following from the three objectives of this project, a qualitative, case study approach was employed. The purpose of qualitative research is to generate knowledge of social events and processes by exploring and documenting these processes, and by understanding what they mean to the people involved. Qualitative research is an holistic, interpretive, naturalistic, organizing framework with a theoretical and methodological focus on the complex relations between personal meanings, individual and cultural practices, and the material environment or context. It seeks to illuminate patterns of

shared understanding, to identify variability in those patterns, and from this, to provide insights into the meanings of decisions and actions (Ulin *et al* 2002).

Qualitative research can be done from multiple theoretical paradigms, is used in many disciplines, and can involve a wide rage of methodologies. In almost all qualitative methodologies though, the researcher acts as the primary data collection and analysis instrument (Creswell 2003). As well, "Qualitative research is emergent rather than tightly prefigured...Qualitative researchers look for involvement of their participants in data collection and seek to build rapport and credibility with the individuals in the study" (Creswell 2003: 181). Since the questions are about how social experience is created and given meaning, the data is often documentary, narrative, or expressive in form, and collected without formal systems of measurement or numerical representation. It then often relies on the triangulation of the data from multiple sources and data collection methods to secure an in-depth understanding of phenomena. Qualitative research attempts to create a rich description of the social world, and to be conceptually representative of individuals' points of view and subjective perceptions in a specific context, rather than statistically generalizable (Denzin and Lincoln 1998).

2.2.2 Case Study Method

A case study method was used because this is the preferred strategy for answering how and why questions about current phenomena in real life contexts over which the investigator has little control. Case studies are appropriate when one is interested in exploring a complex topic in depth, and it allows the investigation to retain the holistic character of real life events. Case studies are used when the contextual conditions need to be included because they are thought to be important to the topics being studied. The

products of case studies are often a description of an intervention and the real life context in which it occurred, but they can also be used to explain causal relationships (Yin 1994).

A case study is bounded by time and activity, and researchers collect detailed information using a variety of data collection procedures (Creswell 2003). Because of its less structured nature, case studies can combine the more factual aspects of documentary data with open ended interview data which can access the thoughts, feelings and motivations of participants which informed events (Punch 1994). This use of multiple sources of evidence, the wealth of data that is collected, and the recognition of many uncontrollable variables means that it is important to define the concepts that will be explored at the outset, and during analysis use triangulation of the data to validate arguments (Gray 2004).

For this project, the case is the introduction of regulated midwifery in Manitoba. This case study will also use an embedded case study design, where within a single case attention is given to subunits, which in this study are the stakeholder groups from which participants are selected. These stakeholder groups were defined at the outset, and served as an important tool for focusing the case study and the variability that would be explored (Yin 1994).

2.3 Data Collection

2.3.1 Community Ethics

The first step in data collection was contacting the College of Midwives of Manitoba (CMM). While the ethical guidelines of the University of Manitoba would protect the individual rights of participants, I also wanted to ensure that the project was not threatening to the midwifery profession itself (Weijer 1997). This partly came from

the project's intended purpose of helping to ensure further integration of midwifery in Manitoba. It was also important because as a regulated and instituted profession, representatives of the midwifery profession could now act as either gatekeepers or facilitators to accessing documents and participants (Kezar 2003). To ensure that the College of Midwives of Manitoba would find the project relevant, members of the Council of the CMM were provided with a copy of the research proposal. On 11 September 2003, I met with the Council of the CMM to discuss the proposal in further detail and answer any questions that members had. Council members made some suggestions, primarily around the accuracy of some historical facts in the proposal, and these points were incorporated. The College of Midwives of Manitoba did not influence decisions about the research methods or the data that would be collected. Following this meeting, the Council of the CMM wrote a letter of support for the proposal (see Appendix A).

2.3.2 Documentary Data

The data collected for this study included a systematic collection of primary and secondary documents from midwifery implementation and integration which took place between December 2003 and May 2004. All of the documents used were from the public domain. Because the distinction between private and public documents is not always clear cut, the power to determine whether a document was in the public or private domain was given to the organization which was the source of the document. The documents collected include reports, newsletters from consumer, midwifery and medical organizations, policy documents, submissions to policy-making committees, government speeches and press releases, legislative proceedings, and newspaper articles. The

majority of the documentary data was collected from public documents in the archives of the College of Midwives of Manitoba. I was given permission to access these archives once I signed the College of Midwives of Manitoba *Pledge of Privacy and Confidentiality* (See Appendix B). Many of the final reports were available from the University of Manitoba and University of Winnipeg libraries. Documents were also collected from the Winnipeg Regional Health Authority (WRHA). Newsletters from the now disbanded HomeBirth Network were provided by a past member who had distributed the newsletters and kept an archive of the originals. Hansards from the Manitoba Legislative Assembly (available for 1995-present) and current CMM documents were collected from the internet.

Minutes of meetings are generally considered to be a part of the private domain. In discussion however, members of the Midwifery Implementation Council (MIC) said that they saw the minutes of their meetings as part of the public record. In preparation for the minutes becoming public documents, the proceedings of the Council were also recorded in a composite way, such that the viewpoints of individual members could not be discerned. As a government-appointed body, Manitoba Health is now responsible for the minutes of the Midwifery Implementation Council meetings, and Manitoba Health also agreed that these documents were part of the public domain. A letter from the Director of Primary Health Care of Manitoba Health authorizing the use of the MIC minutes for research was then obtained (see Appendix C).

2.3.3 Participant Selection

The data from documentary sources was combined with information from in-depth interviews with participants knowledgeable about or influential in various aspects

of the midwifery implementation and integration processes. Participants were selected through stratified purposive sampling. Stratified purposive sampling was used because it allows the variation in perspectives and experiences within subgroups to be explored and facilitates comparisons between them. It also allows the researcher to look for themes that emerge even in the presence of many differences between participants (Punch 2001; Ulin *et al* 2002). In stratified purposive sampling, the study population is divided into groups or categories. Subgroups within these larger categories are identified. Participants are then contacted to represent these categories and subgroups, taking into consideration the information richness they can offer the project (Rice and Ezzy 1999).

Participants were selected to represent the five identified stakeholder groups: 1) midwives, 2) women as maternity care consumers, 3) health care professionals, 4) provincial representatives, and 5) midwifery implementation and professional bodies. A detailed list of subgroups within these five stakeholder groups was developed so that variation within these stakeholder groups could be explored, and participants were selected to ensure that all of the subgroups were represented. See Table 2.1 for the selection categories used to select participants from the identified groups and subgroups.

Individuals were identified who fit the stakeholder groups and subgroups from documentary sources and discussion with the Chairperson of the College of Midwives of Manitoba and the Chairperson of the Midwifery Implementation Council. Many participants selected represented more than one stakeholder group. This was especially true of the participants in the 'midwifery implementation and professional bodies' category since most individuals in this category were in these bodies because of their membership in another stakeholder group. Participants also represented between 1 and 5

subgroups within their stakeholder groups. It was ensured that a participant was selected from each of the six Manitoba Regional Health Authorities (RHAs) which offer midwifery services, and each of the four community clinics in Winnipeg with midwifery practices.

2.3.4 Contacting Participants

An initial list of 29 possible participants was created in January 2004, and the contact information for the majority of them was provided by the College of Midwives of Manitoba. Each person was sent an introductory letter outlining the objectives and procedures of the study, and pertinent personal attributes of the researcher. See Appendix D for a copy of the information letter used to contact participants. The individuals were given a month to contact me if they were interested in participating. After three weeks, individuals were sent an email or left a phone message reminder to contact me if they were interested in participating in the research study. 24 of these individuals agreed to be interviewed. Contact letters were then sent out to 3 more individuals to ensure appropriate representation from the five stakeholder groups. 2 of these 3 agreed to an interview. Thus, of the 32 total individuals contacted about participating in the study, 26 agreed to be interviewed. Of the six who did not agree, 3 were on sick or family leave, and 3 did not contact me.

Table 2.1 Guide used to Select Participants from the Identified Groups and Subgroups

Selection Categories: Stakeholder Groups and Subgroups	Number of Participants Representing each Stakeholder Group in Study
1. Midwives	**8**
Representatives from the Nurse Midwives Association of Manitoba	
Representatives from the Traditional Midwives Collective	
Representatives from the Manitoba Association of Midwives	
Midwives practicing in rural/northern RHAs	
Midwives practicing in the Winnipeg RHA	
2. Women as Maternity Care Consumers	**6**
Representatives from women's organizations which participated on behalf of consumers from rural, northern, immigrant and Aboriginal communities, and midwifery consumer groups	
3. Health Care Professionals	**6**
Practicing physicians involved with midwifery implementation:	
Obstetricians/Gynecologists	
General Practitioners	
Representative from the College of Physicians and Surgeons of Manitoba	
Practicing nurses involved with midwifery implementation	
Representative of the College of Registered Nurses of Manitoba	
Representatives from community clinics with midwifery practices	
4. Provincial Representatives	**5**
Representatives from Manitoba Health	
Regional Health Authority administrators from Winnipeg, rural, and northern RHAs	
5. Midwifery Implementation and Professional Bodies	**15**
Representatives from the Working Group on Midwifery	
Representatives from the Midwifery Implementation Council	
Representatives from the College of Midwives of Manitoba	

Note: *Numbers in the second column add up to more than 26 because many participants in the study represented more than one stakeholder group. This is especially true of the participants in the 'midwifery and implementation professional bodies' stakeholder group since most individuals in this category were also a member of one of the other four stakeholder groups. Many participants also represented more than one subgroup within their stakeholder group.*

2.4 Interviews

The interviews occurred between January and May 2004. Five participants requested more information about the project and how their confidentiality would be protected before agreeing to an interview. One participant requested a copy of the interview guide in advance to better prepare for the interview. The interviews with 23 of the participants occurred in person, and 3 were done over the phone due to geographical distance. Of the 23 interviews conducted in person, I traveled outside of Winnipeg for 3 of them. All of the interviews were conducted in homes, participant's place of work, or at the College of Midwives of Manitoba. In one interview, 2 of the participants were interviewed at the same time for the first half, and following a short break, one of these two participants was interviewed further alone. In all other cases, participants were interviewed individually and with no one else present. Interviews lasted from 30 minutes (for those involved in only a few aspects of midwifery implementation) to 3 hours (for those with greater involvement in the overall process). A field journal was kept during the period I was contacting and interviewing participants. This allowed me to keep track of who I had spoken to and when, what my feelings and preparation were before interviews, and what my initial responses to the interviews had been.

The interview guide approach to open ended interviews was used. This allowed the topics and issues to be covered to be identified in advance, although the sequence and wording of questions was decided during the course of the interview. The interview guide also increases comprehensiveness and makes data collection somewhat systematic for each respondent, while still allowing the interviews to retain a fairly conversational style (Ulin *et al* 2002). The interview guide (see Appendix E) was developed based on

an extensive review of the midwifery literature from Canada and Manitoba. It was designed to focus on particular issues that had been identified in the Canadian midwifery literature as central to midwifery implementation and definition in this country, or dealt with issues which had been resolved differently in Manitoba than in any other province.

The techniques of elite interviewing were used (Kezar 2003). Documents which were written by the participant or their organization were reviewed prior to the interview and were used to inform the questions asked. Participants often spoke freely of their involvement with midwifery implementation in Manitoba during the interview, and touched on most aspects of interest without being asked specifically. Interviews followed many directions, and the guide mostly acted as a checklist to confirm that all areas of interest were covered at some point during the interview. One of the main characteristics of elites is that they are busy and have limited time, thus multiple interviews are not always feasible, and connections often have to be developed and maintained through less time consuming methods (Kezar 2003). Interviews with some participants in this study had to be scheduled months in advance, and continuing contact was usually maintained through email and the telephone.

2.5 Data Analysis Procedures

2.5.1 Creating the Transcripts

Written notes were typed up, and interview recordings were transcribed verbatim using *Dragon Naturally Speaking 6* voice recognition software. All of the participants were sent their interview transcripts and/or notes between January and June 2004. 19 of the participants were sent their transcript/notes by email, such that they could make their changes directly into the document, and 7 participants were sent their transcript/notes by

regular mail. About half of the participants chose to make changes to their transcripts. Most simply rephrased a few comments to make their meanings more clear. A smaller number removed sections for reasons of confidentiality. Almost all of the participants retained a copy of the transcript for their own records. Participants were asked to review the transcripts/notes, make any changes and get back to me within one month, but few made this deadline. The transcripts/notes were returned between March and September 2004.

2.5.2 Coding and Analysis

The data from this project was analyzed using content analysis. Content analysis involves coding and sorting the data into categories. Day (1993: 42) describes this process succinctly: "We can picture categorization as a process of funneling the data into relevant categories for analysis. The data loses its original shape, but we gain by organizing it in ways which are more useful for our analysis." Categories may be subdivided or subsumed under more abstract categories when they fail to be repeated. Logic may require the addition of new categories not present in the data to produce a comprehensive classification. Classification may also be shaped by the need for categories to maintain reasonable and manageable groupings of data. Once the data is classified or coded, it can be examined for regularities, variations and exceptions (Day 1993). Logical connections between the categories, patterns in the data, and the meaning of exceptions are explored which leads to emerging themes and tentative explanations. These findings are then synthesized into the research account (Ulin *et al* 2002).

To begin content analysis, all of the documentary sources were scanned into the computer using *Paperport* software. The data were arranged according to source.

Combined with the electronic copies of the interview transcripts and typed notes from books, this meant that all of the data could be analyzed within a single program. Coding of the data was conducted between June and September 2004. The coding was formally conducted in the *PowerPoint* software program which allowed for combining data from multiple electronic formats.

Because the data from case study research is extensive, the primary questions and purpose of the research must be kept at the forefront when determining which data should be included in the analysis (Day 1993). To ensure this, an initial coding tree for the content analysis was developed in June 2004 from the research topics identified in the proposal and the themes which became apparent from my initial overview of the documentary sources and interview data. Documentary sources were coded first, in rough chronological order. This was then compared and contrasted with data derived from interviews. The coding tree in which the data was analyzed changed throughout the coding process, going through 7 iterations in all. The coding tree was updated following the completion of coding of data from a given source (for example, Integration reports or Working Group documents). This allowed me to be able to see how the coding was affected by each data source. Towards the end of the analysis, the codes were reviewed to check for miscoded data, to combine codes which had been created but were not reflected in the data, and to subdivide codes which had become unwieldy and needed to be clarified to offer better insight. While all of the data provided valuable perspectives to the research, they were not given equal weight in the analysis (Hiebert 2003). Some of the weighting decisions were based on the perceptions of importance of the different reports and documents expressed during interviews by participants.

2.6 Ethics

The ethics of the research was assured in several ways. Health Research Ethics Board approval for the data collection was obtained from the University of Manitoba (See Appendix F). The letter for contacting participants not only included information about the objectives and procedures of the project, but also personal information about the researcher. These personal attributes were included as they might affect whether participants would be willing to participate in the research project, since the role of the researcher as the primary data collection and analysis instrument in qualitative research means that personal values and biases can play a role in the research project. More detailed information about the project was included in the written *Participant Information and Consent Form* obtained from all participants (See Appendix G). Participants were given a copy of their signed consent form for their records. All of the participants consented to further contact beyond the initial interview. To ensure privacy of surroundings, interview locations and times were arranged so that the interview environment was confidential. Primary data collected was kept in a locked filing cabinet at the Department of Community Health Sciences, University of Manitoba. All of the interviews were transcribed by the researcher to ensure confidentiality.

The primary ethical issue with this study was keeping the identities of the participants confidential within such a small professional community. All of the participants were given an identifying number at the beginning of the project to protect their identities. In some cases, compositing was also used to convey participants viewpoints. Full anonymity was chosen because long term research relationships were not developed with participants to give them an opportunity to become more familiar

with the project, and decide how much they wanted to be affiliated with it. Further, the names of many of the participants are in the public domain, and identification of a participant's role could be easily matched to their name on public documents. Finally, the midwifery, women's health and medical maternity care communities in Winnipeg and Manitoba are small and people generally know each other and the roles they have played.

Participants were given the option of having the interviews tape recorded, or having written notes taken during the interview if this was preferred. Two participants requested that notes be taken, and in one interview, the researcher switched from recording to taking notes to make the participant more comfortable. Notes were taken during all telephone interviews. All other interviews were recorded. Participants were given transcriptions of their interviews or the notes from their interviews to look over to ensure they reflected the participants' perspective on the issues, and they were given the opportunity to change, remove or add material to the transcript, particularly for issues of confidentiality and accuracy. Once participants returned the transcripts to the researcher, the transcripts were anonymized.

Participants were also given the opportunity to review quotes in early drafts of the thesis taken from their interview transcript or notes. They were asked to make any changes to the quotes that they felt were necessary before they were comfortable having them included in the thesis, and to indicate which quotes they did not want included in the thesis. Before giving their approval for using the quotes, the majority of the participants made grammatical corrections. Less than five made larger changes or denied the use of certain quotes because of issues of accuracy or confidentiality. With the quotes, participants were also given drafts of the statements the quotes were being used to

substantiate, which gave the participants the chance to comment on some of the themes which had been developed in data analysis. Participant comments about these themes were incorporated into the thesis. The quotes were sent to participants by email and regular mail in November 2004. Changes were sent back by email, regular mail or discussed over the phone between November 2004 and March 2005.

2.7 Reflexivity

Research relying on open ended interviews relies heavily on the ability of the researcher to develop rapport with participants and the researcher's writing ability to describe what they found, making personal attributes of the researcher central to the success of the project (Punch 1994). Knowing this, it is important that the qualitative researcher systematically reflects on who s/he is in the inquiry and is sensitive to how her/his personal biography shapes the study. This introspection and acknowledgement of biases, values and interests, known as reflexivity, is an important aspect of qualitative research (Creswell 2003).

I attempted to bring this awareness of my personal values into the research from the very beginning. In both the consent form and the contact letter, personal information was included about my volunteer work with two community organizations, the Manitoba Association for Childbirth and Family Education, and the Women's Health Clinic. Both organizations had been active in midwifery implementation, although I was not involved with these organizations until after midwifery was regulated in Manitoba. This personal information was included so that individuals contacted for interviews could consider, before they agreed to participate, the biases I might hold from volunteering with these organizations.

In practice, this decision appears to have given participants more information about me upon which they could build their trust, since I was otherwise almost an entire unknown on this issue. For some participants, my affiliation with the Faculty of Medicine was seen as far more of a negative bias than my community affiliations, and I believe it was the information about my community involvement which led them to agree to an interview. In other cases, I believe my affiliation with the Faculty of Medicine and the Department of Community Health Sciences were important personal attributes for gaining participants' trust. I also believe that my initial work contacting the College of Midwives of Manitoba was important for giving my research study the added legitimacy necessary for busy professional participants to agree to an interview. The active role my supervisor had played in midwifery implementation also meant that her name being attached to the project influenced participants decisions to participate, and in the majority of cases this was viewed positively. Thus, these personal aspects of the researcher, while viewed as a possible hindrance, also played a very useful role in developing trust and rapport with participants.

In addition to the information available to participants in the information letters, it is also important to note that my volunteer work with the Manitoba Association for Childbirth and Family Education included attending less than ten births as a doula or labour companion. In this role, I developed relationships with women from mid-pregnancy to the postpartum period, and attended their births, assisting them with information, emotional support and non medical pain relief measures. All of these births occurred in hospital, and one was attended by midwives. Through this experience I got a taste both of the joy of attending a birth, and the strain of being on call. I have also done

volunteer work in the areas of sex education, equitable access to reproductive health services, and reproductive choice including unplanned pregnancy counseling. This volunteer work has given me some personal insights into the issues affecting professionals working in reproductive health without ever having worked in the medical, nursing or midwifery professions.

The point during the research process in which personal attributes can most affect the project is during data collection when using open ended interviews. All successful interviewing relies on creating rapport to develop the interconnection and trust needed so that a participant will open up. Developing this rapport can be a delicate issue though, and in a few cases I felt that offering details about my life beyond those made clear at the onset of the project, or choosing not to share certain details (examples include my interracial marriage, my religion, my political views), was influential in the quality of the information I received and the atmosphere of the room during the interview. In elite interviews, Kezar (2003), points out that creating rapport also implies affinity which the researcher can only achieve authentically because of their own higher social status. She believes that the interviewer should reflect on how his or her own privileges may facilitate connection with elites interviewed. My being a woman facilitated this research project on a profession dominated by women, and where the majority of my participants were women. My white race also facilitated this project since the majority of my participants were also white. In the cases where the participant was not the same race, I believe this also influenced what the participant felt comfortable telling me, since no topic of discussion may be as infused with racialized discourse as reproduction. My education level also matched that of most of my participants.

The impact of my personal attributes on this project did not stop with the interviews. During data analysis and writing, I worked hard to balance honest representation of what I heard from the participants and saw in the documents, with a critical eye for the hidden ways that power works. My marriage into a non-European immigrant family influenced my focus on the status of non-European immigrant women with midwifery training in the province. The thesis has also been influenced by my move to Alberta in the middle of this project. The status of midwifery in this province is unfunded and declining, and I became far more appreciative of the model in Manitoba, and the depth of the successes and progress which has been made in that province. During the editing stages of this thesis, I also became pregnant for the first time and entered midwifery care in Alberta. There is little question that all of these factors influenced the final product of this thesis.

Chapter Three: Conceptual Framework

3.0 Introduction

This chapter will review the history of midwifery in Canada to illustrate the multiple groups of midwives which have attempted to gain legal status for midwifery. It will discuss the strength of the medical dominance which grew in Canada and was able to suppress these movements, and the recent changes in the health care system which have increased support for the regulation of midwifery. This review of midwifery in Canada will identify four discernable groups of midwives who are now interested in practicing: Aboriginal women, community midwives, nurse midwives and immigrant midwives. These midwifery groups show great variation both within and between them. The concept of medical dominance will then be discussed as it applies to the historical suppression of midwifery in Canada. This will be followed by a review of two reinforcing trends in health care which are now creating a possible niche for the midwifery profession. The first is the recent decline in medical dominance which includes a focus on using non physician health professionals to provide medical services as a strategy to rationalize health care costs. The second is the concept of biomedicalization which refers to profound philosophical shifts in the health care system which include new support for alternative health care approaches and models of practice, such as those held by autonomous midwives.

3.1 History of Midwifery in Canada: Suppression and Revitalization

Although Canada was the last industrialized country to recognize and regulate the profession of midwifery, women with midwifery training have practiced in the country and worked towards formal recognition of the profession throughout its history (Task

Force on the Implementation of Midwifery in Ontario 1987). This section will review these historical movements and identify the four groups of midwives which have grown out of this history and are now interested in practicing as part of the present implementation of midwifery in Canada. The first midwives in the country were Aboriginal and Inuit midwives. Their practices and traditions were actively suppressed as part of colonialism, but they have seen a resurgence in recent years. European settlers also brought midwifery traditions with them, but their attempts to re-establish the formal role midwives had in Europe were not successful, nor were attempts to develop Canada specific midwifery programs. Following the subsequent medicalization of birth in the first half of the twentieth century, community midwives began practicing as a form of resistance, attending home births and organizing for legal status beginning in the 1970s. At the same time, nurse midwifery pilot projects were also started in hospitals throughout Canada by nurses with midwifery training who advocated for the regulation of nurse midwifery. Finally, as immigration trends have changed in Canada, more women have immigrated with direct entry midwifery training from non-European countries, and have been frustrated to find that they can practice here neither as nurses nor as midwives. Thus, Aboriginal midwives, community midwives, nurse midwives and immigrant midwives make up the four current groups of midwives wanting to practice in Canada.

3.1.1 Historic Midwifery Practices and the Medicalization of Childbirth

The Aboriginal and Inuit Peoples of Canada have a long history of developing and utilizing sophisticated midwifery knowledge and skills (Task Force on the Implementation of Midwifery in Ontario 1987). There is great variation in how childbirth was attended from one cultural group to another and midwifery traditions

changed and developed over time. In general, birth was seen as a sacred and important event, and a certain amount of childbirth knowledge was often widespread in communities. Childbirth care could also be provided by many people, sometimes including men. In many communities though, certain women came to be recognized because of their greater skill, knowledge and experience of childbirth. These midwives were often women Elders who were responsible for passing down moral principles to the next generation, and in some cultural groups, systems of apprenticeship with these Elder midwives were developed for young women seen to have a calling to midwifery (Albert 1997; Carroll and Benoit 2004; Hiebert 2003).

The impact of colonialism on Aboriginal midwifery and childbirth practices was multifaceted and devastating. Many Aboriginal midwives found themselves threatened, punished or ignored by both missionaries and government officials. Residential school policies further broke down traditional knowledge systems and cultural practices. Patriarchal government legislation and cultural influences from the colonial occupation also challenged the survival of Aboriginal midwifery. Then, in the 1950s and 1960s the federal government constructed nursing stations in many northern communities. With the loss and suppression of so many Aboriginal midwifery traditions, these stations quickly became the centre of medical care (including maternity care), although a few Aboriginal midwives continued to practice in more remote areas (Hiebert 2003; Carroll and Benoit 2004; Albert 1997).

While playing a role in the suppression of Aboriginal midwifery practices, European settlers to Canada in the eighteenth and nineteenth centuries also came with long traditions of midwifery, and many brought both midwifery expertise and

expectations about midwifery as a formal occupation to the colonies (Task Force on the Implementation of Midwifery in Ontario 1987). In many French colonies there were initially salaried town midwives elected by the women in the community just as there had been in Europe. As immigrants began coming from other parts of the world, they too brought their own midwifery traditions and midwives continued to care for women across Canada (Donnison 1981). The Canadian situation was different though, and families were often widely dispersed and health professionals scarce. Neighbour women became the primary source of midwifery support for most women (Relyea 1992). These women did not move towards organizing into a professional group in Canada. Since the women with formal midwifery training tended to be new immigrants, they were often isolated from each other geographically and through language. As well, many of the respected neighbourly midwives were women of advancing age who did not work full time in the profession and did not conceive of midwifery as a career (Bourgeault 1996).

The midwifery profession was thus quite vulnerable in Canada when the number of physicians began to increase, and the doctors began to organize. Physicians had legislation passed that gave them the sole right to offer midwifery services in Upper Canada in 1795. Over the next hundred years, neighbour women and midwives would continue to attend births, and the legislation shifted back and forth between exempting midwives from the legislation regulating medicine, and making their practices illegal. Although rarely enforced, the presence of these laws likely served to intimidate and discourage midwives from practicing. The laws were also about more than just creating a monopoly in childbirth for physicians. Many people involved in maternity care issues believed that medical care was more progressive and modern. As a new colony, they

thought Canada had a chance to break away from the old European traditions, including midwifery, and start fresh with a new modern medical maternity care system. The midwives' credibility was undermined as physicians were promoted for having superior scientific and technological training in childbirth (Bourgeault 1996; Task Force on the Implementation of Midwifery in Ontario 1987).

One challenge to this push for medicalization was that there simply were not enough physicians, especially outside Upper Canada, to attend every woman, nor could all women afford the physicians' fees. Recognizing this reality, there were attempts to organize midwifery services in many areas of the country. These services were seen as an unfortunate necessity required until more physicians became available. Specific legislation for midwifery practice was introduced in Nova Scotia and Quebec in the 1870s, and midwifery remained legal in these provinces until after the First World War. The National Council of Women also tried to get a Canadian training program started for lay midwives in 1897, called the Victorian Order of Home Helpers, but the organizing nursing profession felt that home based health care was in their scope of practice, and the Victorian Order of Nurses was started instead. As these nurses began serving remote communities, they quickly found that they lacked the midwifery skills which were in high demand. The Victorian Order of Nurses then attempted to get their own formal midwifery training program started, but this was not successful because of support for the medicalization of childbirth within the wider nursing profession (Relyea 1992).

While these attempts indicate an acceptance of midwifery services for remote areas of the country, the campaign to medicalize childbirth continued in the cities, towns and surrounding areas. Women across Canada became the focus of campaigns promoting

instrumental childbirth and physician-attended hospital birth as safer and a part of modern progress in the first half of the twentieth century. While these arguments have never been proven, they are powerful nonetheless and there was a rapid move to hospitals and doctors for childbirth. With the rise of aseptic techniques and antibiotics, hospitals were no longer feared because of their high rates of infection (Shroff 1997). Following World War II, federal grants became available to municipalities to build hospitals. Physicians working in rural areas began to have easier access to hospitals, and municipalities were supportive of moving childbirth to the hospitals to keep them in use to their full capacity. Further, with the passage of universal hospital insurance in 1957, low income women no longer had to use midwives because their services were less expensive than giving birth in hospital (Fierlbeck 2000). Hospital birth soon became the norm for those who could access them (Shroff 1997).

One exception to this trend was Newfoundland. In Newfoundland and Labrador, which remained a British colony into the first half of the twentieth century, a *Midwives Act* was passed in 1920 modeled on the midwifery services of Great Britain. The region had a direct entry program for midwives until 1934. However, following Newfoundland's incorporation into Canada, nursing was given responsibility for regulating midwives in 1953 and their direct entry program was lost. Soon after, the number of midwives began to dwindle, and by the 1970s regulated midwifery services were no longer being offered in Newfoundland (MacLellan 1997; Benoit 1991).

Another exception was the Federal Health Services for First Nations communities. In the 1950s, the federal government began to hire nurse midwives, primarily from Great Britain, to staff the nursing stations that were being built to serve

Inuit and First Nations communities. Many Canadian nurses traveled to Great Britain for midwifery training, or learned it informally while working in the north with nurse midwives. Soon, extended scope of practice training programs which incorporated midwifery skills were started for Canadian nurses who wished to take advantage of the expanded practice opportunities which had been created in the north. The first program was started in Edmonton, Alberta in 1944[3] and followed by similar programs in Halifax, Nova Scotia in 1967, and St. John's, Newfoundland in 1978 (Relyea 1992; Bourgeault 1996). This anomalous federal hiring policy led to many nurse midwives working in a limited scope of practice as maternity nurses in southern Canadian hospitals as they migrated to urban centres later in their careers.

In the 1970s, there was a discontinuation of this pattern of hiring foreign trained nurse midwives due to tighter immigration policies, and a new philosophical focus on trying to address broader issues of public health in First Nations communities. Rather than hiring nurse midwives, the Federal government began to focus on recruiting Canadian trained public health nurses instead. Initially there had been a policy of the nurse midwives attending lower risk births in the nursing stations while higher risk pregnant women were evacuated to urban hospitals for birth. Soon the shortage of qualified nurse midwives meant that more and more normal pregnancies were being evacuated as well (Hiebert 2003). By the 1980s, almost all pregnant First Nations women were evacuated weeks before their due dates to wait in often unfamiliar towns and cities for birth (Hiebert 2003; Bourgeault 1996).

[3] This program was initially started to produce nurse midwives for remote areas of the province, but was later used to prepare nurse midwives for practicing in the north (Relyea 1992).

3.1.2 Aboriginal Women and the Resurgence of Aboriginal Midwifery Traditions

This 100% evacuation policy was not accepted easily by many First Nations women who found it extremely stressful to be away from their communities, families and cultural traditions for many weeks at the time of childbirth. First Nations women began asserting their right to regain control over childbirth and health care within their own communities. This change developed from a number of factors, including wider movements for greater Aboriginal autonomy, self-government and devolution of federal health programs, and the establishment of Aboriginal women's organizations. This was combined with recognition that revitalization of traditional healing practices and worldviews was critical to the renewal of Aboriginal communities (Hiebert 2003). This movement to return childbirth to communities and revitalize Aboriginal childbirth traditions led to the development of a few Aboriginal and Inuit maternity care projects in northern Canada which offer a complement of Aboriginal and Western childbirth practices (Carroll and Benoit 2004).

3.1.3 Nurse Midwifery

At the same time that childbirth was becoming more centralized in First Nations communities as Aboriginal women were transferred to towns and cities to deliver, this trend was also occurring to a lesser degree throughout the country as maternity care continued to become increasingly medicalized and technology centred in the 1960s and 1970s. Soon few community hospitals were able to offer obstetric services because they did not have the technologies that were increasingly considered necessary equipment, and there was a trend towards centralizing all births into urban tertiary hospitals. Pressure also increased on physicians to remain current in their understanding of technological

innovations. These factors gave rise to a trend among general practitioners, especially in rural areas, to give up their obstetric practices. This was compounded by a trend among obstetrician/gynecologists to increasingly opt out of obstetrical care as the cost of liability insurance for obstetrics grew. Both to fill this growing gap, and because of the consumer interest, government review committees began recommending the integration of hospital based nurse midwifery supervised by doctors to address this growing shortage of physicians attending childbirth. Invigorated by the results of these reviews, nurses with midwifery training, many of whom had practiced in the north, began to form Nurse Midwifery Associations and to advocate more strongly for legalized nurse midwifery (Scurfield 2002; Kornelsen *et al* 2000; Bourgeault and Fynes 1997a). In response, pilot nurse-midwifery programs developed in the 1980s and 1990s in Edmonton, Calgary, Toronto and Winnipeg (James 1997; Scurfield 2002). Many nurse midwives hoped that the success of these pilot programs would develop into the regulation of nurse midwifery as a recognized nursing specialty (McKendry 1997).

3.1.4 Community Midwifery

Many maternity care consumers were also concerned about the effects of this medicalization and centralization of childbirth on the care they were receiving. Some became troubled as they saw the psychosocial aspects of birth being neglected, normal labour and delivery experiences being pathologized, and iatrogenic birth complications rising (Scurfield 2002). In response, a natural childbirth movement began to gain momentum in Canada in the 1970s. The natural childbirth movement had started in the 1940s in Great Britain, and it advocated for women being more active in childbirth. It also initiated the growth in non medical strategies for alleviating childbirth pain because

of concerns about the implications of the routine use of analgesia. As this movement gained strength in Canada, women began to be more vocal about their dissatisfaction with the impersonal treatment they received and the overuse of interventions and analgesics in hospital. They started to advocate for childbirth education, birthing rooms, distinctions between abnormal and normal birth, and the presence of fathers and other family members at births to reintegrate the emotional and social aspects of the experience (Scurfield 2002).

Along with these attempts to reform the medical care of childbirth, there was also a resurgence of community midwives who did home births to move childbirth entirely out of the medical realm of the hospital and its technological interventions (Mason 1990). Most supporters of this movement came out of the anti-establishment counter culture of the 1960s, but there were a number of philosophies within this home birth movement about what model of care midwives should offer. Cut off almost completely from the midwifery traditions of their predecessors, women began to again rely on their own experiences and a few texts and herbs as they assisted their friends in giving birth. Over time, certain women in these communities began to be interested in learning more about midwifery, and many started study groups, went to other countries for education, and apprenticed with more experienced midwives or supportive physicians to educate and train themselves (Bourgeault 1996; Sharpe 2004). With time, these community midwives began to organize into midwifery associations to share information, knowledge and get social support from others doing similar work (Benoit 1996/7; Page 2000).

The community midwife's philosophical commitment to assisting women in taking greater control over their health prompted support from the women's health

movement. Home birth became a symbol of women regaining control over the reproductive process, and midwifery began to be regarded as a feminist act. Demand for women with home birth experience grew beyond the original close groups of friends, and the community midwives' practices became more formalized (Benoit 1996; Page 2000). This expansion raised concerns about safety and competition among many physicians. In the 1980s and 1990s, charges were laid against community midwives ranging from practicing medicine without a license, to criminal negligence. While some community midwives did not believe that birth attendants required any professional status or training, other community midwives responded to these legal challenges by advocating for professional legitimacy, formal training programs, and established standards of practice (Benoit 1996/7; Bourgeault and Fynes 1997b). Many of the organizations originally formed for self education and social support began to engage in political action to achieve legislation and incorporation into the existing health care system (Bourgeault 1996).

3.1.5 Immigrant Midwives

At the same time, a growing number of women with midwifery training remained peripheral to both the nurse and community midwifery movements. Canada is a country which accepts large numbers of immigrants. Since midwifery care is the norm in most of the world, many women immigrating to Canada have midwifery training and are often frustrated to find that they cannot practice here. As trends in Canadian immigration have changed, these immigrant women with midwifery training have increasingly been women of color from non-European countries (Nestel 1996/7). While most immigrant midwives trained in the United States, Europe and British Commonwealth countries could fit into either the nurse midwifery or community midwifery groups, the increasing numbers of

midwives from Asia, South America and many African nations did not fit so easily into these two models. The midwifery professions they had been trained in were very diverse in their model of care and levels of medicalization and autonomy. Many were educated in direct entry programs and did not have nursing qualifications, or their nursing qualifications were not recognized in Canada. They could neither practice in the public health care system as perinatal nurses nor risk their immigrant status by attending home births in the community and providing care outside the law. With their professional status lost, their employment opportunities were limited and most worked outside of the health care system in low paying, marginal jobs. They were often isolated from one another because of language, and never formed a cohesive, organized group (Kaufert and Robinson 2004). While largely invisible outside of their ethnic communities, immigrant women of color with midwifery training nevertheless constituted a significant proportion of the potential midwifery practitioners in provinces across Canada, and had a great deal to gain from the possibility of being able to practice their profession again (Task Force on the Implementation of Midwifery in Ontario 1987; Nestel 1996/7).

3.1.6 Summary

Thus, as many Canadian provinces considered midwifery legislation, there were four rather disparate groups of midwives interested in regulated practice. Aboriginal women in many communities were organizing and advocating for a resurgence in Aboriginal midwifery traditions as part of a movement to revitalize their communities. While the medicalization of childbirth in the nineteenth and twentieth centuries had tried to erase midwifery from the Canadian health care system, the lack of physicians available in remote areas led to hiring and training policies which introduced a steady stream of

nurse midwives who wanted their credentials recognized. The number of community midwives offering home birth services also increased in the second half of the twentieth century, and as they became more visible, their need for regulation to protect themselves from legal harassment was becoming heightened. The number of midwives who wished to practice was also continually added to by the many immigrant women who came to Canada with midwifery training and found to their frustration that they could not practice here. The presence of so many movements for professional midwifery in Canada illustrates both the continued resistance to the medical monopoly on childbirth, but also the strength of medical dominance throughout Canadian history which has been able to suppress a role for midwives for so many years. The repeated failure of midwifery services to become accepted parts of the mainstream in Canadian history also indicates that clearly there have been recent changes in the health care system which have made acceptance of a formal midwifery profession possible.

3.2 Medical Dominance, Decline, and Biomedicalization

This section will further define the concept of medical dominance, describe the reasons for its recent decline, and describe how the combined trends of declining medical dominance and biomedicalization can be used to explain present changes in the health care system, including those which make midwifery regulation possible. The term medical dominance has been used to describe the trajectory of the Canadian health care system which gave physicians a near monopoly on health care and allowed the system to grow while excluding or limiting a number of other health professions. Recent changes in the health care system have begun to challenge medical dominance though, and many researchers describe a decline in physicians' control of the health care system, client care,

and other health professions such as midwifery. The term biomedicalization has been coined by Clarke *et al* (2003) to describe some of the recent philosophical shifts in the health care system which also lend greater support for alternative practitioners such as midwives.

3.2.1 Medical Dominance

Coburn *et al* (1997: 2) define the concept of medical dominance as "...medical control over: 1. the content of care; 2. clients; 3. other health occupations; and 4. the context of care (*e.g.* health care policy)." The rise of medical dominance in Canada can be traced back to the nineteenth century when the state began to use its regulatory powers to create a monopoly for medicine. The first *Medical Act* passed in 1795 in Upper Canada attempted to create an all inclusive definition of medicine, and limit the practice of 'physic and surgery' to practitioners with university degrees. Because of the small number of practitioners who fit these requirements this act was repealed as impractical, but was re-enacted in 1866 once the numbers of physicians in Canada increased. Following this 1866 *Medical Act*, no other health profession could perform certain medical tasks except under the direct supervision of a physician (Benoit 2000). With this government sanction of a medical monopoly in place, the medical profession then began to organize into associations which used their leverage to continue to ensure that as the health care system developed, other health professions would remain limited or excluded. These efforts were aimed at midwifery but also many other health professions including nursing, pharmacy, chiropractic, naturopathy and dentistry (McKinlay and Marceau 2002; Coburn 1993; Scurfield 2002; Burtch 1994). Medicine further secured their monopoly with state support for medical education, which allowed the medical

profession to educate and produce new physicians at a rate which far outstripped all other health professions (McKinlay and Marceau 2002).

This medical dominance reached its peak in the mid twentieth century as physicians began to staff the majority of positions in government health departments, up to and including the role of Minister of Health. Leading physicians often influenced or even wrote health policy. Rather than having the support of government, the medical profession thus began to make up the government which regulated health care in Canada through World War II. Physicians also played a key role in writing the federal and provincial health insurance legislation in the 1950s and 1960s which restricted health insurance coverage to physician and hospital care (Coburn 1993). The *Canada Health Act* (1984) is the most recent legislation which reinforces this medical monopoly by stating that reasonable access to health services without financial or other barriers only applies to those health services deemed required by the medical profession and offered by hospitals and physicians (Benoit 2000).

3.2.2 Declining Medical Dominance

While there is no question that medicine remains the most powerful health profession in Canada, starting in the 1960s when the provincial and federal governments became involved in offering public health insurance, some researchers argue that there has been a decline in medical dominance (Coburn 1993; Coburn *et al* 1997). With federal and provincial health insurance plans, the state soon became more closely involved in regulating medical care to rationalize costs, and physician services were viewed as the primary cost of the health care system. Physicians also began to be replaced in health ministries with managers and accountants, and there was a transferal of

decision making power out of the hands of physician run organizations to lay (whether state or corporate) organizations (Coburn 1993; Coburn and Biggs 1986; McKinlay and Marceau 2002; Coburn *et al* 1997; Coburn *et al* 1999; Benoit 1997). This has gradually led to an erosion of state support for the medical profession's autonomy as the interests of medicine became secondary to the state's focus on rationalizing costs (McKinlay and Marceau 2002).

One of the first ways that the state encroached on physician's dominance to reduce health care costs was when provincial governments decided that they would set the fees they would pay for physician's services rather than letting the medical associations set the fees (Coburn *et al* 1997). Reducing physician's fees did not work well to reduce medical costs to the health care system though, because physicians maintained their income by seeing more patients, and including more high paying specialty services in their practices. Once this was realized, there developed a movement towards introducing bureaucratic mechanisms to monitor physician's fee claims data and investigate physicians with unusual billing patterns. Initially, these data systems judged physician's practices compared to the practices of their peers. Soon, this standard began to be seen as unreliable, and economists and epidemiologists were hired to research clinical guidelines and develop health policy to determine which treatment options offered the best balance of efficaciousness and affordability. This research then became the basis for micromanaging medical services by non physician administrators. This use of clinical guidelines which are researched, written and enforced by non physicians undermines medicine's claims to expertise and judgment about the content of medical services (Coburn *et al* 1997).

In recent years, non physician health practitioners have also begun to garner greater support from the state as cheaper health care providers, and they have become responsible for increasing amounts of medical care that was previously provided by physicians. With the focus on cost containment, non physician providers become more appealing because they are less expensive to pay, and studies indicate that their clinical outcomes are similar to medical care. There has also been a shift towards chronic conditions as the primary diseases affecting the Canadian population. These health concerns require regular monitoring and caring to improve the quality of life (rather than curative measures), which may be more appropriately provided by non physician practitioners (McKinlay and Marceau 2002). Through legislation and regulations, the government has begun to grant increased practice rights to these other health care providers. In Ontario, Alberta and British Columbia there has even been a transformation in the way the health professions are regulated to make it easier to introduce new professions. By creating a single system through which all health professions are regulated, this legislative reform puts medicine on a more equal footing with other healthcare providers (Coburn *et al* 1997). This state support for providers which medicine has until recently been able to suppress and limit indicates a decline in medicine's dominance over the other health occupations.

The introduction of new providers has also been fostered by the increasing specialization that is occurring within medicine. Medical specialization has fragmented the once unified and powerful pressure that could be exerted by the medical associations. According to McKinlay and Marceau (2002: 408), "Fragmentation of physicians into specialist societies and internal dissention…have created a divide-and-conquer

opportunity for both private business interests and the state. Groups of physicians with particular specialty interests can be pitted against each other to achieve an outcome that is sometimes not in the overall or long-term interest of the profession." The interests of these groups have also become more varied because of the hierarchical nature of medicine which views some specialties as more prestigious than others, and generally places family practitioners at the bottom. This is especially important since most new health care providers are infringing on the scope of general practitioners which elite specialists within the profession may be less concerned about protecting (Coburn *et al* 1997; Angus and Bourgeault 1999).

Through advances in information technologies, patients have also begun to undermine the authority of physicians as they increasingly have direct access to medical knowledge about their care. Medical knowledge and technical expertise was, until recently, possessed only by doctors which contributed to their privileged position. Now patients can get up to date information on conditions, diagnoses, tests and treatments from the internet, and they can use this information to informally evaluate the appropriateness of particular treatments and procedures recommended by their doctor. Patients can also access information on the comparable performance of medical facilities and particular practitioners, information which medical colleges used to be able to keep privileged. This changes the physician-patient relationship as patients are able to observe, judge and question physicians and their actions in a whole new way, reducing medical prestige and authority.

Thus, through these changes, medicine has seen a decline in all aspects of their previous dominance. As patients become more informed, they have been able to control

more aspects of the physician-patient encounter. Physicians in Canada also no longer have complete control over the context of care in terms of the funding mechanisms and policy regulating the health care system. Increasing state support for non physician researchers and administrators has led to a loss of medical control over clinical decision making about care. Finally, with the introduction of new legislation which gives greater autonomy and extended practice rights to other health occupations, physicians are increasingly losing control over the other professions in the health care field.

One of these health professions is midwifery, and many of the trends which are detrimental to medical dominance can be seen to lend support for regulating midwifery. Midwifery is one of the non physician health professions which is perceived as a possible lower cost replacement for medical obstetric care. By focusing only on normal pregnancy and birth, the niche being created for midwives focuses more on monitoring and caring than treatment, and infringes primarily on the scope of practice of general practitioners which may be less threatening to medical elites. However, midwifery also brings a philosophy and model of practice which is distinct from and sometimes even contradictory to medical maternity care. Were declining medical dominance the only trend in health care at present, support would be primarily given to the lowest cost, most medicalized model of midwifery to replicate medical obstetric services at a rationalized price. This would lend greatest support to introducing a nurse midwifery service (Bourgeault 1996). The fact that autonomous midwifery, modeled most closely on community midwifery, has been regulated in Canada instead, would thus appear to indicate that the decline in medical dominance has been accompanied by a trend towards introducing new philosophies in health care as well.

3.2.3 Biomedicalization

Clarke *et al* (2003) argue that there has been a recent philosophical shift in the health care system which they term biomedicalization. They describe the recent historical shift from medicalization to biomedicalization as one from using scientific innovation and technology to *control* the body, to using technologies and innovations to *transform* the body. One of the best examples of this is the shift from primarily caring for mental illness within institutions towards using pharmaceuticals to transform individuals' psychological states while they remain in the community. This biomedical process encompasses multiple new trends in the health care system as these systems become increasingly complex. This complexity includes the fact that while many researchers write of a decline in medical dominance, the health care system is also becoming an increasingly larger portion of our economy and daily lives as aspects of health and social identities continue to be incorporated into the medical domain. The last twenty years has seen extensive advancement and growth in biotechnologies in the areas of genetics, pharmaceuticals, microsurgeries and implant technologies. Thus, much broader, sometimes seemingly paradoxical, changes have been occurring in the health care system.

The concept of biomedicalization argues that there has not just been a decline in medical control of clinical care, but that clinical care has fundamentally changed as risk and surveillance practices are now seen as central to maintaining health, and medical monitoring is extended beyond illness and disease to health and the risk or possibility of disease. Clarke *et al* (2003) write that the medicalization of social issues such as homosexuality, the treatment of stigmatized differences such as obesity through diet pills,

the long term management of chronic illnesses, and the increased focus on prevention, have all developed into a medicalization and commodification of health. Health has thus become a difficult to attain ideal which individuals are told to strive for through an unending process of self transformation brought about by education, behavior change, buying the appropriate technologies and resources, and medical and psychosocial treatment. As the focus has shifted further into health and away from disease, more of individual's lives are commodified, medicalized, and placed under surveillance.

With the focus on health, there is also a focus on risk and risk levels. Risk assessment tools and information technologies are used to determine risk factors in daily life, and people and populations are defined not as healthy or ill, but by their level of risk. Once everyone is defined as potentially at risk, surveillance becomes a constant part of daily life, such that more processes of biomedical surveillance are occurring but they are done in the home and are the responsibility of the individual. Health care providers become specialists in risk populations, marketing different technologies and forms of care to different populations. This creates customized care for different risk populations and individuals in a more stratified health care system: "In the move from universalizing bodies to customizing them, biomedicine has also allowed for some destabilization of differences. Human bodies are no longer expected to adhere to a single universal norm. Rather, a multiplicity of norms is increasingly deemed medically expected and acceptable" (Clarke *et al* 2003: 181).

There also comes a greater acceptance of the knowledge systems and philosophies of alternative practitioners, and the care decisions of patients who have become more knowledgeable about their care choices through the internet and consumer health

movements. With the focus on individuals monitoring their own health status, researching their care options, and working/shopping to attain health, there is a blurring of private/public boundaries with a devolution of health care services from the hospital to the home and community. This devolution of care to the home also reflects a focus on rationalizing costs and centralizing expensive health care technology so that it can be used most efficiently. At the same time, micro technologies, implant technologies, and pharmaceuticals make it possible for more care to occur in the community.

The regulation of autonomous midwifery fits within this process in a number of ways. Seen through the lens of biomedicalization, integrating autonomous midwifery becomes possible through the use of medically developed risk assessment structures which define low and high risk pregnant women and verify this designation through technological tests. Since high technology care is centralized, midwives become the specialists in the care of low risk populations offering customized services. Midwifery's philosophy of individual responsibility, self monitoring, informed choice, increased social as well as physical surveillance, and rationalized and devolved care also become more appropriate. Midwifery personalizes care, yet does so from an acceptance of evidence based practice, thereby relying on information technologies to verify their model of practice (Bourgeault and Fynes 1997a). Midwifery care in the community also relies on micro-technologies such as hand held Dopplers which can be used in any setting. In the advent of a client becoming high risk, she can be transferred to the centralized high technology care available in hospital. Finally, it also indicates the acceptance of multiple genres of knowledge (Bourgeault 1996). With this support for some of the philosophical aspects of midwifery, the concept of biomedicalization lends

greatest support to the regulation of community midwifery. Because of this processes' focus on multiple genres of knowledge and customized care, biomedicalization also explains how midwifery regulation could be more inclusive of other midwifery groups at the same time.

Thus, according to the biomedicalization concept, within an increasingly stratified health care system, midwifery becomes the low technology customization which allows the high technology and bioengineering branches to grow with minimized protest because they become care customized for high risk individuals and those seeking technological interventions. This conceptual model does not lead to the conclusion that the regulation of midwifery indicates co-optation by the system it initially challenged or that the regulation of midwifery signifies some sort of victory over the medical profession. Instead, it views the health care system as fundamentally changing such that autonomous midwifery has a role in this new system for multiple reasons. As Clarke *et al* (2003: 185) make clear, biomedicalization is a transformation of health care which is not inherently coercive and oppressing but leads to multiple outcomes which are differentially beneficial and empowering for different groups: "Instead we see new forms of agency, empowerment, confusion, resistance, responsibility, docility, subjugation, citizenship, subjectivity and morality." It creates new sites of negotiation which must be engaged in and evaluated in new and more complex ways. It is also an incomplete process, such that the introduction of midwifery may find support and challenges from different sources (Clarke *et al* 2003). Within the complex dynamics of biomedicalization, midwifery regulation can be understood to serve multiple purposes and create multiple outcomes as midwifery becomes a new site of negotiation and power within the health care system.

3.3 Summary

While Canada is the last industrialized country to have regulated midwifery, this does not mean that it does not have a long history of movements to get the profession formally recognized. From a review of this history, it becomes possible to conceptually divide the midwives now interested in practicing into four groups. Aboriginal women, nurse midwives, community midwives and immigrant midwives have all attempted time and again to get the midwifery profession recognized and/or incorporated into the health care system. The concept of medical dominance has been used to explain Canada's historical trajectory where despite these movements, physicians have had almost total control over the health care system and been able to use this power to exclude other health occupations such as midwifery. However, a decline in medical dominance has been identified caused by the state's interests in reducing health care costs combined with changes in the medical knowledge held by patients and the internal organization of medicine. Contemporaneous with this decline in medical dominance in Canada have been larger structural and philosophical shifts in Western health care systems around the world, a process termed biomedicalization by Clarke *et al* (2003). The theory of a decline in medical dominance combined with the concept of biomedicalization offers a cohesive framework for understanding how the new focus on reducing costs, customizing care, and risk populations creates seemingly paradoxical support for growth in both new medical technologies and autonomous non physician practitioners such as midwives.

Chapter Four: Implementation of Midwifery in Canada

4.0 Introduction

This chapter will outline the pertinent aspects of the structure of the Canadian health care system affecting the introduction of the midwifery profession, and the national context of midwifery implementation in which Manitoba finds itself. It will review the history of midwifery implementation in Manitoba, and identify the initiatives which differentiate midwifery in this province from the other Canadian provinces with regulated midwifery. The Canadian health care system is actually thirteen separate health care systems each coordinated by a provincial or territorial government since the Canadian Constitution defines health care as a provincial jurisdiction (Fierlbeck 2000). While this gives the provinces some autonomy about the introduction of services such as midwifery, there are a number of similar pressures affecting all of the provinces. In seven of the thirteen Canadian provinces and territories these factors have recently allowed the passage of midwifery legislation, and five of these provinces have since implemented midwifery services, the fifth being Manitoba. While the prior regulation of midwifery in four other provinces put positive pressure on Manitoba to replicate their decisions, in many ways Manitoba followed its own trajectory, and tried different things.

4.1 The Structure of the Canadian Health Care System

Despite the fact that health care is a provincial jurisdiction in Canada, there is national universal health insurance regulated by the federal *Canada Health Act* (1984). This Act sets standards that all of the provincial health care systems must meet in exchange for the federal financial support which the provinces require to maintain health insurance coverage for their residents. Beyond the minimum guidelines set by this Act,

the provinces and territories also have the autonomy to determine what extra services they want to offer, and to determine the administrative organization of their health care systems. Recently, the majority of the provinces have chosen to use this autonomy to reorganize their health care services into Regional Health Authorities (RHAs)which adds a third level of structure to the health care system. Each of these levels of the health care system, federal, provincial and regional, adds its own economic and political pressures affecting the implementation of midwifery in Canada.

In Canada, the state does not provide health services, but regulates and finances a universal, public, single payer health insurance plan which allows independent physicians and hospitals to bill the government for the majority of services they provide to Canadian residents (Fierlbeck 2000). This system developed in a piecemeal fashion in the post World War II era. As early as 1942, interest in a public health insurance program was expressed by the federal government and by many provinces. While unable to agree on a national strategy at this time, a few provinces chose to implement hospital insurance programs on their own over the next ten years. The success of these provincial programs spurred the passage of national hospital insurance with the *Hospital Insurance and Diagnostic Services Act* in 1957, which was implemented by all of the provinces by 1961. This was then supplemented with the national *Medical Care Act*, passed in 1966, which introduced universal insurance for all physician services (Fierlbeck 2000; Weller and Manga 1983).

Initially, the Federal government agreed to cover 50% of itemized hospital and medical services costs incurred by the provinces through these Acts. This financial situation did not last long though, as the provinces sought greater autonomy in structuring

their health care systems, and as the federal government became interested in reducing its funding contribution. In 1977, the federal government implemented the *Established Programs Financing Act*, which created block health care funding. This gave the provinces greater freedom in determining how they would spend the money, but it was also tied to reducing the federal contribution to health insurance. It soon became apparent though, that while the provinces desired more autonomy, they lacked the resources to manage their health care systems on their own. Provincial funding cutbacks in health care in the 1980s led to the rise of extra billing, where a minority of physicians charged patients for the difference between the fee the government would cover, and the fee their medical associations believed was appropriate. To end extra billing and any other possible future intrusions into the principles of the health insurance acts, the *Canada Health Act* was introduced in 1984 to formalize both the services that the provincial health care systems had to include, and the principles these systems had to uphold (Fierlbeck 2000; Weller and Manga 1983).

The Passage of the *Canada Health Act* brought together hospital and medical insurance, and articulated the principles upon which the Canadian health care system is based: accessibility, universality, comprehensiveness, portability and public administration (Fierlbeck 2000). The aim of the *Canada Health Act* is to offer insured persons reasonable access to medically necessary insured services without direct charges at the point of service. Insured health services are broadly defined as hospital, physician and surgical-dental services determined to be medically necessary by physicians in conjunction with their provincial or territorial health department. The *Canada Health Act* serves to define the minimum of what must be covered by the province's health insurance

plans, but provinces and territories can provide programs and services outside the scope of the *Canada Health Act* at their own discretion, and with their own terms and conditions (Health Canada 2004).

The *Canada Health Act* thus reinforces a monopoly for physician services and medical treatment. It also stopped the supplementation of the provincial health budgets with fees to patients, but it did not signify a new federal commitment to maintain its portion of health care spending, and the federal contribution to health care continued to decline through the late 1980s and 1990s. This led to an increasing provincial focus on rationalizing healthcare expenditures which soon combined with growing philosophical support for strategies to prevent illness rather than treat it as the best way to keep the population healthy and thus, to reduce costs (Cohn 1996). The primacy of these two interests prompted each of the provinces, except Ontario, to reorganize their health care systems into Regional Health Authorities (Church and Barker 1998).

Regionalization means an organizational rearrangement which creates an intermediary administrative structure to carry out functions previously assigned to either provincial or local structures. Regionalization was introduced to rationalize health costs by facilitating better planning of the distribution of health services. It was believed this reorganization would create a more effective health care system by broadening the range of services provided, and would be more responsive because as a more localized system, the region could customize care to its own demographics, geography and cultural groups. It was also believed that a regional system could better coordinate the range of services and practitioners available to put a greater focus on prevention, health promotion and community based services (Church and Barker 1998).

Once implemented, the health regions were funded through a global budget with few conditions, which was supposed to be able to give the region the autonomy to reorganize the way health services were provided to best suit the needs of the area. However, in practice most of the health regions in Canada have populations which are too small to warrant a health region offering all of the health services its constituents will need, such that patients still have to cross region boundaries and travel into urban centres for much of their care. This is especially true for specialty services where the small number of practitioners makes them better coordinated at the provincial level. As well, all regional global budgets exclude physician and drug costs, two primary cost drivers whose exclusion hinders regional control and planning, and does not allow for the replacement of doctors with non physician practitioners (Church and Barker 1998).

Thus, the support for the introduction of midwifery varies between the organizational levels of the health care system. At the federal level, the *Canada Health Act* reinforces the medical monopoly on maternity care and does not define midwifery services as a medically necessary and insured service, which makes the implementation of midwifery an add on program that provinces can choose or not choose to introduce and fund. At the provincial level, midwifery services do meet the agendas of many health care systems though, as a community based, prevention focused service, which also has potential to generate cost savings by replacing doctors with a non physician health practitioner. At the regional level, organization of the health care system was designed to better implement services, such as midwifery, that fit this provincial agenda. However, as a specialty service not yet big enough to be duplicated in all regions, midwifery may not be well suited to the regional scale. Regional implementation of midwifery will also

be limited by the fact that midwifery services cannot be used to replace physician costs since medical care is covered directly by the province, while midwifery services would have to be funded either out of the regions global budget, or as an add on program.

4.2 Implementation of Midwifery Across Canada

Considering the multi-tiered structure of the Canadian health care system, with its conflicting trends and sources of support at each level, it is not surprising that the struggle to implement midwifery in Canada has been differentially successful across the country. Beginning in the 1980s, a number of Canadian provinces took the first steps towards implementing midwifery services, and by the year 2000 regulated midwifery was available in the five most populated provinces (see table 4.1 for a brief description of the status of regulated midwifery across Canada). To offer some context for the process in Manitoba, the following section will offer a short historical outline of midwifery implementation across Canada. It will also discuss how the provinces which have introduced midwifery services have addressed issues within the midwifery model of care, access to midwifery care, integration, and access to practicing as a midwife.

In the first three provinces to regulate midwifery, Ontario, Alberta and British Columbia, midwifery regulation and implementation occurred during a provincial reorganization of their health professions legislation. By switching to having a single Act to regulate all of the health professions, it became easier to regulate smaller services. This process also eased the introduction of new health professions by diffusing medical opposition, since the medical profession had to respond to the introduction of multiple health professions at once. In all three provinces, community and nurse midwives joined to form a single organization and submitted a single application requesting the regulation

of midwifery. Implementation bodies were then created in all three provinces to develop the regulatory framework for the profession, and to oversee the assessment and upgrading of the first groups of registered midwives. The initial assessment process for the first groups of registered midwives was also almost identical in Ontario, Alberta and British Columbia, and used the practice history portfolio method combined with written and clinical testing (Bourgeault 1996; McKendry 1997; Rice 1997).

However, there was no such legislative reorganization happening in Quebec, and a very different scenario developed there. In 1985, the Quebec Minister of Health and Social Services stated her intent to legalize midwifery. As the process of regulating midwifery began, the community and nurse midwives organizations in the province were not able to find the necessary common ground to unite during negotiations with the government, and this weakened their influence on the process. Further, since midwifery regulation was not done as part of a general review of the health professions, physicians were able to focus more clearly on opposing legalized midwifery. Primarily due to this opposition, the province, as a compromise, decided to experiment with midwifery before making it an autonomous profession. In 1990, an Act was passed that authorized legalization of autonomous midwifery until 1998 confined within eight pilot projects incorporating 40 midwives (Vadeboncoeur *et al* 1997). Midwives began practicing in the pilot projects in 1994 once the practice locations were chosen and ready, and assessment and upgrading of the registered midwives was complete. The eight community health clinics offering the midwifery pilot projects were responsible for addressing all other implementation and integration issues. Following the pilot project, midwifery was made a regulated profession in Quebec in 1999 (Vadeboncoeur 2004).

A number of other provinces are currently moving towards midwifery regulation. In May 1999 the Saskatchewan government passed midwifery legislation, but the province has been stalled in the process of implementing midwifery, and it is not known at this point when the midwifery legislation will be proclaimed (Saskatchewan Health 2004; Canadian Association of Midwives 2005). In June 2003 the government of the Northwest Territories passed midwifery legislation (Canadian Association of Midwives 2005), but it has also not yet been proclaimed (Carroll and Benoit 2004). In Nunavut, the territorial government recently decided to hire a midwifery consultant to help introduce regulated midwifery. This decision was largely based on the success of the Rankin Inlet birth centre which opened in 1993 and has a small staff of nurse midwives registered in other provinces and Inuit maternity care workers (Carroll and Benoit 2004). The territorial government of the Yukon has made commitments to regulate and fund midwifery services in 2000 and 2002 which have not yet been acted on (Canadian Association of Midwives 2005).

None of the Atlantic Provinces have reintegrated midwifery into their health care systems yet. Nova Scotia has been stalled in the process of writing midwifery legislation since 1999 (Marion 2004; MacLellan 1997). Newfoundland is the only province which never made midwifery illegal, and *The Midwives Act* passed in 1920 continued to be reprinted until 1990, although few nurse midwives continued to practice under it. In 1999 the Newfoundland government appointed a committee to consider updating this legislation so that midwifery could be reintegrated into its health care system. After the committee completed its mandate in 2001, the provincial government set a date for introducing autonomous midwifery legislation, but the following year chose to postpone

the development of this new midwifery legislation indefinitely (Association of Midwives of Newfoundland and Labrador 2005).

In the four provinces which have regulated and implemented midwifery, the documents which regulate the profession are quite similar in the model, scope, and philosophy of care they describe. All of these provinces have recognized midwives as direct-entry autonomous primary caregivers with a similar scope of practice including prescription privileges and well woman care during the childbearing year (Scurfield 2002). Informed choice is a central tenet of midwifery care in all provinces with regulated midwifery, and continuity of care is protected in all provinces through continuity of care standards of practice, and through funding arrangements, such as salary and course of care payments, which limit the possibility of the practice model becoming fragmented. Midwives are also limited to attending a maximum of forty births a year as the primary caregiver to ensure they have time to devote to extra prenatal and postpartum support for their clients (Scurfield 2002).

Choice of birth place has become part of the model of care in all provinces, but it was more challenging to achieve in some provinces than in others. In Ontario, the midwifery legislation protects home birth as part of the model of care. Midwives in Ontario have also received hospital admitting privileges at certain hospitals (Klymasz 1997). In Alberta, midwives are allowed to attend births at home and at the hospital, but it took them a year to achieve hospital admitting privileges (McKendry and Langford 2001). In British Columbia, physician opposition to home birth and provincial uncertainty about its safety led to a compromise whereby home birth was restricted to a demonstration project for the first two years. Following the evaluation of this

demonstration project, home birth was fully incorporated into the midwives scope of practice in 2000 (Page 2000). During the pilot projects in Quebec, midwives were allowed to practice in birth centres and hospitals, but because of opposition from physicians, they were not able to get hospital admitting privileges, and births were restricted to the birth centres. Following the introduction of regulated midwifery in 1999, midwives were legally allowed to practice in all settings, but it was not until 2004 that the home birth guidelines were agreed on and implemented, and hospital admitting privileges were granted (Vadeboncoeur 2004).

Midwifery is a publicly funded service in Ontario, British Columbia and Quebec (Scurfield 2002). Midwives in Ontario are paid on a salary model from the province. With their salary, they are also given extra funding to cover their overhead expenses, and they own their practices. A small number of midwives practice independently while the vast majority are in group practices of between four and eleven midwives (College of Midwives of Ontario 2004). When midwives began practicing in Ontario in 1994, over 60 midwives were registered to practice (Bourgeault 1996). There are now more than 275 practicing midwives, and in 2004 the government announced it was going to add another 55 funded midwifery positions, bringing the total number of midwives in the province to over 300 (Ferguson 2004).

In British Columbia, there are over 75 midwives currently practicing. Midwives own their own practices and some work in group practices while others operate out of their own homes. The midwives are not employees of the provincial health service and are reimbursed for their services on a course-of-care basis (College of Midwives of British Columbia 1997 and 2004). There are currently approximately 77 midwives

registered in Quebec working out of eight birth centres in practices of three to eight midwives. Midwives are paid a salary by the birth centres which are funded by the province directly. The Ministry of Health has decided that any future birth centres will have to be funded by their Regional Health Authority. Some Regional Health Authorities are planning on opening their own birth centres (Vadeboncoeur 2004; Canadian Association of Midwives 2005).

Registered midwives in Alberta are not publicly funding. The provincial government supports privatization in health care, and decided that since midwifery services are not defined as medically necessary, they did not need to be covered by public insurance (McKendry and Langford 2001; James and Bourgeault 2004). Regional Health Authorities can fund midwifery services out of their existing global budgets, but the province has stated it will not enter into an agreement with the Alberta Association of Midwives that would enable midwives to bill the province directly. Since the Regional Health Authorities do not have to fund physician services out of their global budgets, hiring midwives would mean the Regional Health Authorities would have to pay for maternity care services which it could otherwise get for free from the province. Regional Health Authorities in Alberta which choose to hire midwives can also limit the scope of practice and autonomy of their employees (Rayment 2001). Thus, the consequence of the province's decision not to fund midwifery is that most midwives practice privately and charge their clients directly, while a few have become employees of the one Regional Health Authority which has chosen to hire midwives as part of a small hospital program which does not offer continuity of care or choice of birth place (Mykietka 2004). For the midwives in private practice, the course of care fee their clients must pay has risen above

$2500.00 to cover their liability insurance, making midwifery less financially accessible than it was before legalization (James and Bourgeault 2004). The lack of public funding has also meant that the initial 32 midwives eligible to register with the province has now decreased by half, since many have chosen to move to provinces where funding is available or have stopped practicing (James and Bourgeault 2004).

Alberta is also the only exception to the pattern of provinces with regulated midwifery creating distinct measures to address concerns that regulating midwifery would discriminate against the renewal of traditional Aboriginal midwifery. The legislation in British Columbia dealt with this issue by making distinct categories for traditional First Nations midwives practicing on reserves who were exempted from regulation, and for First Nations midwives who were regulated midwives who had both Western and First Nations midwifery training (Rice 1997). While this was done to allow both traditional midwives to continue to practice unhindered, and to foster the development of a new hybrid midwifery combining facets of traditional Aboriginal and Western midwifery practices, Carroll and Benoit (2004) write that there are not yet any Aboriginal midwives registered to practice with the College in either category.

In Ontario, an exemption clause was placed in the midwifery legislation for Aboriginal midwives providing services to Aboriginal communities (Scurfield 2002; Carroll and Benoit 2004). Through this exemption, a Maternal and Child Centre, *Tsi Non;we Ionnakeratsha Ona:grahsta'*, at Six Nations of the Grand River, was opened in 1996. The center has two community midwives on staff and two Aboriginal midwife apprentices. They offer well woman care, primary care through pregnancy and childbirth, offer choice of birth place, and incorporate traditional Aboriginal midwifery

practices for Aboriginal women (Carroll and Benoit 2004). The Centre also offers a three year midwifery study program, but because this was done through the First Nations exemption clause, it is not clear whether midwives who train through this program will be able to practice outside of it (Hiebert 2003).

The first birth centre with midwifery services in Quebec was a pilot project for Inuit women in the north which opened in 1982. When the provincial midwifery pilot projects started in 1990, this birth centre was incorporated into the larger pilot of eight midwifery birth centres. The Inuulitsivik Health Centre located in Puvirnituk offers midwifery care to Inuit women in their own language, and trains Inuit women to become midwives themselves. However, with the passage of Midwifery legislation in Quebec in 1999, the situation for the centre has become somewhat precarious. The *Quebec Midwifery Law* recognizes the five midwives currently working at the Inuulitsivik Health Centre and wards these midwives membership in the Quebec Order of Midwives, but their licenses to practice remain restricted to the Nunavik territories. Further, the education program at the birth centre has not been recognized as creating eligibility to register, and student midwives currently training there will not be able to apply for a midwifery license and are working outside the law (Carroll and Benoit 2004). With the current plans to open a second Aboriginal midwifery training program, the *Iewirokwas Midwifery Program*, located in Akwesasne, a Mohawk reserve that straddles Quebec, Ontario and New York State, a campaign has started for an exemption for Aboriginal midwives in the *Quebec Midwifery Law*. There is a clause in the *Quebec Midwifery Law* which states that First Nations councils can negotiate with the provincial Ministry of

Health for arrangements for the practice of traditional midwives (Carroll and Benoit 2004).

All of the provinces with regulated midwifery have also introduced baccalaureate midwifery education programs except, again, Alberta. Along with regulating midwifery, Ontario set up a four year baccalaureate degree in midwifery in 1993. The program is jointly offered by 2 universities and a community college and graduates over 30 students per year (McMaster University 2004; Human Resource Strategy for Midwifery Implementation Committee 1998). With the passage of the *Quebec Midwifery Law* in 1999, a four year baccalaureate program in midwifery was started that same September at the University of Quebec in Trois Rivieres and is expected to graduate over 20 students a year (Vadeboncoeur 2004). The government of British Columbia established a direct entry four year midwifery program in September 2001 at the University of British Columbia which accepts 12 students a year (University of British Columbia 2004). A baccalaureate midwifery program has also been developed and approved in Alberta, but the Alberta Ministry of Education will not fund the program without a publicly funded midwifery service in the province (James and Bourgeault 2004). All four provinces also require midwives to have baccalaureate degrees or baccalaureate equivalency to register (Alberta Health and Wellness 2004; Ryerson University 2004; College of Midwives of British Columbia 2003; Vadeboncoeur 2004).

Ontario, Alberta and British Columbia have also developed programs designed to assess internationally trained midwives so that they can register to practice in the province. In Ontario this takes the form of the International Midwifery Pre-Registration Program which is a one year program offered through Ryerson University. The program

is available to internationally trained midwives and offers a skills assessment, orientation to Ontario midwifery, clinical placements and mentoring. Applicants must have documented midwifery education and must have practiced in the last five years (Ryerson University 2004). In Alberta and British Columbia this assessment of internationally trained midwives is done through a Prior Learning Assessment (PLA) based process which has no educational or upgrading component (Alberta Health and Wellness 2004; College of Midwives of British Columbia 2003).

In sum, despite the fact that midwifery has had to be implemented separately in each Canadian province, there is a great deal of similarity in the midwifery professions implemented across the country. The model of care and scope of practice is basically identical in all of the provinces with regulated midwifery. Midwifery is also publicly funded, and Aboriginal midwifery initiatives have been given their own legal status in every province except Alberta. All of the provinces with regulated midwifery have also defined it as a profession requiring baccalaureate preparation, and three have instituted baccalaureate midwifery education programs. While this information reflects only four provinces, these provinces making up more than two thirds of the Canadian population, and their uniformity puts pressure on all of the subsequent provinces and territories to implement a similar midwifery model.

Table 4.1 Status of Regulated Midwifery Across Canada

Province	Regulated Midwifery, Year	Regulated Midwives practicing, Year	Publicly Funded, Form
Ontario	Yes, 1991	Yes, 1994	Yes, provincial, salary plus overhead
Alberta	Yes, 1994	Yes, 1998	No
British Columbia	Yes, 1995	Yes, 1998	Yes, provincial, paid per course of care
Quebec	Yes, 1999	Yes, 1999 (midwives working in 8 pilot projects 1994-1998)	Yes, provincial, salary through community health centres
Saskatchewan	Yes, 1999	No	No
Newfoundland	No, a *Midwives Act* (1920) exists but has not been updated for midwifery reintegration	No	No
Nova Scotia	No, but in consideration since 1999	No	No
Prince Edward Island	No	No	No
New Brunswick	No	No	No
Northwest Territories	Yes, 2003	No	No
Yukon	No, but in consideration since 2000	No	No
Nunavut	No, but nurse midwifery Program at Rankin Inlet since 1993	No	Salary funding for nurse midwives in Rankin Inlet birthing centre program

4.3 Midwifery in Manitoba

This section will review the history of midwifery implementation in Manitoba, which was the fifth province to regulate midwifery. This historical summary will offer a chronological framework for midwifery implementation in Manitoba. It will also identify the Manitoba initiatives which differentiate it from the other provinces and which will be the focus of the remainder of the thesis. In Manitoba, the discussion around midwifery implementation began with organized consumer demand for the service in the 1980s. The provincial government responded by commissioning, in 1991, the Manitoba Working Group on Midwifery to determine whether or not midwifery should be regulated in the province. In 1993, the final report of the Working Group was released which recommended both the regulation of midwifery, and the appointment of a Midwifery Implementation Council (MIC) to develop the necessary structures, documents and relationships to make this happen. The Midwifery Implementation Council began meeting in 1995. The MIC drafted *The Midwifery Act*, which was passed without amendment in the Manitoba Legislature in June 1997. It also developed the regulatory structures of the profession, and assessed the first group of midwives who began working in the province as Regional Health Authority (RHA) employees in June 2000. There are now approximately 25 registered midwives practicing in Manitoba. See Appendix H for a chronology of midwifery implementation in Manitoba.

The path to regulated midwifery largely began when a number of childbirth consumer groups were established in Manitoba during the 1980s, including the Manitoba Association for Childbirth and Family Education and the Manitoba Chapter of the Association of Parents and Professionals for Safe Alternatives in Childbirth. One of the

most outspoken of these consumer groups in support of midwifery was the HomeBirth Network which was established in 1982. Out of the HomeBirth Network grew the Manitoba Traditional Midwives Collective in 1985, which was made up of practicing community midwives and aspiring midwives, many of whom were women who had community midwifery care and home births themselves. Nurse midwives also began to organize in the 1980s, forming the Nurse Midwives Association of Manitoba (NMAM) in 1988 (Garvie 2001). These two midwifery organizations rarely interacted, and advocated for the legalization of two different models of midwifery (Evans 1985; Scurfield 2002).

A number of reports were released in response to this consumer demand for regulated midwifery. Reports which recommended introducing a midwifery service in Manitoba include the Social Planning Council of Manitoba reports on Maternal and Child Health and Midwifery Law (Community Task Force on Maternal and Child Health 1982 and 1981), the Manitoba Advisory Council on the Status of Women reports on midwifery released in 1987 and 1988, and the Manitoba Health Alternatives Network report on midwifery (1992). However, when these reports were coming out, the larger trend in maternity care in Manitoba was towards having all women give birth in hospitals with the most sophisticated obstetric technology and specialist care available (Manning 1993).

The efforts of the consumer and midwifery organizations and the early midwifery reports were given more weight though, following a 1990-1992 inquest into the fetal death of a second twin of a woman in midwifery care transferred from home to hospital (midwifery inquests also galvanized the midwifery regulation processes in Ontario, British Columbia and Alberta) (Conner 1992; Scurfield 2002). While the Judge who presided over the court proceedings kept the scope of the inquest limited to the individual

case and did not rule on issues of midwifery and the right to choose home birth, the inquest itself got a great deal of media coverage which drew attention to the issue of regulating midwifery. The inquest spurred the HomeBirth Network's advocacy efforts around midwifery regulation, and members of the organization staged rallies outside the courthouse and the provincial legislature in support of midwifery (Grant 1993). Soon after the intrapartum death occurred in the spring of 1990, a report to recommend whether midwifery should or should not be regulated was commissioned by the Minister of Health jointly from the College of Physicians and Surgeons of Manitoba (CPSM) and the Manitoba Association of Registered Nurses (MARN) (1991). This report recommended the introduction of hospital based nurse midwifery. While the province did not implement the recommendations of this report, nurse midwifery pilot projects were started at two hospitals in Winnipeg in 1993 (Garvie 2001).

Nonetheless, this report did not address the issues of how to make community midwifery and home birth safer, and the Minister of Health appointed the Manitoba Working Group on Midwifery in 1991 to again recommend whether or not midwifery should be regulated and how this should be done. The Working Group had over 20 members who represented consumer organizations, medical organizations, nursing organizations, both the community midwifery and nurse midwifery organizations, and health researchers. Many of the individual members had participated in putting together earlier midwifery reports. The Working Group acted as a forum for discussion between stakeholder groups which prior to this point often had strained relationships. Despite challenges in being able to work cooperatively, the Working Group was able to reach a

consensus that midwifery should be regulated in Manitoba, and found much agreement on the form that it should take (Manitoba Government 1993).

The various stakeholders had differing and sometimes contradictory philosophical reasons as to why they thought midwifery should be regulated. These differences shape the definition of midwifery and had to be thoroughly discussed by the Working Group members. There was general agreement on one reason why midwifery should be regulated, which was that midwives needed to be able to practice rurally and in remote communities in the north to address provider shortages and women's frustrations with having to travel long distances for care. By creating a midwifery model which would allow practitioners to attend births in remote northern communities, midwives could address some northern women's concerns about the policy of evacuating all women to southern hospitals for birth. Midwives might also be able to return childbirth to rural communities where obstetrics had stopped being offered and health care facilities were being closed. See Appendix I for a description of the increasing centralization of childbirth in Manitoba in the 1990s, and the challenges this was creating which it was thought midwifery might be able to address (this appendix also offers a map of the Regional Health Authorities in the province).

The various stakeholders also had other differing philosophical reasons why they thought midwifery should be regulated. For many physicians and some nurses the need was to stop home births from happening by offering another in hospital alternative (College of Physicians and Surgeons of Manitoba and the Manitoba Association of Registered Nurses 1991; Manning 1993). For other stakeholders, midwifery offered a radically different philosophy which could increase women's empowerment and

satisfaction with childbearing (Homebirth Network, Undated). Others believed that the extra prenatal time in the midwifery model and the trust that developed with continuity of care was best for women who had social risk factors, such as adolescents, immigrant/refugee women, women of Aboriginal descent, and low income women (Physicians and Surgeons of Manitoba and the Manitoba Association of Registered Nurses 1991; Manitoba Advisory Council on the Status of Women 1987; Manitoba Government 1993). Another perception was the idea of midwives as the specialist who would attend the more than 80% of childbearing women with normal pregnancies. In its final report, the Working Group attempted to subsume all of these ideas about midwifery into a single flexible model of care and scope of practice instead of deciding between them (Manitoba Government 1993).

Working Group members also held different practice model ideals for midwifery, but after much discussion the group practice model was recommended. This model is in many ways a compromise between the solo practice model primarily used by community midwives, and the hospital shift model nurse midwives had worked in previously. Despite medical opposition, the Working Group also recommended that midwifery be a self regulating profession, and that midwives be autonomous primary care providers who would be allowed to attend women in all birth settings, including homes, nursing stations and in hospitals with hospital admitting privileges. This definition of the profession was modeled closely on the scope and practice style being implemented concurrently in Ontario (Manitoba Working Group on Midwifery, Undated; Manitoba Government 1993).

Another issue was whether midwifery would be a specialty of nursing or a direct entry profession. Following negotiations, the Working Group chose multiple routes of entry to the profession since this was the direction midwifery was going in throughout the country. However, the Working Group also recommended that midwives with the requisite nursing qualifications should be allowed to dually register in both professions. This was expected to be particularly useful in remote communities where a dually registered nurse midwife might be the only health care provider (Manitoba Government 1993). These discussions, and the opportunity to explore the direct entry midwifery model getting implemented in Ontario led the Nurse Midwives Association of Manitoba to choose to change its name in 1992 to the Association of Manitoba Midwives (AMM) in recognition of the validity of direct entry midwifery training (Kaufert and Robinson 2004).

The Working Group also recommended the formation of a Midwifery Implementation Council to oversee the implementation process (Frost 2001; Manitoba Government 1993; Scurfield 2002). A year and a half later, the Health Minister announced on International Midwives' Day, May 5, 1994 that midwifery was going to become an insured service in the province. The Health Minister also stated that midwifery would be an autonomous profession with its own legislation and regulatory body. At the same time, he announced the appointment of the Chair of the future Manitoba Implementation Council, who was to lead the MIC in implementing the recommendations of the Working Group (Manitoba Government Press Release May 5, 1994). Six months later, in December 1994 the other 12 members of the Midwifery Implementation Council were appointed and it was announced that they would begin

their work immediately (Manitoba Government Press Release December 14, 1994). A Midwifery Coordinator was also provided by Manitoba Health who worked closely with the MIC throughout its tenure (MIC Minutes, Cumulative).

As recommended by the Working Group, the MIC had four committees, each with an appointed chair. The Midwifery Implementation Council was made up of a family physician who was appointed the Chair, a lawyer, an education professor, a midwifery consumer advocate, nurse midwives, a consumer who had lived both in the north and rurally, a non-European immigrant woman with direct entry midwifery training, an obstetrician, a community midwife, a nursing professor, a midwifery consumer of Aboriginal descent, and a women's health advocate. All of the members of the MIC were women (Scurfield 2002; Garvie 2001). While the Working Group recommended that all members should be compensated for their time (Manitoba Government 1993), this did not end up being the case, and only the four committee Chairs were remunerated (MIC Minutes, 8 May 1995).

The four MIC committees included the Practice Committee, which determined the midwifery scope of practice, and put together the standards, guidelines and policies which would regulate the profession. Much of this was developed from the model of practice recommended by the Working Group, but a unique decision was also made to allow midwives who registered in the first three years of midwifery regulation to choose to limit their practice to either only hospital or only out of hospital births. This was done primarily to address nurse midwives concerns about attending home births (Kaufert and Robinson 2004). When these tasks were complete, the Practice Committee then became focused on developing the policies needed to integrate midwifery services smoothly into

the Manitoba health care system, and sub-committees were formed to write these guidelines for integration with public health, emergency medical services (EMS), and the hospitals.

The Equity and Access Committee consulted extensively with women across Manitoba about the model of midwifery they desired, and what needed to be in place so that all Manitoba women could access the service. The Committee did outreach to women from multiple backgrounds with midwifery training, and worked closely with all of the other committees to ensure midwifery was being developed in an equitable way. The Committee also paid particular attention to consulting with Aboriginal, Métis and First Nations women. The results of the extensive Aboriginal consultations is that regulated midwifery in Manitoba does not exempt traditional Aboriginal midwives, but instead requires that the College of Midwives of Manitoba (CMM) have a *Standing Committee on Issues Related to Midwifery Care for Aboriginal Women* (this Committee is now referred to as Kagike Danikobidan). The members of this Standing Committee have a permanent seat on the College Council and on all committees of Council. Combined with the consensus decision-making model used by the College of Midwives of Manitoba, the goal was to have Aboriginal women's voices heard in every aspect of defining midwifery practice. It also means that any midwifery services or education programs developed to target Aboriginal women are to be included in the provincial regulatory structure (Scurfield 2002).

The Legislation Committee put together *The Midwifery Act*, followed by the *Midwifery Regulation*, and the College of Midwives of Manitoba bylaws and statutes. One of the primary activities of the MIC was the writing of *The Midwifery Act* in

conjunction with staff at Legislative Counsel. In Manitoba each profession continues to have its own health act, and one for midwifery had to be written, introduced and passed by the Legislature. The Act was referred to as Bill 7 until it was passed. The Legislation Committee went through 21 drafts before the final bill was submitted to the legislative drafters and then the Minister of Health for approval. The Legislation Committee also consulted widely on the bill before submitting it. These consultations were with over 30 consumer groups, midwifery organizations, medical organizations, a wide distribution of health profession organizations, rural and northern professionals, the heads of all the RHAs, and a number of government departments. In the spring of 1997, the bill went through first and second reading in the Legislature. The debate on the bill during the second reading was widely supportive. This was partly due to the consultations held by the Legislation Committee beforehand which generated widespread support for the bill. On June 12, 1997 the bill went to Manitoba Legislative Assembly Committee. The bill was passed in the Manitoba Legislative Assembly Committee without amendment, and later that month passed unanimously in the Manitoba Legislative Assembly and given Royal Assent. A provision was included delaying proclamation of the Act until the first group of midwives had been assessed and registered, and were ready to start practicing (Frost 2001; Garvie 2001; Manitoba Government 1997).

The fourth committee was the Education Committee which developed and worked towards implementing a baccalaureate midwifery education program. It also created the assessment and upgrading process for women in the province who already had midwifery training and experience. Developing an assessment process was a complicated task. The Education Assessment Sub-committee first worked on creating their own assessment

process in 1995 which followed the Ontario portfolio model. Then, in 1996, the committee became aware of the assessment process offered by the North American Registry of Midwives (NARM), which primarily works to certify community midwives in the United States. Following a great deal of research into this assessment process, NARM was determined the most affordable and defensible option available and chosen to assess the midwifery candidates in Manitoba (Garvie 2001). Since the competencies of the NARM did not cover all of the ones that were being required in Manitoba, it was determined that an upgrading program would also have to be offered. This assessment and upgrading program would refresh candidates on certain aspects of midwifery, educate them on new skills required in the scope, and supplement the written and clinical exams of the NARM by assessing the competencies it did not cover. In the fall of 1997 the Health Sciences Centre, a tertiary hospital and primary location of medical training in the province, was given the job of developing, coordinating and offering the 16 upgrading modules, minus a few which had to occur in the community (Garvie 2001).

A number of changes were made to the assessment and upgrading to make it more accessible to all competent candidates in the province. According to the application package for the women interested in applying to the assessment and upgrading process, to be assessed by NARM, applicants had to document some form of education in the competencies of midwifery. This education could be in any form including apprenticeship, self study or in another health profession such as medicine or nursing. Training was accepted from any country and candidates did not have to have baccalaureate equivalency. Applicants did have to document that they had attended 40 births, of which 20 had to be as primary caregiver. They also had to document having

conducted 75 prenatal exams including 20 initial prenatal visits, 40 postpartum exams, and 20 newborn exams. They were only required to document having offered continuity of care to 3 clients, which is much lower than other provinces. All applicants had to take communications testing to ensure they could communicate effectively with other health professionals and clients in English. An English language upgrading program, *English for Midwives* was developed to assist candidates who did not pass the communications test and for whom language ability was a barrier to being able to register (College of Midwives of Manitoba, Undated).

With the assessment and upgrading designed and ready to start, the MIC had completed its mandate and disbanded in 1998. A subset of the members then continued on to form the Transitional Council of the College of Midwives of Manitoba which was responsible for registering the first group of midwives until there were enough registered midwives that they could take over the self regulation of the profession (Scurfield 2002; Garvie 2001; MIC Minutes, September 1998; Transitional Council of the College of Midwives of Manitoba, May 1999). The assessment and upgrading was financially supported by Manitoba Health (Manitoba Hansard, 5 May 1999), and an executive committee made up of members of the Transitional Council of the College of Midwives of Manitoba and Health Sciences Centre representatives ran the program. There were five sessions of the assessment and upgrading program. Each session lasted between three and six months. The assessment and upgrading sessions ran from November 1998 until February 2001. With 50 seats available, 49 women were admitted to the assessment and upgrading, and 39 completed it successfully and were eligible to register (Garvie 2001). Because of the attempt to make the assessment and upgrading more accessible,

almost half of the first registered midwives were community trained, one quarter were trained as nurse midwives, and one quarter had trained in direct entry programs. The midwives who were also registered nurses were allowed to maintain their nursing registration if they so chose through a dual registration agreement between the two professional bodies. Manitoba was one of the first provinces to create the possibility of dual registration (Scurfield 2002).

With the passage of the *Midwifery Regulation* in 2000, the midwifery registration guidelines in Manitoba also require midwives to have currency of practice which is defined as having attended 10 births in the last 2 years. Midwives must also have current certification in neonatal resuscitation and CPR. For those candidates which passed the assessment and upgrading but did not have currency of practice in all areas of the scope, the midwife was required to practice under supervision, either in all areas of practice or in discrete areas, until she was determined to be competent. The entire process, from application to full registration, took most candidates about a year to complete (Garvie 2001).

As the assessment and upgrading process began, midwives from the Manitoba Traditional Midwives Collective, the Association for Manitoba Midwives, and midwives with direct entry training from other countries who belonged to neither group came together in the winter of 1997 to discuss forming a single association to act as representation for negotiation with Manitoba Health (MIC Minutes, 17 November 1997). The Manitoba Association of Midwives (MAM) was formed from these groups in the spring of 1998 (MIC Minutes, 23 March 1998).

On May 5, 1999 the Health Minister announced funding to start the College of Midwives of Manitoba and earmarked funds to pay the first group of midwives (Manitoba Government Press Release, May 5, 1999). Employee status for midwives was first recommended by the Working Group (Manitoba Government 1993), and this recommendation was taken seriously throughout the implementation process, although the contract funding models implemented in other provinces was also discussed. Manitoba had regionalized their health care system in 1997, and it had been determined that midwifery would be a regional service to facilitate midwives working throughout the province in rural and remote communities. Initially, Manitoba Health considered giving the Regional Health Authorities both the employment and contract funding options. These options were expected to be attractive to midwives who were used to different funding mechanisms, and depending on the RHA setting, would allow midwives to set up different kinds of practices such as working in a group practice of midwives, working more closely with other health professionals, or working as a nurse midwife in a small community (Human Resource Strategy for Midwifery Implementation Committee 1998). In November 1999, a large majority of the members of MAM voted for having both contract and salary funding options available to midwives (Fogg 1999).

However, these options were not sustained through the funding negotiations. The formal negotiations about remuneration between Manitoba Health and the Manitoba Association of Midwives started in August 1999 (Anonymous 1999a). Present at the negotiations were four Manitoba Health representatives, two RHA representatives, four MAM negotiators, and a facilitator (Anonymous 1999b). At some point during the negotiations, contract funding was taken off the table. Following legal counsel, Manitoba

Health felt that it could only fund through one mechanism. Following a tight vote within MAM, MAM agreed to the employment funding model, and in June 2000 a two year memorandum of understanding was signed which stated that the midwives would work as salaried employees of Regional Health Authorities. Manitoba Health created a designated fund for midwifery services which RHAs could draw from to hire midwives.

Before they could implement a midwifery practice, the Regional Health Authorities had to develop a midwifery program proposal which met Manitoba Health requirements. One of these requirements was that the midwives would be allowed to offer their full model of care and scope of practice. Another requirement was that RHAs approved to offer midwifery services had to develop a Midwifery Implementation Committee made up of health professionals, midwives, and other staff to develop policies, procedures, and role documents to ease integration (Haworth-Brockman 2002). The third requirement was that the midwifery practices would work towards having 50% of their clients from identified priority populations which include single women, adolescent women, newcomers to Canada, Aboriginal women, socially isolated women, low income women, and other at risk women. This policy was put in place to promote outreach efforts which would improve access to the service (Manitoba Health 2004). This focus on integration and access prompted the Winnipeg Regional Health Authority (WRHA) to locate the midwifery practices in their RHA in community clinics in low income neighbourhoods. This also meant the midwives were co-located with other health professionals.

On June 12, 2000 *The Midwifery Act* was proclaimed and eleven midwives registered and began practicing. Their practice immediately involved offering the full

midwifery scope of practice, but many of the midwives were in partial or complete supervisory relationships since few had been able to practice the full scope of care in the two years before regulation. Combined with involvement in a number of integration initiatives, few could accept a full roster of clients. The government approved funding for 26 midwifery positions for 2000, with 16 of these positions allocated for Winnipeg and 10 for rural and northern regions (Manitoba Hansard, 14 June, 2000). By the end of 2000, there were 18 practicing midwives registered in Manitoba hired by the Winnipeg, SouthEastman and Burntwood Regional Health Authorities. In 2001, there were 25 registered midwives, with 24 practicing at least part time (College of Midwives of Manitoba (Registrar) 2004). That year the Brandon and Central Regional Health Authorities became the fourth and fifth RHAs to offer midwifery services. Although 39 women had completed the assessment and upgrading, and were eligible to register as practicing midwives by 2001 (Garvie 2001), the province's funding cap was not changed from 26 full time positions, which included targeted funding for positions in the north which were never filled.

With the number of positions capped by the Health Ministry, the growth of the midwifery program quickly became a political issue, and the first Minister to speak about his constituents frustration that their RHA did not have midwifery services was in May 2001 (Manitoba Hansard, 22 May, 2001). Further, two of the RHAs were only allowed to hire 2 midwives each and this was quickly seen as an unsustainable way to run a practice because with two midwives at each out of hospital birth, the two women were constantly on call and unable to ever take any time off without closing the program. With the two practices on the verge of closing, the issue of more positions was brought

up in the Manitoba Legislative Assembly multiple times in the spring and summer of 2002 (Manitoba Hansard, 2 May, 2002; 13 June, 2002; 8 August, 2002), there was a public demonstration at the legislature (Anonymous 2002a; Rabson 2002), and many individuals advocated for the program within the RHAs and Manitoba Health. In September 2002 the government announced funding for 4 more positions for three RHAs. At this point, a sixth RHA whose proposal had been approved previously was finally able to get funding for a position and hire one midwife (Anonymous 2002b). The cap at thirty midwifery positions has not changed since 2002. Each RHA also has its own cap on how many midwives it can hire (Haworth-Brockman 2002). In the fall of 2004, there were 37 midwives registered with the College of Midwives of Manitoba, with 28 registered as currently practicing, although not all of these midwives practice full time (College of Midwives of Manitoba 2004c).

Midwives currently practice in six of the eleven RHAs in the province: the Winnipeg, SouthEastman, Burntwood, Brandon, Central and NorMan regions. About half of the midwives work in Winnipeg at four community clinics: Women's Health Clinic, Mount Carmel Clinic, The Health Action Centre and the River East Action Centre. Midwives in the rural and northern RHAs practice in community clinics, hospitals and in stand alone practices. There have been between one and four midwives practicing in the two most northerly RHAs, Burntwood and NorMan, and between 7 and 9 practicing in the three rural RHAs with midwifery services, Brandon, Central and SouthEastman (College of Midwives of Manitoba 2004d). Midwives are expected to offer primary care to between 30 and 40 women a year, as well as being second attendants for other births (Manitoba Health 1999). One midwife practices privately and

her services are not covered by Manitoba Health (College of Midwives of Manitoba 2004d).

With the proclamation of *The Midwifery Act* in 2000, the midwifery profession also became self regulating through the College of Midwives of Manitoba. The shift from the Transitional Council of the College of Midwives of Manitoba to one made up of registered midwives occurred six months later once there were enough midwives registered (Garvie 2001). Because of the small numbers of midwives in the province, and the large task of regulating a profession involved in responding to the possibly life threatening complications of birth, the College is dependent on government funding to function effectively. There was initially an expectation that with the introduction of a baccalaureate midwifery education program, the number of midwives would increase over time, allowing more midwives to share the responsibilities of running and paying for the College (Anonymous 1997a). A baccalaureate midwifery education program was developed and approved to start at the University of Manitoba in 2000. However, since there is a cap on the number of midwifery positions in the province, the implementation of the education program has been put on hold until a long term plan for the growth of the profession has been developed. Therefore, the number of midwives has stayed constant, and the CMM remains heavily reliant on provincial funding.

Although the College is small, and each of the midwives has to take on a great deal of responsibility to keep it functioning, the College accomplished many things in its first four years. The CMM started a permanent assessment process for new midwives with international training (the Prior Learning and Experience Assessment or PLEA), and signed a reciprocity agreement with the other provinces with regulated midwifery which

allows registered midwives to move between provinces. It has worked towards developing a Midwifery Education Programs Approval (MEPA) process which would allow midwives to train in the province through mentorship study. The CMM has amended the *Midwifery Regulation*, and started a Perinatal Review Committee and a Standing Committee on Quality Assurance which has developed a client evaluation mechanism (College of Midwives of Manitoba 2004c). The College is also looking at expanding the scope of practice of midwives to include narcotics, and developing a long term strategy for midwifery with the provincial government (College of Midwives of Manitoba 2004a).

4.4 Summary

Health care in Canada is a provincial jurisdiction, but it is also partially financed and regulated at the federal level through the *Canada Health Act*. However, as federal funding for health care has declined over the forty years since national health insurance was first introduced, the provinces have looked for new ways to rationalize health care costs. In a number of provinces this financial pressure combined with philosophical agendas about reforming the health care system to focus more on community-based preventative care has led to the implementation of midwifery. In the first four provinces to implement midwifery, Ontario, Alberta, British Columbia and Quebec, the model of midwifery introduced has been very similar, with the midwife defined as an autonomous primary caregiver offering continuity of care, informed choice, and choice of birth place. In all four provinces midwives are required to be baccalaureate trained. Midwifery is publicly funded with a special exemption for Aboriginal midwives in all provinces expect Alberta. As the fifth province to implement midwifery, the experience in Manitoba was

influenced by the decisions made by the provinces which came before it, but it also followed its own unique trajectory. Midwifery legislation had to be introduced on its own rather than as a part of a reorganization of the health professions legislation. While the model of care and scope of practice are more similar, the initial assessment and upgrading process used in Manitoba was different, which means midwives from diverse training backgrounds have registered. Manitoba Health also chose to create a designated fund which Regional Health Authorities could draw on to hire midwives as employees rather than financing the program directly. This affects the geographical distribution of midwives and their working experiences. Along with the funding given to the RHAs for midwifery, Manitoba Health also required that each region form a Midwifery Implementation Committee to ease integration, and that socio-economically disadvantaged women be made a priority for midwifery care. Manitoba did not make an exemption for Aboriginal midwives in their midwifery legislation, but instead attempted to include Aboriginal midwifery in the provincial regulatory structure. Manitoba also has no education program and has a cap on the number of midwives the province will fund. Thus, while midwifery in Manitoba was certainly shaped by the provinces which came before it, the province has used its autonomy to make a number of unique decisions about how the service will be offered. The impact of these initiatives on the midwifery model of care, access to midwifery care, the integration of midwifery into the health care system, and access to practicing the midwifery profession, will be explored in the following four chapters.

Chapter Five: The Model of Care

5.0 Introduction

This chapter will look at how the model of care for midwifery was negotiated in Manitoba, the areas of tension in the model and how they have been resolved, and some of the difficulties that have surfaced with the model in practice. Determining the model of care was initially an area of intense controversy. In the end, it was largely shaped by the consensus on the midwifery model of the provinces which came before Manitoba and unique Manitoba changes which were made to accommodate distinct aspects of practicing in this province. Within the model of care the issues to be discussed include the unique decisions that were made to facilitate the introduction of choice of birth place, the attempts to ease some of the challenges of offering continuity of care which were identified by other provinces, the negative implications for the midwives' autonomy which stem from their being Regional Health Authority (RHA) employees, and how aspects of offering informed choice have worked out in practice. While participants were clear that there are a few issues which still need to be addressed, for the most part they stated they were happy with the model of care and that it has worked well in practice.

5.1 Choice of Birth Place and Out of Hospital Birth

Choice of birth place is protected in the *Midwifery Model of Practice* and means that midwives in Manitoba can attend clients in homes, hospitals, birth centres or nursing stations (College of Midwives of Manitoba 2003e). Choice of birth place is one of the most emotionally charged areas of the midwifery model of care, and the area which required the most extensive negotiation between stakeholder groups. However, once the decision was made to include choice of birth location in the midwifery model of care, and

once it was implemented, participants generally described a fairly easy integration of home birth (the most challenging aspect of choice of birth place) into the health care system.

Home birth consumers in Manitoba had organized into the HomeBirth Network in the early 1980s (Garvie 2001), and members of this organization saw home birth as essential for creating a standard for normal, natural childbirth which they believed was being lost in hospital-based care amid the routine interventions. They saw many benefits to home birth including the control it gave the woman, fewer medical interventions, a familiar environment filled with loved ones, and continuous care from a known attendant. They argued that home birth was as safe as hospital birth. As the number of women wanting home births increased through the 1980s, home birth became intertwined with the midwifery issue as more community midwives were practicing in homes, while the number of physicians who attended home births declined (HomeBirth Network, Undated). The connection between midwifery and home birth then became heightened in 1988 when the College of Physicians and Surgeons of Manitoba (CPSM) released a standard opposing home birth and stating that physicians who attended them would be sanctioned (College of Physicians and Surgeons of Manitoba 2003 (1988)). This now meant that women who wanted a home birth could only get a community midwife if they wanted a practitioner to attend them.

Increasing opposition on the home birth issue was then brought to the forefront in Manitoba when an inquest was called in 1990 into an intrapartum death following a transfer to hospital from a home birth (Conner 1992). Many childbirth consumer groups responded to the inquest by arguing that the safety of home birth could be increased by

regulating midwifery, improving the home to hospital transfer system, and improving hospital care so that women do not feel that they have to deliver at home to have the kind of birth they desire (Grant 1993). At the same time, the College of Physicians and Surgeons of Manitoba and the Manitoba Association of Registered Nurses (MARN) (1991) argued home birth is not safe because adverse events can happen precipitously and wanted an outright ban. At this point the Nurse Midwives Association of Manitoba (NMAM) representatives stated they did not completely oppose home birth, but they were not comfortable with home births being attended by caregivers who were not nurses or physicians (Nurse Midwives Association of Manitoba 1990).

Home birth was thus one of the primary issues which had to be negotiated by the Manitoba Working Group on Midwifery, which had representatives from the College of Physicians and Surgeons of Manitoba, the Manitoba Association of Registered Nurses, the Nurse Midwives Association of Manitoba, the Manitoba Traditional Midwives Collective, and the Homebirth Network among the approximately 20 government appointed members (Manitoba Government 1993). While discussion on this issue must certainly not have been easy, the model of midwifery which was being implemented in Ontario and Alberta at the same time included home birth within the midwife's scope of practice. This clearly affected the recommendation in the Working Group's final report which stated that midwives should be allowed to practice in multiple settings including the home. This was recommended based on the argument that research on the safety of home birth appeared to indicate that both locations were equally safe. The report also outlined some of the reasons that women choose home birth, and determined that these

reasons validated an effort to integrate home birth and make it as safe as possible (Manitoba Government 1993).

The decision to include home birth in the model of care did not have to be remade by the Midwifery Implementation Council (MIC), but it was still an area of intense discussion and many position papers. For many community midwives home birth was the heart of midwifery practice, but for many nurse midwives it was something they were not trained in, and challenged their philosophical beliefs around safety. The majority of physicians were opposed to home birth based on safety considerations as well. The MIC consulted heavily with the midwifery organizations and other stakeholder groups about home birth during its tenure (MIC Minutes, 11 September 1995; 1 April 1996; 16 December 1996; 21 April 1997).

Three pivotal moments in these consultations can be discerned. One was when the MIC was in discussion with the College of Physicians and Surgeons of Manitoba. The CPSM was supportive of the introduction of midwifery aside from the home birth issue, and it was recognized that while they would never be able to agree on the safety of home birth, their support for midwifery could allow them to 'agree to disagree' on this issue, and move on in talks about the regulation of the profession:

> **Participant 5:** ...The contentious issue was of course, the home delivery issue.
> **Meta**: Right. That's what I was thinking of. I know that the standards are quite different.
> **Participant 5:** That was going nowhere. We weren't going to relent, either at the [Name 1 Committee] level which was closest to the midwifery issue, or at the executive, or Council level of the College. That was brought forward and again it was unanimous not to condone or take part in home delivery. That was a non-issue in our books...In subsequent meetings, knowing this was going to go nowhere, knowing we favoured implementation of midwifery even if we had differences, we had a meeting [at location] one day and I remember we started this discussion, I said 'we're not going to go anywhere

> with this, so let's agree to disagree'. And it was unanimous around the table. We recognized that they weren't going to change, they recognized that we weren't going to change. We agreed that on that issue we disagreed, and just move on. So we worked around it.

A second moment was in 1997 when the discussion was shifted from 'home birth' to 'out of hospital birth' which was defined as any birth where the midwife is the most skilled caregiver at the site and specialist care is not available (MIC Minutes, 12 May 1997). This would include births in nursing stations and birth centres and focuses on the skill set a midwife requires rather than ideological beliefs about the best location for birth:

> **Participant 16:** They chose to change the way it was stated from home to 'out of hospital birth'...It really changed, the focus and the definition, and it seemed to be a reasonable solution that didn't compromise any principles.

The impact of this decision to switch the way birth places were categorized was seen immediately. The following month, the Association of Manitoba Midwives (AMM) (formerly the Nurse Midwives Association of Manitoba), which had opposed home birth requirements, indicated that it would support out of hospital birth as part of the model of care of the profession (MIC Minutes, June 1997).

However, AMM representatives stated that they wanted some flexibility for their members as they shifted careers, and wanted registered midwives to be able to choose to practice only in hospital first. Many AMM members felt that it had been too long since they had last practiced out of hospital, or felt that it was not a service they were trained to provide. While it was only a small group of nurse midwives who wanted this flexibility (2-5), it was felt that creating a birth place exemption would attract the most midwives to the profession. This was believed to be in the best interest of Manitoba women since there was an expectation that there would be many women who would want midwifery

care in hospital. The AMM advocated for a birth place exemption which would allow midwives who registered in the first three years to limit their practice to only one birth location. The creation of this exemption was difficult for the community midwives to accept because their feeling was that home birth was at the centre of the midwifery model of care (Kaufert and Robinson 2004; Scurfield 2002):

> **Participant 1:** ...One of the big issues when we were talking about who would be eligible for registration and who could practice was the whole home birth issue. Whether midwives would be forced to do home births. And their were strong feelings on both sides. It was one of the big emotional issues obviously. Traditional midwives were adamant that it be there. And their consumers who supported them were adamant that it be there. They felt that it was sort of the basis of midwifery. The holy grail of midwifery was home birth. And yet a lot of the nurse midwives had first of all never trained to do home birth and secondly were not convinced that it was entirely safe. And were not at all comfortable being responsible for a woman at a home birth.

When the proposal for a birth place exemption was put forward to the MIC Practice Committee in 1997, agreement could not be reached and it was referred to the MIC Council for consideration (MIC Minutes, 10 March 1997; 17 March 1997). Issues which were raised included fears that the benefits of home birth could be lost, considerations of what kind of care women would receive if they were not given choice or if they were cared for at home by providers that did not want to be there, and whether nurse midwives would practice if they were required to do out of hospital births. The three year window for the exemption was seen as a short term clause which would not affect the midwifery model of care over the long run. Through further discussion and consultation on the idea of this exemption, it was added that midwives who chose the exemption needed to be educated in the other birth location. Anyone who chose the exemption would also not be allowed to vote or have a say on College of Midwives of Manitoba (CMM) issues and standards which affected the birth location which they had

chosen not to practice in. A few months later, consultations on the proposed exemption were held with midwives from both midwifery organizations, and both groups agreed to support the creation of the exemption (MIC Minutes, July 1997; Scurfield 2002).

In practice, only four women chose to register to practice only in hospitals, and two of them subsequently upgraded to offering services in all birth locations. While the clause also allows midwives to restrict their practice to the home, none have chosen to do so (Scurfield 2002). Although it was not used that often, participants described the birth place exemption clause as an important symbolic act which reduced conflict around the home birth issue and allowed more nurse midwives to feel comfortable registering as midwives:

> **Participant 1:** It made a huge difference. I think knowing it existed for one thing, it showed we were listening, we were willing to make accommodations. 'We understand how valuable you are even if you don't want to do home births. We value your skills'...

With agreement negotiated to include home birth in the scope of practice with the exemption, the Manitoba *Standard for Planned Out of Hospital Birth* was then created and follows Ontario closely (College of Midwives of Manitoba 2003a; Ontario Hospital Association 1994).

After choice of birth location was successfully protected in the College of Midwives of Manitoba standards, it then came under threat again when the details of the midwifery funding structure were being negotiated. Many of the Regional Health Authorities considering hiring midwives were uncomfortable with midwives offering choice of birth place, but Manitoba Health protected choice of birth place by requiring that RHAs respect the CMM *Model of Practice* as a funding requirement:

> **Participant 3:** Following proclamation, Manitoba Health ensured that home birth was an option for birthing women by requiring funded Regional Health Authorities to comply with the Manitoba *Model of Practice* developed by the College of Midwives of Manitoba. The Model requires registered midwives to offer their clients a variety of birthing options including home birth if appropriate. Generally speaking, RHAs expressed 2 concerns regarding the early stages of implementation; can we introduce home birth at a later date once midwifery is fully implemented; and do we have to grant admitting privileges to midwives? Manitoba Health wanted to ensure that the *Model of Practice* was respected by the RHAs and thus, worked hard to provide the RHAs with the information they needed to be comfortable to incorporate home birth into their policies and to grant admitting privileges to midwives. Good communication and an exchange of relevant information assisted all RHAs to understand and comply with the *Model of Practice*.

With the requirement for midwives to offer home birth from Manitoba Health, all of the RHAs which chose to introduce midwifery services worked closely with midwives to integrate home birth into the current system. This process of integration included education and liaison with emergency medical services (EMS), and working with hospital staff to ensure that home to hospital transfers occurred smoothly and in a timely manner. It was also decided that midwives would send the prenatal records of home birth clients to the chosen back up hospital at 36 weeks in some RHAs. The midwife would then inform the hospital after the birth that it had occurred at home uneventfully (College of Midwives of Manitoba 1999):

> **Participant 10:** ...So what we started doing at 36 weeks, is the midwife would send in the prenatal record to the hospital of the family's choice so that if they needed a transfer from their home birth, the hospital would have the record. This was also to inform them that a home birth was planned. When the home birth was done, the midwives faxed a notice that said, 'this is to notify you that this home birth has happened and please remove those records from your files'. So the hospital staff could see that there were lots of home births that they were never seeing at the hospital...And it was also helpful for them to have those files if you do have to transfer. The purpose was safety, ensuring the records were available at the hospital if needed. But it also helped them to see that home births are going on, and more often than not, the outcomes are great.

The relative ease with which home birth has been integrated into the healthcare system is also reflective of work on the part of the midwives to attend home births conservatively and transfer to hospital often:

> **Participant 12:** 'This is going to succeed...So if we do anything we're going to be ultra-cautious'. And I think that we were successful because early on we were concerned that if anything does happen, it doesn't matter if it was no one's fault. You know, sometimes terrible things happen.
> **Meta:** Right.
> **Participant 12:** But if a terrible thing happens –
> **Meta:** at home –
> **Participant 12:** is that going to kybosh midwifery?
> **Meta:** Right.
> **Participant 12:** You know, 'you're not going to go to a midwife, do you know what happened down the street?'
> **Meta:** Right.
> **Participant 12:** So we really wanted to avoid that. And the midwives were very supportive.

Because of these efforts to smooth the integration of home birth services, many participants felt that home birth was becoming a more accepted part of the health care system.

5.2 Continuity of Care

When the MIC began to meet, the Ontario definition of continuity of care had set the standard for the country, and was repeated in Quebec, Alberta and British Columbia (Vadeboncoeur 2004; College of Midwives of Ontario, 1994; College of Midwives of British Columbia 1997; Midwifery Regulation Advisory Committee, Undated). It appears that there was very little chance that the MIC would consider altering this model given the uniformity of the other provinces, although the sacrifice it requires of midwives was considered more than once as a facet of the model that should be thought out further (Transitional Council of the College of Midwives of Manitoba Minutes, 19 April 1999).

This was especially true once it became clear that midwives in Ontario were experiencing real difficulty with fatigue from offering 24 hour on call availability (Sharpe 1997).

The definition of continuity of care which has been implemented across the country is not the only one that can be given for continuity of care though, and it had to be negotiated. Community midwives practicing prior to legislation defined continuity of care as one on one care between a single midwife and the woman, which was believed to develop a much closer relationship resembling friendship more than professional and client. This was seen as intrinsic to the support and care that the midwife could offer the woman during labour and birth (Manitoba Traditional Midwives Collective, Undated). It probably also developed the higher level of trust between woman and midwife which was necessary to practice in the uncertain legal climate before regulation. This practice model required constant 24 hour on call availability by the midwife and a commitment to drop everything when labour started (Participant 2). However, many professionals who had not practiced within this model felt that this was a huge sacrifice to ask of a midwife and one which could not reasonably be sustained with a full time practice. They felt that continuity of the midwifery philosophy, where a woman would have one midwife for the prenatal and postpartum periods but would be attended during childbirth by whichever midwife was on shift, was sufficient continuity (College of Physicians and Surgeons and the Manitoba Association of Registered Nurses 1991). The idea of a small number of midwives offering shared continuity of care or a system of a primary midwife and secondary midwives offering back up was determined to be the best balance of the woman's desire for continuity and the quality of life of the midwife (Manitoba Government 1993).

Once this definition of continuity of care was implemented in Manitoba, similar issues with offering this model have developed here as was seen in other provinces. Being on call requires a great deal of commitment, and it can be particularly difficult for women to offer because they often have greater family responsibilities than men (Benoit 1996/7). The midwives in Manitoba are also offering 24 hour on call accessibility to their clients at the same time that many have become overextended working on College of Midwives of Manitoba committees, and hospital, clinic and RHA committees. While none of the midwives complained about participating in these extra-professional responsibilities, many expressed how fatigued they were and how more midwives were needed to sustain the professional structure (Participants 9 and 11).

This definition of continuity of care also matches the community midwifery model more closely than nurse midwifery models. Thus, participants noted community midwives were often more familiar with the lifestyle this model requires, while midwives who have worked nursing shifts were not used to being on call and had to do more adjusting:

> **Participant 1:** ...Now in some ways it was easier for the traditional midwives or the lay midwives or community midwives, all the 2000 different names for them, right? For those midwives it was a little bit easier because within that model is the continuity of care issue, right? For the nurse midwives that was a bit harder -- not because they didn't want to do it, but that they hadn't been doing it. They hadn't really had a place or a way to do that within the system. And the other big issue for them was that they hadn't had it even in their training some of them, had the opportunity.

Other challenges of offering continuity of care included doing it within practice groups not of their making. As employees, the midwives are hired by an RHA, and an RHA administrator determines which practice group they will work in. If they want to share care and not be on perpetual call, they must share their clients between them, which

can be challenging when they hold different philosophies and practice protocols. Just as physicians in call groups must balance out these differences in their philosophies, it is important that midwives are also able to form groups with shared philosophies so that their clients can expect similar care from the midwives in the practice, and the midwives can create call schedules which work for them.

While these challenges were identified about offering continuity of care, participants were clear that it was not something which should be negotiated away:

> **Participant 15:** I think the evidence is overwhelming that having one person sit with you through your labor is clearly where we need to go.
> **Meta**: Yes.
> **Participant 15:** That it provides for best outcomes - it is all about reducing anxiety, and watchful waiting with the knowledge and skills to support labour. Women have continually asked to birth with familiar attendants in a supportive, safe atmosphere. I think we have overwhelming evidence that it's not just that women would kind of like it, it actually delivers better outcomes.

Instead, participants considered other solutions to the fatigue and burnout which can plague this practice model. One point which had consensus from almost all of the participants was that midwifery practice groups work best with four people, which is still small enough to offer continuity of care, but allows midwives to set up call schedules which give them a satisfactory amount of time off call (Participant 3; Human Resource Strategy for Midwifery Implementation Committee 1998):

> **Participant 13:** I spoke to having mandatory minimums. I would like to see it mandatory that practice groups be at least four minimum…Four seems to be, sort of the magic number for the system working better so that midwives are able to be off call for a portion of time.

Participants also mentioned allowing midwives to hire full time administrative assistants so that they can focus more of their time on caring for clients, and hiring more midwives so that the responsibilities of the profession are spread out among a more reasonable

number of women. The importance of allowing midwives to hire non midwife second birth attendants was also brought up many times so that fewer midwives would have to be on call at any one time (Participants 6, 9, 15, 17 and 24).

5.3 Midwifery Second Attendants

The issue of second attendants at births has been an issue in provinces with regulated midwifery throughout the country because all provinces have required two attendants at each midwifery birth, but the demand for midwives is still far greater than what midwives can provide. Non midwife second attendants at births allow midwives to attend more women. The MIC attempted to address the second attendant issues which they saw developing in other provinces by giving midwives more flexibility in who could be their second attendants, but their efforts did not prove successful. In practice, midwives in Manitoba have ended up with fewer rather than greater options than midwives in other provinces.

Ontario was the first province to require two midwives at each birth, based on the belief that with two clients after the birth, the woman and the newborn, two midwives would be better able to handle adverse situations if they involved both clients (Ontario Hospital Association 1994). British Columbia made a similar standard, where two midwives are expected to attend all home births, but in hospitals or situations where only one midwife is available, she can secure the assistance of a person trained in neonatal resuscitation and managing maternal complications (College of Midwives of British Columbia 1997). In Alberta, midwives are allowed to hire people with the requisite skills to work as second attendants for them (Midwifery Regulation Advisory Committee, Undated). Over time, Ontario has also allowed midwives to use non midwife second

attendants for births so that two midwives do not need to attend each birth (Klymasz 1997).

In Manitoba, the principle of non midwife second attendants was supported from the first meetings of the MIC, with the expectation that the second attendant could be another health professional or a hired assistant (MIC Minutes, 29 September 1995; 22 July 1995). The original standards described a system where other health professionals assisting midwives through their own health profession's Act need not be registered with the College of Midwives of Manitoba, but anyone who was not a member of a health profession would have to be approved by the CMM and would be required to take an orientation course. The document listed the training a second attendant was required to have, and the activities which would be appropriate for second attendants to carry out. The midwife would accept liability for all acts of her second attendants (MIC Minutes, 30 May 1998).

However, when trying to implement this standard the MIC came up against a number of barriers including whether the MIC and College of Midwives of Manitoba had the authority to regulate midwifery second attendants, or whether this was the creation of another new profession (MIC Minutes, 30 May 1998). In 1999 it became clear that the midwifery legislation gave the CMM no power to regulate second attendants and that second attendants would not be covered by the midwife's liability insurance if the second attendant was not from a regulated health profession (Transitional Council of the College of Midwives of Manitoba Minutes, 15 March 1999). There were also issues about who would pay second attendants, and how they would get neonatal resuscitation training

since this is only open to regulated health professionals in provinces where midwifery is regulated (Maize 1999b).

> **Participant 1:** ...We tried to set up a system for another option but we really didn't have the legislative permission to do that. We were legislating midwifery not midwifery second attendants. We did try it. We put out some guidelines, but it's still an issue. I think it would still be an important thing to develop. It would be a really good thing to have and we have talked a lot about it. We have developed some papers on it. About the training and assessment of them. But it is beyond the scope of the midwifery College at this point. They now do physician's assistants in the College of Physicians and Surgeons so maybe they can do midwifery assistants at the midwifery College.

Further as employees, the RHAs can also set who is allowed to be a midwifery second attendant in their region, and in some it is explicit that at this point midwifery second attendants must be employees of the region and must be a physician, nurse or midwife (Winnipeg Regional Health Authority 2001 (2003)).

According to the CMM standard on second attendants, it is still possible for a second attendant to be a non health professional in Manitoba (College of Midwives of Manitoba 2003f), but the above mentioned barriers mean that no non health professionals are being used as second attendants. At home births, the second attendant is almost always another midwife, but occasionally may be another health professional. During implementation, the College of Registered Nurses of Manitoba (CRNM) (formerly the Manitoba Association of Registered Nurses) determined that registered nurses can work as second attendants at home births, although the registered nurse must be competent to do it (Participant 20). However, since nurses are usually hospital employees, this would have to be done during their own time (Participant 23). Finally, it was also determined that to pay a nurse to be a second for a midwife at a home birth would cost more than the midwife was getting paid for the birth, making this not the cost saving measure it was

expected to be (Participant 6). Thus, the issue of non midwife second attendants at home births remains a problem.

5.4 Autonomy and Employment

The first point of the model of practice in Manitoba is that midwives are autonomous primary caregivers (College of Midwives of Manitoba 2003e). This is seen as central to the ability of midwives to offer the model of care. However, this is also one of the most controversial aspects of the profession which had to be negotiated. In early talks, the focus on autonomy was that midwives should not have to report to physicians because this would dilute the differences between their practice model and the medical model of care. The report of the Working Group recommended that the midwives be self regulating through their own College, and this was implemented by the MIC. While midwives have not ended up being under the supervision of physicians, with the decision to fund midwifery by having RHAs hire them as employees, midwives have come under the supervision of RHA administrators which limits their autonomy to a certain extent.

Like many other aspects of the model of practice, autonomy was a term which meant different things to different stakeholder groups. Midwives as autonomous caregivers was supported in the Manitoba Advisory Council on the Status of Women (1987) *Midwifery* paper, but the joint College of Physicians and Surgeons of Manitoba and Manitoba Association of Registered Nurses (1991) paper advocated for midwives working under the supervision of physicians. Representatives holding these divergent views on the appropriate level of autonomy in midwifery were brought into dialogue during the meetings of the Working Group. Discussion papers from the Working Group indicate that the discussion around autonomy developed into an understanding that as

autonomous caregivers, midwives would not report to another provider, but neither would they work in isolation. The Working Group considered the autonomy of midwives working in solo practice, in collegial teams and as hospital employees, with autonomy seen to decrease going from one of these models to the other (Manitoba Working Group on Midwifery, Undated). The Working Group ultimately recommended the middle option, that midwives should work in collegial teams, describing these collegial teams as possibly made up of a group of midwives, in a community clinic, with a private practice obstetric team, with a group of nurses, or in partnership with a general practitioner (Manitoba Government 1993).

As part of not reporting to another profession, the Working Group also advocated that midwifery should be self regulated within a College structure. This decision by the Working Group was supported by the fact that midwives were already defined as self regulated and autonomous primary caregivers in Ontario (Manitoba Government 1993). These recommendations were supported by the Provincial Government (Manitoba Government 1994a), and implemented by the Midwifery Implementation Council. Midwives in Manitoba are autonomous caregivers regulated by their own College made up of midwives and consumer representatives (College of Midwives of Manitoba 2004a).

In practice however, autonomy is much trickier to work out. The greatest threat to the autonomy of the midwives is their Regional Health Authority employee status. While the employee status was decided on for many reasons which have to do with integration and access, in many ways it replaces supervision by a physician with supervision by an RHA administrator which places very different pressures on the midwifery practitioners. The first concern was that as employees, the Regional Health

Authorities could limit the scope that midwives can practice in their region. However, Manitoba Health ensured that in exchange for funding, the RHAs had to allow midwives to practice the full model of care (Manitoba Health 1999):

> **Participant 3:** There was some concern that as employers, RHAs could try to limit the scope of practice of employed midwives. However, to ensure a full understanding by all parties, Manitoba Health and each funded RHA signed an Agreement for Services. The Agreement contained a clause that required the RHA to uphold the *Model of Practice*.

Employee status has also meant that midwives do not pick their practice groups. With the birth location exemption, this means that sometimes the midwives are practicing in groups with midwives who have a different scope of practice:

> **Participant 1:** ...But being an employee they've been told: you four are working at (Clinic 1) or you four at (Clinic 2). And away you go. Which is not ideal. I don't think that's a good way to set up a practice. The midwives are so interdependent, you know, when it comes to their work, really you should like who you are working with and have a similar philosophy. Because you're going to do favors for her and she's got to do favors for you. I mean that's the nature of the job...
> **Meta**: Does that affect scope of practice at all?
> **Participant 1:** Sometimes.
> **Meta**: If you're working with a midwife who has a different philosophy?
> **Participant 1:** Yes. It's been an issue for home birth because the midwife who doesn't do home birth -- in one of the practices there's one midwife who wants to do home birth but no one else in the practice was able to cover her at one point.
> **Meta**: As a second attendant and a backup?
> **Participant 1:** Yes. So she had a hard time doing home birth. Now there's somebody else there who does home birth. That's good. But that was an issue. The rest of the group didn't do them.

Employee status also means that the midwives did not choose the location of their practice. Frustration with these intrusions on their autonomy because of their employee status combined with concerns about issues of micro-managing by RHA supervisors, not allowing midwives to cross RHA boundaries, and the fact that there were not enough jobs for all of the midwives who were registering, were brought by the Manitoba Association

of Midwives (MAM) to a meeting with the provincial Ministers in the fall of 2000 (Maize 2000). A year later when these concerns continued to be unresolved, the MAM newsletter (Maize 2001) printed the initial list of concerns that some of the midwives had about employee status which had come true including lack of say on: practice sites, equipment, support staff, and decisions about adding midwives to practice groups. They also expressed frustration about the time and energy to fill in time logs and having to report their every action to a supervisor; being restricted to serving women in their region; and no allowance for working part time (only job share), no locums, and no temporary positions. Many participants reiterated these challenges to the midwives' autonomy which stem from their employee status:

> **Participant 1:** ...It's still a major issue. There are still some midwives who are very resentful of employee status...So the employee status looked more attractive to some of us anyways. It also meant we had to be concerned about who the employer would be. Because you wanted an employer who was supportive of midwifery, that would respect the model of practice, that would allow them to do what they had to do. That was built into the first contract. It didn't necessarily work very well. Because once you actually get into the situation things work differently. The issues, and how midwives could have a say over things in the budget hasn't worked out very well. In some regions anyways. They haven't been able to say 'I want to buy this piece of equipment' and go out and buy it. You have to fill out a form, you have to send it in, it has to be approved. It has to have a number. So it's been a bit cumbersome that way...
>
> **Participant 10:** ...I think that when we started, there were some midwives who were unhappy with the employment model. You may have heard this from some of the midwives, from their perspective they were very worried about autonomy.
> **Meta**: Right.
> **Participant 10:** And they were worried about being able to maintain their model of practice...And I think that initially there was real resentment of the managers, me and others, questioning their practice, or questioning them, or following up on an issue.
> **Meta**: Yes.
> **Participant 10:** Although I don't see that anymore, but in the beginning it was, 'who are you to question me?'

Meta: Right.
Participant 10: And in many ways me not being a midwife probably added to their apprehension.

Another frustration many participants mentioned was that while home visits are a part of the model, a cap on mileage has occurred in some RHAs, limiting the amount that midwives can do them:

Participant 13: Yes absolutely. I think it's been huge. Things, some thing as simple as mileage. You know we encourage homes visits, right? But you're getting hassled because of the mileage you are racking up. So then there is a cap on mileage.
Meta: Really?
Participant 13: And how curious is that.
Meta: So I guess there's a different commitment to the model.
Participant 13: Well, yes, so we've got the model on paper. We've got the RHA protocol. How does it mesh to make it fit OK?
Meta: Right.
Participant 13: Maybe if the midwife didn't have to count her mileage when she was taking her samples to the lab, she could do two more home visits in a week. Who knows? I mean it's just, I think, it's all these little things like that too I guess.
Meta: And you think there's a number of those?
Participant 13: Yes, there seem to be tensions.

Participants also noted that with employee status comes the possibility of being fired and losing your position for reasons which do not have to do with your standard of practice or other issues which would be addressed at the College level (Participant 6).

The issue of professional autonomy does appear to show some regional variation though (Participants 11, 18 and 16):

Participant 3: ...we went with the employment model. My guess is that a good percentage of the midwives are comfortable with it. Do I think there are some purists out there who feel that their autonomy is totally compromised? Yes, probably, but I think they are few in number. There seems to be different views on the extent of professional autonomy throughout the province. Midwives working in smaller rural RHAs don't seem to have the same concerns as midwives working in larger urban centres. Obviously, RHAs that have significant responsibilities require extensive administration and policies to ensure consistent, quality service. I think for some midwives who were

> used to working as community midwives, the level of bureaucracy and administration in urban centres was very challenging. However, as both midwives and RHAs gain more experience in providing midwifery service as part of the health care system, the more comfortable both parties will become.

Changes in the way midwifery is going to be managed in the Winnipeg Regional Health Authority (WRHA) may address some of the midwives' autonomy concerns. While initially the midwives were managed centrally by an RHA administrator whose main purpose was to ease the integration of the midwifery program, the WRHA is presently planning to shift to the midwives being managed at the clinics where they practice. A clinical midwifery specialist position, filled by a practicing midwife, will then be created at the WRHA level who will primarily offer practice support in terms of research for evidence-based practice, practice consultation for midwives and other professionals, continuing education, program statistical reporting, and quality assurance (Participant 10). Participants generally viewed this change positively, and described the benefits of having a WRHA position filled by a person who understands firsthand about practicing as a midwife. They also indicated this would mean more management would happen at the clinic level by someone who could help work through problems with full understanding of the climate of the clinic (Participant 21). This will also likely lead to more variety between the midwifery practice groups in terms of how they are managed, which may create more or less autonomy at different clinics in Winnipeg (Participant 1). However, it may also give the midwives more freedom to move from one clinic to another to match their practice philosophies (Participant 8).

While most midwives have not let these challenges to their autonomy deter them from working as employees, the lack of autonomy from employment has led one midwife to choose to practice independently, which means her clients have to pay for her service

out of pocket. This gives her the freedom to cross RHA boundaries and practice throughout the province, to work out of her home and use her own equipment, and generally have more autonomy in how she practices. She keeps her fee low to keep her services accessible to low income women. One difficulty she has is finding a second attendant for births because the employed midwives are not allowed to assist her (Participant 19).

5.5 Expanding the Scope of Practice

While the midwives come from multiple training backgrounds and experiences, there were a few areas within the scope of practice which almost none of them had done within midwifery before. This expanded scope required greater adjustment on the part of the midwives and the health professionals they worked with, but these areas were expanded based on the assumption that this would make it easier for midwives to practice autonomously. The new areas include prescription privileges, ordering lab tests including ultrasound, some minor surgical procedures, and well woman care (routine gynecological care). Herbs and alternative therapies are also an expansion of the scope of practice for midwives trained in more medical models. A final area of expanded scope which was hoped for was certain narcotics, but this has not yet been possible. In practice, it appears that this scope is viewed favourably by midwives and other stakeholders and has successfully been able to allow midwives to practice autonomously.

While not controlled acts, the use of herbs and alternative therapies has expanded the scope of practice of midwives who had not used them before, and expanded the care options open to women among publicly funded maternity care practitioners in Manitoba. Education in herbs and alternative therapies was offered to all of the midwives in the

assessment and upgrading so that all would be familiar with their use. The use of alternative therapies to treat some pregnancy and labour difficulties are also referenced in the standards and policies of the CMM as possible options in treatment plans, although specific herbs and treatments are not explicitly recommended (College of Midwives of Manitoba 2003c). Alternative therapies have thus become a sanctioned care option, but never a required one:

> **Participant 16:** I think that what we wanted to do, what we tried to do, was to create a certain amount of latitude in practice so that midwives could use herbs in their practice if they had the knowledge. It gave an option rather than only having the choice of allopathic methods, but the underlying expectation was that the midwife would have the knowledge to advise and use non-allopathic methods in a safe manner. This is the same expectation that you would have for a midwife who was prescribing any other medication or treatment.

Prescription privileges for pharmaceuticals were an issue which the MIC started to address early in its tenure, forming a list of possible medications that midwives could prescribe in 1995. The CPSM was consulted extensively on this list (MIC Minutes, 14 December 1995; 25 October 1996). The final list of medications which was included in the *Midwifery Regulation* (Manitoba Government 2000) follows the other provinces closely, but it is generally less specific, outlining drug groups rather than the specific names, dosages and routes which are proscribed by other provinces (Alberta Government 2001; Ontario Hospital Association 1994). It also includes antibiotics for vaginal/cervical infections which was added because initially in Ontario and British Columbia, midwives had to consult with physicians for prescriptions for antibiotics for common infections of pregnancy, and this was seen as a poor use of physician time. Physicians did not want this repeated in Manitoba (Scurfield 2002; Transitional Council of the College of Midwives of Manitoba Minutes, 15 March 1999; Manitoba Government

2000). The expectation was that this expanded list would facilitate midwives being autonomous in offering routine care. Midwives interviewed generally agreed that this had in fact occurred:

> **Participant 9:** ...The scope of practice is good.
> **Meta**: Yes.
> **Participant 9:** The regulations provide a framework that allows the midwives to provide this service without involving a lot of other people in a normal course of care. Yes, it's, I think it's probably the best. I think it's the best model in Canada. We have combined elements from all the other provinces that have regulated midwifery and it has been possible for us to become integrated and still maintain autonomy.

The success midwives have had practicing with this scope attests partly to the extensive work done before they began practicing to ease this change, including education meetings with the diagnostic staff and pharmacists as well as the aforementioned extensive consultations about the lists with physicians (Irvine-Wallace 2000). This integration work combined with knowledge of how things had worked out in other provinces allowed many operational issues to be worked out before the midwives began practicing.

The expanded pharmaceutical list has created some tensions within the midwifery profession however. Midwives with baccalaureate training appear to have some trepidation about midwives without academic backgrounds or scientific training prescribing such an extensive list of drugs (Participant 22). Some of the community trained midwives have difficulty being required to include in their repertoire drugs and procedures which generally fall outside of their own non interventionist philosophies (Participant 6).

Like prescription rights, many midwives also had no previous experience offering women pap smears, sexually transmitted infections (STI) testing, and prescribing and fitting contraceptives. The well woman care midwives can offer in Manitoba was also

extended to include more contraception than was initially implemented in other provinces. This means midwives can insert Intra-Uterine Devices (IUDs), and prescribe oral contraceptive pills and Depo-Provera. This was done because only being able to offer a few contraceptive choices was seen as unfairly limiting the postpartum contraceptive options of midwifery clients, or requiring an unnecessary medical consultation (Scurfield 2002). Many of the midwives interviewed stated they enjoy being able to offer well woman care. They also said that many of their clients have requested they offer this care outside the reproductive year:

> **Participant 11:** Some women will come to us and we'll do a pap smear. And they'll say, 'can I come back to you in two years?' And we have to say, 'well no, you can't, because we have to do it in the context of your birth care', and they respond, 'awww'.
> **Meta**: Yes.
> **Participant 11:** It might make the difference for them between having one and not.

This limit on well woman care is partly to ensure midwives are not unnecessarily duplicating services:

> **Participant 16:** It is perceived to be a slippery slope. Well Woman Care could involve a well woman at 55 who has different health issues. The scope of practice really needed to be exclusively around the childbearing year, or issues related to pregnancy, birth and postpartum, and the newborn. I think at the beginning some other professionals were afraid that midwives were going to be practicing beyond their scope and essentially practicing medicine without a license.

The limit also comes from Ontario, where midwives can only do well woman care within the reproductive year. However, in the *Task Force on the Implementation of Midwifery in Ontario* report (1987) the writers recognize that well woman care is a part of midwifery in many European countries, but did not think a well woman care provider

was needed in Ontario. Many participants noted though, that such a practitioner is needed in Manitoba in rural and remote areas:

> **Participant 15:** ...And at the same time that the discussions on midwifery were going on, here at the clinic we had undertaken a province wide outreach and consultation program on women and primary health reform.
> **Meta**: Yes.
> **Participant 15:** And we were out in the community talking about restructuring and access to care. We did a large report and followed up with recommendations to the province, the Regions, and community groups. And it was clear that access to primary reproductive health was a huge, huge issue for women. So it felt to me that if we could introduce this provider that did the scope of reproductive care for women, we would be doing the women in this community a huge service... That's what I heard from women and particularly in the rural areas. It's not just about birth. It's pap tests, female providers.

The limit of well woman care to the reproductive year is in *The Midwifery Act* itself which makes it very difficult to change (Manitoba Government 1997), but there does seem to be increasing recognition that a method of adjusting the model for rural and remote communities is needed.

The MIC also wanted to include a few narcotics in the midwifery scope of practice. Negotiations to include Tylenol with Codeine and Demerol on the list of medications were held throughout the term of the MIC but with no results (MIC Minutes, 25 October 1996; 6 February 1998, 9 June 1998). Narcotics are regulated federally and they have not yet been able to change the *Controlled Drugs and Substances Act* (formally the *Narcotics Act*) to include midwives as practitioners who can prescribe narcotics. At present, midwives can only prescribe Demerol and Tylenol with Codeine under the direction of a physician:

> **Participant 9:** We need to be able to sign the standard postpartum orders. There are a couple of things on those orders that we don't have the authority to prescribe, for example, Tylenol No. 3 which has codeine in it.
> **Meta**: Yes.

Participant 9: But that's a standard postpartum medication.
Meta: Right.
Participant 9: Everyone gets to have it except our clients. And then if they need it, we have to call a doctor to get an order for it.

Narcotics are thus an area where midwives have to routinely consult physicians.

5.6 Informed Choice

The philosophy of care and ethics documents appear to have required little negotiation and to be largely working in practice. The *Philosophy of Midwifery* and *Ethics* documents are largely based on their equivalents in Ontario (College of Midwives of Manitoba, 2003g; College of Midwives of Manitoba 2003j; Bourgeault 1996). However, there is one ethical dilemma which a number of the midwives brought up. While all the midwives and most of the other participants interviewed were supportive of the concept of informed choice in midwifery care, in practice many midwives are finding that it can be challenging to offer when the woman chooses care outside the scope of practice of the midwife.

At no point during the implementation discussions and negotiations was informed choice not an assured part of what midwifery was going to offer, but how it would be operationalized in practice took a great deal of discussion and is still something which midwives are struggling with. The informed choice standard of the CMM is very specific on how this should be operationalized, and is almost identical to the informed choice standard of the College of Midwives of British Columbia (College of Midwives of Manitoba 2003d; College of Midwives of British Columbia, Undated). It states that each woman should be given, preferably in writing, the education and experience of the midwives in the practice, the services provided including scope of practice and standards of practice, 24 hour contact information for the midwives, and protocols for consultations

and transfers. Throughout the course of care, the CMM also requires midwives to provide each woman with the potential benefits and risks of, and alternatives to, any procedures, tests and medications offered, as well as any relevant research evidence and practice standards. They are also required to create opportunities to discuss the information, and offer care that is individualized and sensitive (College of Midwives of Manitoba 2003d).

This standard can be challenging to operationalize in the complexity of real life though, and a few participants mentioned that informed choice may be even harder to offer when the client base that midwives are seeing has become more diverse:

> **Participant 1:** ...I think the whole midwife relationship with the woman, while it's on paper very clear, right? Like informed choice, it's been a real struggle. For everybody. Not just the nurse midwives who people thought it might be more of a struggle for because they were used to a medical mode from observing that kind of behavior from the physicians. It has also been a struggle for the community trained midwives because their clients aren't the same kind of people. Doing informed choice with a pregnant 16-year-old glue sniffer is really a challenge. Her decisions are not at all like the decisions of a 30-year-old architect. It's been a real challenge to maintain that kind of commitment to informed choice.

However, the midwives interviewed did not mention a lot of difficulties with offering informed choice except when a client chose care outside the midwife's scope of practice, such as refusing the advice of the consulting practitioner, or refusing to be transferred outside of midwifery care because of a medical contra-indication. In the fall of 1996, the MIC decided that if such a situation arose during labour, a midwife would not be allowed to refuse to care for the woman (midwives are not allowed to refuse care during labour in any Canadian province) (MIC Minutes, 21 November 1996). From this came the policy for *When a Client Requests Care Outside the Scope of Midwifery*, which was almost identical to the corresponding document in Ontario (Bourgeault 1996; College of

Midwives of Manitoba 2003h). This policy combined with the detailed *Standard for Consultation and Transfer of Care* makes it very clear what the midwife's scope of practice is, and what the protocols are for situations when a client chooses care outside this scope (College of Midwives of Manitoba 2003b). This is important for allowing the midwives to offer informed choice without being overly concerned about liability.

While it is good that the midwives have the protection of this policy when a client requests care outside the scope of practice, it has still been challenging to implement. One aspect of it which it appears took some time to understand is that a woman's choices do not determine the decisions and behavior of the midwife, only the care the woman receives. Thus, if a situation arises which according to practice standards requires the midwife to initiate a consult, the midwife is required to make that consultation even if she and the physician she consults both know that the woman will not be following their advice. She is then required to report to the client her actions, the advice of the consulted practitioner, and why the consult was made. It is then the client's choice whether or not to follow the consult (Participant 21):

> **Participant 18:** ...I have consulted an obstetrician who said, 'I don't know if this is really a consult because the client is not going to do what I say'. Some clients do not want to see the obstetrician etc, so I may have to consult with the client not meeting the consult. This is still a consult. I consult because my College guidelines say I have to. I then go back to the client to give her the information given to me by the obstetrician. The client then makes the decision, not me. That is a consult. It's an informed choice. At other times the client will go and meet with the obstetrician etc, but again she still has the right to refuse treatment or recommendations made.

There is one choice clients may request which cannot be covered by this policy and that is if parents would like to choose to not have the newborn resuscitated at birth based on religious reasons. This was brought up in 1998 in the MIC and it was

determined that this was an issue of criminal law whereby the parent has a legal duty to give their child the necessities of life. The midwife also has a legal duty following birth to do everything for the child once it is born, and could be held negligent if they did nothing (MIC Minutes, 17 April 1998). Midwifery thus does not offer an alternative for parents who seek this option, something which more than one midwife brought up:

> **Participant 6:** And we have now agreed that if there is a problem with the baby, the parents understand that we are required to do all that we can do for the baby, but we will respect the mother's right to decline care for herself. This is usually for families with a strong religious conviction to follow 'God's Will'.

Midwives have also been circumscribed in operationalizing informed choice because at this early stage of integration, practices are being watched very closely. Accepting an informed choice which might increase the risk of morbidity or mortality to the mother or newborn thus becomes reduced because an adverse event could be catastrophic for the profession:

> **Participant 6:** OK. Well, there is also a document called W*hen a Client Requests Care Outside the Scope of Midwifery*. 'In the course of care or urgent situation, the midwife may not refuse the request to attend the client as in keeping with the College of Midwives of Manitoba *Code of Ethics*'. So when I was in that situation, I just explained this to the parents and thought that I would be covered by this…if I stayed with that family, but I was afraid of the ruffle. And it was a new time for the profession.
> **Meta**: Yes that's what I was thinking.
> **Participant 6:** It was a new time and we were trying to keep our reputation crystal clean.

This kind of pressure to make 'appropriate' informed choices which protect the image of the profession was discussed prior to legislation in Ontario (Mason 1990), but this appears to also be an issue in the early implementation stages. The consequences of what will happen if a midwife continues to care for a woman when she chooses care outside of the scope of practice and there is an adverse outcome, and whether or not the standards

and policies of the College of Midwives of Manitoba will work in this situation to protect the midwife or not, is not yet clear.

5.7 Summary

The Manitoba midwifery *Model of Practice* document was largely worked out during discussion by the MIC, and while there was pressure to create a unified profession across the country to allow for portability, Manitoba made a number of unique decisions which reflect their attempt to accommodate a diversity of midwifery models (College of Midwives of Manitoba 2003e, Saskatchewan Midwifery Advisory Committee 1996). The area in which Manitoba diverged the most from other provinces is choice of birth place, and it is the only province which has allowed the initial registered midwives to choose not to attend out of hospital births. This exemption garnered more widespread support for the new profession. While midwives are autonomous from the supervision of other health professionals, the unique decision of Manitoba to fund midwifery through RHA employment has also affected the model of care by taking some of the client care decisions from midwives and putting them in the hands of RHA administrators. Continuity of care and choice of birth place have been protected because of the requirement that these be offered by the RHA in exchange for funding from Manitoba Health, but midwives are limited in offering both because they cannot hire non professional second attendants. Informed choice appears to be well protected through the standards of the CMM, but it has been challenging to offer during this early implementation period when an adverse event could be disastrous for the new profession. Despite these challenges though, most participants perceived the model of care positively and felt that these issues could be worked out in time.

Chapter Six: Access to Midwifery Care

6.0 Introduction

As a newly introduced service with only a small number of practitioners, it has been recognized throughout Canada that without a concerted effort towards accessibility, midwifery services could end up being exclusively used by an elite group of women well educated about their maternity care options. In Manitoba, a two-fold strategy was implemented to try to keep this from occurring, and this chapter will discuss the facets of this approach. The first part of this strategy was to develop the profession in a way that was responsive to the desires of women throughout Manitoba. To facilitate this goal, the Midwifery Implementation Council (MIC) was made up of a diverse group of women who worked together to create a midwifery profession that could accommodate their different viewpoints. The MIC also attempted to talk to women from throughout the province and transform their ideas into a flexible service that could be individualized to their needs. Particular attention was paid to making regulated midwifery services culturally appropriate for Aboriginal, Métis and First Nations women. The second part of this strategy was to then target the service towards women who face more barriers to obtaining quality maternity care. Manitoba is the only province which has systematically targeted midwifery positions for rural and northern communities and prioritized for care women from socio-economically disadvantaged populations. The barriers which these initiatives in midwifery have attempted to address are formidable though, and participants discussed how these initiatives have worked and not worked, and the impact that these accessibility goals have had on the development of the profession.

6.1 Culturally Appropriate

A key issue for accessibility is that the care is culturally appropriate for all Manitoba women such that they would be comfortable choosing midwifery care. A number of initiatives were developed in the province in this area, which were differentially successful. One of the first things which was done was to make the Midwifery Implementation Council itself as representative as possible, and to create a committee of the MIC whose primary function was to focus on equity issues. This Equity and Access Committee then did extensive consultations with women throughout the province to learn more about how they envisioned midwifery services for their communities. Consultations with Aboriginal women led to a change in the structure of the College of Midwives of Manitoba (CMM) so that the profession could be more responsive to their needs, and this has led to initiatives specifically around Aboriginal women and midwifery care. This section will explore these initiatives, and discuss the reflections of participants on whether now, in practice, they have made the profession more culturally appropriate and more accessible.

6.1.1 The Midwifery Implementation Council

The Midwifery Implementation Council was given responsibility for developing the regulated midwifery profession in Manitoba, and the representativeness of the participants and the decision-making structure of the Council were integral to facilitating a profession which was accessible to women as midwifery clients. The terms of reference for the Midwifery Implementation Council included addressing issues of access and equity, and carrying out an extensive consultation process to ensure appropriate representation in developing the profession (Scurfield 2002). The original 13 Council

members, including the Chairs of the four committees, were representatives of community midwifery, nurse midwifery, medicine, nursing, non-European immigrant midwives with direct entry training, and a broad range of consumer groups (Scurfield 2002; Garvie 2001).

The representative composition of the MIC has been identified as part of its ability to successfully implement the profession. Many of the stakeholder groups these individuals were from had not been able to work together successfully prior to this point, and the MIC worked hard to build trust and the ability to work cooperatively (Participant 1). The MIC used a consensus decision making model based on a group agreement created during their first meetings (MIC Minutes, 9 January 1995). This meant that all council members had to speak on all decisions and had to agree to the decision before it could be passed:

> **Participant 7:** ...Well, and people have to move. You know, you can start out with a discussion with one school here and one faction there, and you have to end up somewhere in between. And it's not likely that one is going to come like this (gestures one hand moving entirely to the side of the other).
> **Meta**: Right.
> **Participant 7:** They both have to come together. They both have to give up something. And hopefully what you get in the middle is the balance, the more workable solution. The more, more acceptable solution. Hopefully the most important things are the things that people hold onto.

Participants noted that this was very beneficial for the process, because it meant that stakeholder groups with only one or a small number of members could not be voted down (Garvie 2001):

> **Participant 1:** And the other thing, I think that is a really important part of it all, was talking about decision-making and how we wanted to do that...And I think the strength of that was that each person could have influence over the decisions. If you feel really, really strongly about something you could stop it right? I think that was a really important decision because it gave people at least the confidence to know that they had a say in things. As long as they

were there and willing to stand up for whatever they believed in, then they shouldn't get, you know, voted down, you know railroaded down in a sort of voting system…

Meta: And that, you really felt that the consensus allowed you to be heard and have your say?
Participant 6: Yes. Absolutely. It was amazing because sometimes I wasn't feeling brave enough to speak my mind, and we would do a circle at the end of the discussion and I would get to say my piece. I don't like confrontation too much.
Meta: Yes.
Participant 6: So sometimes I would feel, 'OK I'm just going to say it'. (Laughter)
Meta: Yes.
Participant 6: And I would have support around the table because people there, we had a goal in mind. 'OK, …we need to value what you're saying'. Then I felt heard.

While these aspects of the MIC worked towards creating a representative profession, the funding arrangement of the MIC worked against this effort. In 1995, when the MIC was formed, it was agreed that Committee Chairs would be paid, but only the travel and other expenses of the rest of the Council members would be covered (MIC Minutes, 8 May 1995). MIC members expressed uncertainty about getting the implementation work finished quickly based on volunteer time, and the Chairs expressed concern about feeling a responsibility to do more since they were paid and others are not. It was affirmed that no matter the funding arrangement, decisions would be made by the consensus of the whole Council (MIC Minutes 9 January 1995; 8 May 1995).

The concerns of Council members quickly began to become a reality though. By only funding the Committee Chairs, it indicated that only the labour of the Chairs was of value and tokenized the labour of the other women. The less time the unpaid members had to offer because they were volunteering also meant that the paid Chairs took on more of the work. According to Scurfield (2002: 87), "The Chairperson of the MIC working

with the Chairs of the Committees of the MIC and the coordinator made most of the routine decisions with respect to the business of the MIC." By the fall of 1995 it was raised that some members were already missing a large number of meetings in a row. Since each member represented a certain stakeholder group, without their participation there was concern that certain voices were not being heard (MIC Minutes, 4 December 1995). There was also much higher turnover among the unpaid Council members, such that there was not the same consistent strong voice to support the interests of those they represented. Unfortunately the way the funding was divided, those who were unfunded and the member positions with high turnover included the northern/rural consumer, the consumer of Aboriginal decent, the non-European immigrant midwife with direct entry training, and the community midwife representative. For different periods of time, sometimes years, the MIC did not have representation for these positions, although they tried to find replacements (MIC Minutes, Cumulative).

6.1.2 The Equity and Access Committee and the Consultations

Within the Midwifery Implementation Council, there was also an Equity and Access Committee which was mandated to work with all of the other committees to ensure that they were developing the midwifery programs, documents and regulatory structures in ways which made the profession accessible to all Manitoba women as consumers of midwifery care. The Committee was also expected to carry out extensive consultations throughout the province so that the voices of Manitoba women could be heard and incorporated into the development of the new profession. The Equity and Access Committee took this mandate seriously and over 75 consultation meetings and public information nights were held to hear women's ideas about the introduction of

regulated midwifery across the province. Five consultants were hired to lead the consultations in northern First Nations communities, Métis communities, and with urban Aboriginal community members. Announcements of meetings were translated and published in over 10 languages, and consultations were targeted for certain communities to facilitate hearing from a broad spectrum of consumers (Garvie 2001). This extensive consultation process created tangible results in more inclusive midwifery legislation and regulations.

In Winnipeg there were over 20 consultations and information meetings in 1995 and 1996 which included information nights open to the public, and with organizations that were involved with specific populations (MIC Minutes, 9 January 1996; 31 March 1996; 25 November 1996; Anonymous 1997a). The Equity and Access Committee also attempted to target consultations in Winnipeg with some minority populations which might not be represented at public meetings, including francophone women, women with disabilities, adolescents, and immigrant women, but this was not entirely successful. The first Francophone consultations were in the summer of 1996 and met with a lot of interest leading to the formation of a Francophone subcommittee in the fall of 1996 which met several times (MIC Minutes, 4 July 1996; 29 August 1996; 26 September 1996; 30 September 1996; 28 October 1996; 25 November 1996). However, it soon became clear that the MIC was not going to be able offer a French language midwifery assessment and upgrading:

> **Participant 14:** ...You know we really didn't -- this was one of our shortcomings. We really didn't deal with French-speaking. We couldn't see a way to do that. You would need a whole committee that speaks and writes and reads French. We didn't have that available to us. Although we did do some meetings with the French community. We encouraged them to work in their own way on the steps to bring midwives in. So there is a nursing center

> or midwifery center in one of the French communities and they were working, some of the French midwives were also bilingual. So they worked their way through, but that's a shortcoming.

In the spring of 1995, an invitation to the public consultations to women with midwifery skills was translated into 13 languages and many publications and announcements were sent out to teachers of English as a Second Language (MIC Minutes, 3 April 1995; 4 April 1995). In the fall of 1996, a consultation with immigrant women was attended by 6 women who were mostly interested in practicing as midwives and not speaking as consumers (MIC Minutes, 30 September 1996). A consultation for women with disabilities drew 2 women (MIC Minutes, 28 October 1996), and there was one meeting with adolescent service providers (Anonymous 1997a). Based on the very low number of these consultations, it may be concluded that recently immigrated women, adolescents, and women with disabilities had very little influence on the formation of the profession.

The Equity and Access Committee also focused on the Working Group recommendation that the Committee carry out a comprehensive consultation with Aboriginal, First Nations and Métis individuals to address the current care received, the attributes of a culturally sensitive midwifery curriculum, and whether Aboriginal midwives should be exempted from the midwifery legislation (Manitoba Government 1993). Most of the consultations with Aboriginal women took place after the winter of 1996. Preliminary meetings were held with a number of Aboriginal women's organizations which recommended that the Committee conduct extensive consultations to capture the diversity of Aboriginal women in Manitoba (Equity and Access Committee, 1997; MIC Minutes, 9 May 1995; 23 October 1995). In the spring 1996 there were

consultations with 10 Southern First Nations communities (Anonymous 1997a). At the same time a contract was signed with two northern Aboriginal women to carry out consultations with northern Aboriginal communities (MIC Minutes, 3 February 1996). These consultations reached over 200 women in 20 communities, and concluded in the summer of 1996. The final report illustrated the diversity of the women's and communities' responses to the introduction of midwifery (Albert 1997).

This final report, *Community Based Consultation Process on Midwifery* (Albert 1997), offered quotes of women's problems with the current status of maternity care. Concerns were expressed about the current practice of evacuation of all mothers to urban centres for birth, and the economic and social costs of this policy. In many cases women described wanting the same thing consumers wanted in the south, culturally appropriate and respectful care, choice of birth place, continuity of care, and having a say in the people who would be with them at their birth to support them. However, often the care they were receiving was much farther from these ideals than it was for women in the south. Women also commented on the need for public education about midwifery in many First Nations communities where the memories of midwifery traditions had not been able to be preserved against the introduction of medical services, and the medical and legal harassment of traditional practitioners. Many women expressed long term pain from this harassment and suppression of traditional midwifery, and were reluctant to embrace a new service before the consequences of the older policies were addressed in a substantive way.

The report also outlined women's concerns that traditional midwifery could not be revived after this long, and in the context of so many changes to their communities

due to the legacy of colonialism. Instead, the women consulted envisioned a new midwifery which could combine some of the healing aspects of traditional Aboriginal midwifery taught by community Elders, with the clinical skills of Western care. This fusion of medical and traditional skills was seen as particularly beneficial for any education program which was developed. Recommendations for this education program also included having local community based training possibilities, and extra training for addressing Fetal Alcohol Syndrome. There was a general consensus that the midwifery standards of practice should be uniform whether the midwife was First Nations or not:

> **Participant 1:** ...So we tried to talk to lots of people... And what we were hearing about the Manitoba experience was that first of all there were very few Aboriginal midwives. Certainly very few who would want to practice again. There was an interest in young women to learn midwifery. Especially those whose grannies had been midwives. We also clearly heard that they didn't want a second-class kind of midwifery. They wanted integration of the medical knowledge, that could save lives, and the traditional ways. So they didn't want somebody who didn't know anything about CPR or resuscitating a baby...They wanted an amalgamation of those two. That was useful information because other provinces had said you could be a traditional midwife and do what ever you do only on Reserves. We were hearing that wasn't the way to go.

The following fall funding was secured for a consultation with Aboriginal women living in Winnipeg (MIC Minutes, 26 September 1996). This was further supplemented in the winter of 1997 with the hiring of a consultant to conduct information meetings with Métis women throughout the province. In this report, Hourie (1997) concluded from the consultations that regulated midwifery would be supported if it was felt to be directed with input from the large and diverse Métis community, and if it could incorporate the creation of a midwifery service which combined the best of traditional Métis and Western care. The Equity and Access Committee, with the assistance of Manitoba Health employees, also continued consulting with southern Aboriginal communities, holding

consultation meetings in over 30 towns in the fall of 1996 and the winter of 1997 (Equity and Access Committee 1997). Since these consultations were still ongoing when the MIC's two year mandate ended, the MIC held off submitting the legislation to the government until these Aboriginal consultations were complete and the feedback from these could be incorporated into the legislative recommendations (Haworth-Brockman 2002).

6.1.3 Aboriginal Women and Aboriginal Midwifery Traditions

Following the extensive consultations with women of Aboriginal descent, there was a commitment to ensure this would produce tangible results in the midwifery legislation and the midwifery profession. A Standing Committee of Aboriginal Women was made a requirement of the College of Midwives of Manitoba to ensure the issues in midwifery for Aboriginal women would continue to be heard and shape the profession (Manitoba Government 1997). The presence of this committee has created some initiatives for Aboriginal women including a proposal for an Aboriginal midwifery training program, an Aboriginal Midwifery Consultant at Manitoba Health, and making Aboriginal women and predominantly Aboriginal neighbourhoods a priority for midwifery services. However, jurisdictional issues have acted to limit substantially the midwifery presence in First Nations communities.

6.1.3a Kagike Danikobidan

The Aboriginal consultations led to clauses related to Aboriginal women being written into the midwifery legislation in the fall of 1996 (MIC Minutes, 25 November 1996). The recommendations from the Aboriginal consultations were interpreted as offering greatest support for a system which included Aboriginal midwifery within the

provincial midwifery legislation and which ensured Aboriginal women were represented and heard within the midwifery regulatory body. A proposal for including Aboriginal midwifery within Manitoba midwifery by having a seat on the Council held for an Aboriginal woman was discussed with Aboriginal women during the consultations held in the winter of 1997. The response was that a woman alone on the Council of the College of Midwives of Manitoba would not be effective because of isolation, but if this person had the support of a committee behind her which could represent the diversity of Aboriginal women in Manitoba and could develop its own agenda, creating a culturally appropriate and accessible midwifery service might be possible (Sanderson 1997). The clauses added to *The Midwifery Act* followed this recommendation, and required the College of Midwives of Manitoba to have a *Standing Committee on Issues Related to Midwifery Care for Aboriginal Women* whose Chair would have a permanent seat on the CMM Council and whose members would be on all Committees of the College (Manitoba Government 1997):

> **Participant 3:** In the other provinces Aboriginal women decided they didn't want to be part of the legislation. Mostly from what I can read because they were consulted, like always, at the very end of the process. Manitoba Aboriginal women said, 'we don't want any part of that'. That's why we really tried early on to include the views of Aboriginal women in our deliberations. In fact we delayed recommending the legislation because we felt we [the MIC] hadn't consulted enough.
> **Meta**: Right.
> **Participant 3:** One of the issues that was put on the table by the Aboriginal women was, if Aboriginal midwifery is included in the legislation, how will the interests of Aboriginal women be protected?
> **Meta**: Right.
> **Participant 3:** So that is how Kagike Danikobidan came to be formed. Kagike Danikobidan now represents the Standing Committee mandated by *The Midwifery Act*. Kagike Danikobidan is composed of Aboriginal women from across the province.

Since the Council of the CMM uses a consensus decision making model, this gives the Standing Committee Chair a say in all issues discussed by the Council (Scurfield 2002).

In preparation for the passage of the midwifery legislation in June of 1997, members of the MIC began working to set up this Standing Committee (MIC Minutes, 12 January 1997; 22 April 1997). The committee began formally meeting in the fall of 1997, and soon received operational funding and remuneration for their Chair. That fall, the Standing Committee re-named itself Kagike Danikobidan, which is translated to mean 'Always making grandparents' (MIC Minutes, 18 March 1998). The Committee's mandate was to educate communities about midwifery and do outreach, as well as advise the College on issues in midwifery care for Aboriginal women. The first goals of the Committee as it began to meet were to assist an Aboriginal community which was trying to open a birth centre, and to interview Elders to preserve and honour the traditional midwifery knowledge present in First Nations communities (MIC Minutes, 18 June 1997). They also wanted to find out more about the Aboriginal midwifery education initiatives in Six Nations, Grand Rapids, Ontario. The Standing Committee wanted to have representation from throughout the province including isolated communities which meant travel costs for meetings are high (MIC Minutes, 18 March 1998).

With proclamation of the Act in June 2000, Kagike Danikobidan has continued to meet and work towards initiatives for Aboriginal women and Aboriginal midwifery in Manitoba. One project which the College of Midwives of Manitoba is doing with Kagike Danikobidan is developing a Traditional Aboriginal Midwifery Core Competency chart as a way of being able to assess and recognize midwives who hold these traditional skills:

> **Participant 13:** So we've got funding for that and we've actually got two Aboriginal midwives working on that right now. In my head in the

> foreseeable future if we have someone wanting to be assessed, we'll then be able to speak to the additional skill set an Aboriginal midwife will have...

However, at present the level of funding limits the Standing Committee to only meeting twice a year and does not allow them to do any education and outreach, which is very frustrating for Committee members:

> **Participant 19:** All we could do was have two meetings and what can you do. All you can do is refresh your mind on what you've been doing since the last meeting.
> **Meta**: Yes.
> **Participant 19:** You can't actively do any outreach into the community with a budget like that.
> **Meta**: Right.
> **Participant 19:** So sometimes it feels kind of token. Stuff like that…You know, we should be able to do community education. Going into communities and giving people feedback and telling people what midwifery is about. Inviting them to have input.
> **Meta**: Yes.
> **Participant 19:** We can't do any of that right now.

While there appears to be agreement that a structure has been put in place that can facilitate the participation of Aboriginal women in the development of midwifery in the province so that they can guide the growth of midwifery services in their communities, many participants commented on the importance of now seeing tangible results for Aboriginal women coming from this foundation.

6.1.3b Midwifery Accessibility and Aboriginal Women

The translation of the recommendations from Aboriginal women into greater access to midwifery services has been challenging though, with greater successes in the south than in the north. While no First Nations midwives came down from the north for the assessment and upgrading, 2 self identified women of Aboriginal descent from the south were among the first midwives registered in the province, and they have been joined by a few more since (Scurfield 2002). Once regulated midwives began practicing

in Manitoba, they were required to prioritize for care Aboriginal women, and in Winnipeg, some midwifery practices have been located in neighbourhoods which are disproportionately Aboriginal, and have focused outreach and care to women of Aboriginal descent (Manitoba Health 2004). However, improving access to First Nations women in the north has not proved so successful.

It was this northern First Nations population which was described as most in need of midwifery services by many who advocated for the regulation of midwifery. Many early reports identified the need for a new strategy for addressing provider shortages in these communities, and the many serious concerns that were being raised by consumers and providers about the 100% evacuation policy for pregnant women in remote communities (Community Task Force on Maternal and Child Health 1982; Manitoba Advisory Council on the Status of Women 1987; Manitoba Government 1993). One participant described how in her northern community, the nursing station is understaffed, and prenatal appointments are short and do not involve much time on social and personal issues, or preventative care. Pregnant women are evacuated six weeks before their due dates to wait for their births in towns/cities with hospitals. Many leave children without a stable caregiver to take care of them, which adds to the stress and worry of the woman alone in an unknown city (Participant 25).

The Human Resource Strategy for Midwifery Implementation Committee (1998: 6) of Manitoba Health focused quite heavily on the need for midwives in First Nations communities in the north in their report, stating: "That Manitoba Health, in partnership with Medical Services Branch (Health Canada), and First Nations communities in Manitoba, aggressively pursue the provision of midwifery services for First Nations

women and their families." The report included documentation of interest and support for having midwifery services from six First Nations communities. The report also indicated initial cooperation between all levels of government and the Northern Medical Unit.

In the fall of 1998, Manitoba Health also hired an Aboriginal Midwifery Consultant. Her position was described as being responsible for outreach and public education to Aboriginal women and their communities, gathering information about traditional Aboriginal midwifery, and investigating means of delivering midwifery to Aboriginal communities. She was also expected to assess the readiness of health professionals in communities for the introduction of midwifery services and search for funding for education and employment of Aboriginal midwives. Finally, her position also included working on resolving federal/provincial jurisdictional issues and developing the intergovernmental partnerships needed for offering midwifery services (MIC Minutes, 1 October 1998). The Aboriginal Midwifery Consultant was very active in this position, assisting Kagike Danikobidan with their education and outreach initiatives, strategizing on how to get an Aboriginal midwifery training program started in Manitoba, recruiting Aboriginal midwives from other provinces, and negotiating with the Federal Medical Services Branch about offering midwifery services (MIC Minutes, 15 February 1999; 15 March 1999; 19 April 1999).

However, negotiations with the Federal Medical Services Branch broke down in 2000 as it was dealing with its own internal transformation such that jurisdictional issues could not be addressed (Transitional Council of the College of Midwives of Manitoba, 17 January 2000). The woman holding the Aboriginal Midwifery Consultant position at

Manitoba Health also passed away early on in the midwifery integration process. With her death, the position of Aboriginal Midwifery Consultant was terminated (College of Midwives of Manitoba 2004a; Participant 13). With the commitment to inter-jurisdictional cooperation faltering, nurses with midwifery training hired by the federal government to work in First Nations nursing stations did not get support from their employer to take time off and travel south to complete the midwifery assessment and upgrading (Hiebert 2003). This is unfortunate since Hiebert (2003) writes in her study on midwifery in northern Manitoba that there were a number of nurses in northern nursing stations who were interested in practicing midwifery and had the required qualifications for the midwifery assessment. The provincial government on the other hand, did try to facilitate having midwives in the north by setting a higher salary for northern practitioners, and targeting midwifery positions for the north (Human Resource Strategy for Midwifery Implementation Committee 1998). Yet without a method of local training and assessment, midwifery has the same problems of recruitment and retention as any other health profession. Thus, there are currently less than four midwives in the north, located in two town centres (College of Midwives of Manitoba 2004d), and there has been no impact on women being evacuated from First Nations communities for birth:

> **Participant 9:** One of the big issues in Manitoba that was presented from the very beginning was services for Aboriginal and Northern residents. There was a lot of discussion about that. That was one of the issues that actually moved midwifery forward.
> **Meta**: Right.
> **Participant 9:** But then the attention to that didn't follow… there is minimal midwifery presence in any of the First Nations communities. That is a very frustrating issue because that was a huge part of the intent of the initial legislation.
> **Meta**: Right.

Participant 9: It was to have that service available to Aboriginal women. And all of the consultations that they did with these women and then no follow-up.
Meta: Right.
Participant 9: There's a sense of, that, that this segment of the population has been sort of dismissed.

Women who receive their prenatal care in the Federal nursing stations and are transferred into these two towns for birth may be referred to midwifery care for the birth and initial postpartum period. While these midwives try to do some outreach to nearby First Nations communities (Participant 23, Hiebert 2003), few First Nations women in communities outside of these centres even know that it exists (Participant 25). One midwife, self identified as of Aboriginal descent, has tried to work intensively with Aboriginal women in the north, and her practice was viewed quite favourably by participants (Participants 13 and 16). Hiebert (2003) points out though that with regionalization, should the northern RHAs be able to hire more midwives, the First Nations communities will be low on their priority list because they are outside their jurisdiction.

To address this shortage, a northern assessment and upgrading for nurses with federal support could be explored as a possible route to having more midwifery services available in the north. Since it is the federal government which covers the costs of transports, accommodations while evacuated, and hospital services, it is the federal government which First Nations communities see providing midwifery services (Hiebert 2003). Also, one participant spoke at length about the importance of a community based midwifery education program for Aboriginal women in the north (Participant 25). Without one, it is likely that midwifery, especially with its small numbers, will face the same problems with recruitment and retention as all other health professions, and will not

be able to address the needs of First Nations communities, or put a dent in the 100% evacuation policy.

Kagike Danikobidan, with the Executive Director of the CMM and the Midwifery Consultant of Manitoba Health have been working on developing just such a program. They wrote a letter of intent for funding through the Primary Health Care Transfer Fund to develop a proposal for an Aboriginal Midwifery Education Program (AMEP) which was accepted (College of Midwives of Manitoba 2004d). Many participants spoke of this development positively, but with only cautious hope because it is still in the early stages of development (Participants 13 and 16). This training program would create the hybrid midwifery service envisioned by so many Aboriginal women during the consultations, and would involve training Aboriginal women in their own communities:

> **Participant 3:** Yes, because I think what you'll find is that we really tried to map out a culturally appropriate Aboriginal midwifery education program. We don't necessarily have to start from scratch in developing a curriculum. Various midwifery education programs are being used in Canada which can be adapted. However, components such as involving Elders and traditions associated with childbirth need to be incorporated. In addition, the AMEP will attempt to utilize various learning models and develop a variety of student supports. Each community will have their own traditions and they need the opportunity to learn that. The big thing is that, and we heard this over and over again, is that we need to bring birth back to the community. Birth used to be a very vital part of the community... I think that this kind of initiative would start to bring some of those traditions back to the community. But that's a long process. Very long.

The Manitoba government decided to fund further development of the AMEP in fall 2004 (Manitoba Hansard, 22 November 2004). The University College of the North, created in July 2004, is the planned institution to offer the proposed four year midwifery education program combining Aboriginal culture and Western midwifery practices for Aboriginal students. It has been reported that 10 people will be enrolled in the first year, and 5

students will be admitted each year after that. A date for the start of this program has not yet been set (Rabson 2004). Implementing this program combined with refilling the Aboriginal Midwifery Consultant position could make inroads into addressing the maternity care needs of women in remote northern communities, and midwifery accessibility throughout the province.

6.2 Access to Midwifery Services

The commitment to accessibility which guided some of the restructuring of the profession to make it more culturally appropriate, especially for Aboriginal women, was followed after proclamation with tangible mechanisms which it was hoped could overcome some of the other barriers many women face when trying to obtain quality maternity care. Some of the mechanisms which were put in place to ease access to midwifery services for all Manitoba women include publicly funding the service, targeting positions for rural and remote areas to reduce geographic barriers, prioritizing midwifery services for women who come from socio-economically disadvantaged groups, and in Winnipeg, placing the midwifery practices in community clinics in low income neighbourhoods. This section will explore these targeting mechanisms, and discuss the perspectives of participants on how these mechanisms have worked or not worked in practice to make the service more accessible.

6.2.1 Public Funding

Public funding can be viewed as the single most important aspect of ensuring that all Manitoba women can have access to midwifery services following regulation (Garvie 2001). While Ontario set a precedent by deciding to publicly fund midwifery services in 1991, one province (Alberta) chose not to fund midwifery, and the possibility that this

could have happened in Manitoba as well was always present (Bourgeault 1996; James and Bourgeault 2004). Advocacy for midwifery funding was present in almost all reports recommending regulation of midwifery in Manitoba based on securing access to the service for disadvantaged populations. These groups were often described as those who would most benefit from midwifery (Manitoba Advisory Council on the Status of Women, 1987; College of Physicians and Surgeons of Manitoba and the Manitoba Association of Registered Nurses 1991; Manitoba Health Advisory Network 1992; Manitoba Government 1993).

The final report of the Working Group (Manitoba Government 1993) went a step further by also recommending that midwifery should be funded through the hiring of midwives as salaried employees of the province. Participants stated that the reason for this recommendation was primarily based on considerations of access:

> **Meta**: Were you involved in the Manitoba Health employment model and how it was going to be funded and those questions?
> **Participant 24:** It was the opinion of the Working Group that a salaried model was the best way to direct, to some extent, what midwives would do – whom they would serve. Making a positive impact from a population health perspective means that you must direct services to Manitobans who can most benefit from the service. Of course, all women can benefit from having a midwife, but perhaps the greatest benefit is to those women who are at high risk owing to factors such as their economic status or their age. Teens, immigrant women, Aboriginal women – ensuring that those groups of women receive good maternity care can make a positive impact on their long-term health and that of their children.

During a time of healthcare cuts, equity goals needed to be combined with evidence of cost effectiveness for midwifery to achieve public funding. Consumer groups advocated for public funding for midwifery services to give women choice of caregiver regardless of their income, but they also lobbied for midwifery as a lower cost service because of reduced childbirth interventions, less evacuation costs, and prevention

of medical complications leading to better infant outcomes in the long run (Manitoba Advisory Council on the Status of Women 1988). The *Final Report of the Working Group on Midwifery* (Manitoba Government 1993) includes recommendations for midwifery to be publicly funded because of evidence that midwives could create savings through shortened hospital postpartum stays, lower use of technological interventions in childbirth, prevention of high risk pregnancies, and a reduction in evacuations from northern and remote communities. Further, Manitoba Health commissioned a paper on the cost effectiveness of midwifery in 1993 which determined that while fair compensation for midwives is more expensive than current medical fees for maternity care, these extra professional costs could be more than made up by reducing intervention rates, elective repeat cesareans, and shortening hospital stays (Kilthei 1993).

These combined arguments proved effective, and with the announcement of the decision to legalize midwifery in Manitoba in 1994, the provincial government also announced that midwifery would be an insured service (Manitoba Government 1994). To make sure that this commitment was kept, the MIC met with provincial Ministers and Manitoba Health administrators throughout its tenure to advocate for this public funding (MIC Minutes, 1 April 1996; 4 July 1996). On May 5, 1999 the provincial government announced that funding had been allocated for midwifery services (Manitoba Government 1999). A salaried employment model which allows the midwifery practices to be targeted for specific populations and permits greater emphasis to be placed on access initiatives was also implemented, creating a very different practice structure in Manitoba than other provinces (Manitoba Health 2004).

6.2.2 Priority Populations

Following proclamation, Manitoba Health created a policy which requires midwives to prioritize for care clients from identified socio-economically disadvantaged groups as a part of their funding agreement for the service. This policy came out of beliefs about the benefits of the midwifery model of care for women with social risk factors which were shared by most stakeholder groups. Once implemented, midwives have been able to meet the requirements of this policy, and most participants felt that the midwifery model of care was working to give extra support to disadvantaged women. They were also surprised that consumers who did not fall into these priority groups were not more vocal about being turned away from the service, but midwifery consumer frustration around access may be increasing as demand grows but the supply of midwives stays the same.

The idea of focusing midwifery services on socio-economically disadvantaged groups came from many of the early reports. These reports recommended midwifery partly based on the ability of the midwifery model to offer extra support and education for groups of women that are seen as at greater risk of difficulties with pregnancy, birth, and early parenting because of socioeconomic status, age, language or cultural differences, lack of familiarity with the health care system, or a lack of developed support systems (Community Task Force on Maternal and Child Health 1982; Manitoba Advisory Council on the Status of Women 1988; College of Physicians and Surgeons of Manitoba and Manitoba Association of Registered Nurses 1991; Manitoba Government 1993). A commitment to serving diverse clients also came from the community midwives practicing in Manitoba before legislation. Johnson *et al* (1996) indicate that

one third of the births attended by the midwives of the Manitoba Traditional Midwives Collective were rural or northern. Many of the midwives lived rurally themselves or in the inner city, and often worked for free:

> **Participant 19:** Which is the reason why I never charged a lot of money for what I was doing.
> **Meta**: Yes.
> **Participant 19:** Because I always wanted it to be something that was accessible to everybody…In Ontario, the Ontario midwives tended to be serving an upper middle-class feminist sort of group of people.
> **Meta**: Right.
> **Participant 19:** But that wasn't the case here. That was partly because some of us made sure that didn't happen. Yes, those women are important, too.
> **Meta**: Right.
> **Participant 19:** But we have to serve women of all economic backgrounds. We practiced rurally a lot. [Midwife 1] and I did, [Midwife 4], we all lived rurally for many years.

In a 1985 video on midwifery in Manitoba, *Midwives*, the community midwife interviewed stated she traveled rurally to attend home births and only charged for her mileage (Evans 1985). In a *Winnipeg Free Press* interview with a practicing community midwife, the midwife was quoted as saying: "There are people that I help who won't pay me any money. I trade with people a lot. A lot of things here are gifts, the mirror, the spinning wheel. Like, I don't buy meat at Safeway, for example. I trade for fish, moose meat, beef, lamb, vegetables, art lessons for my children, time at cabins. Those are things that are valuable for me" (Paul 1994: D4). This means that the commitment to accessibility in Manitoba has a long history in midwifery.

This attention to accessibility and disadvantaged populations from so many stakeholder groups made a strong case for tangible access initiatives which would ensure that midwifery services were available to all women, but especially those who were identified as having social risk factors:

> **Participant 15:** My critique was, well, questioning who gets to be a midwifery client. Midwives shouldn't run their practice on a 'first come first served' basis. Access to midwifery care should be assessed on need, not just preconception planning. In fact, the promise of midwifery for society is about improving the experience of birth and improving pregnancy outcomes. That is, a community based midwife who provides continuity of care will impact birth outcome with people who have significant socioeconomic and psychological stress - where they're smoking or their environment isn't safe, and they need a mentor through... And you know, this is the group that needs education and support to breastfeed.
> **Meta**: Right.
> **Participant 15:** That's the group that needs support to quit smoking. And that's the group that needs help to deal with abuse and getting into life training. Providing a continuity of care provider with a woman centred model of care in that environment as a mentor will help. It takes a lot more than just blood pressure checks... To have somebody whose job is to be respectful and engaging and empowering them. It's magical.

A system of auditing midwifery practices for the diversity of their clients and the level of outreach they were doing was created by the Transitional Council of the College of Midwives of Manitoba, but once it became clear that Manitoba Health was going to make this a part of the midwives' employment agreements, this equity standard was dropped (Midwifery Implementation Council 1998).

When the midwives began practicing, Manitoba Health instituted a priority populations policy which requires midwifery practices to work towards having 50% of their clients from identified socially disadvantaged priority populations (Manitoba Health 2004):

> **Participant 3:** ...We know clearly that middle class women who have education, who know how to get a midwife, will do that and they'll try to retain a midwife even before they have conceived. We really wanted to ensure that women from all walks of life could have the opportunity to have a midwife. What we've done is create a standard that requires all funded RHAs to ensure that at least 50% of their midwifery clients come from 'priority populations.'

In general, participants were supportive of the priority populations policy and felt that it had been successful in improving access to the profession:

> **Participant 16:** ...I think we're getting there. I just talked to a midwife last week or this week and she had a 14-year-old with some issues but she had a great birth. The midwife developed a great relationship with that young person and the outcome was great and may have positive long term effects.
> **Meta**: Yes.
> **Participant 16:** I know there are a couple of other midwives who are building a relationship with a particular community and it seems to be coming along in a positive way. It takes time.

> **Participant 12:** So we've got our three major priorities. And one is trying to give preference to the people who would benefit the most.
> **Meta**: Right.
> **Participant 12:** Everyone, we believe, would benefit from the midwifery experience, but if you're 16 years old and having a kid or having trouble putting bread on the table or a new immigrant then you have an even tougher time. So we believe that the influence of midwifery would achieve better outcomes. I was talking to one of our midwives this morning...I forget the percentage but her caseload was well over 50% priority populations.

This was not only because the midwives were actively doing outreach to these populations and accepting them on a priority basis, but also because other health professionals now associate caring for these populations with the midwifery services and make appropriate referrals:

> **Meta**: So that, those are the priority populations? You think that has an impact on that?...
> **Participant 11:** The priority populations, yes, because normally we get referrals from public health, or places that may have that first contact with the priority populations.
> **Meta**: Oh.
> **Participant 11:** Before we wouldn't have gotten that referral...

> **Participant 10:** And we've had a lot of help from other professions who now understand who our priority populations are and will make appropriate referrals.
> **Meta**: Right. Right.
> **Participant 10:** So we are really seeing an increase in the referrals as well, that are from our priority populations. So some of the practice groups actually are almost full with priority populations clients.

Not all participants were supportive however. Some saw the priority populations as groups which physicians largely did not want to serve, and so were left to midwives so that introducing midwifery would not be as threatening to the medical community. Others did not agree that the midwifery model was most appropriate for these populations:

> **Meta:** Yes. How do you feel about the goal generally for why midwives have priority populations? And are in community clinics?
> **Participant 9:** I feel generally, and I felt this way at the very beginning, I remember. (Laughter). And that hasn't changed, I feel like there is, to a certain extent a contradiction.
> **Meta:** Yes.
> **Participant 9:** To say, 'here is what we want the midwives to do. Here's what Manitoba Health thinks would be a great new group of professionals to throw at a very old problem,' which is poverty and lack of education and skills, and access.
> **Meta:** Right.
> **Participant 9:** And I think that you can't expect midwives to only deal with that group of the population. And that's not necessarily who gets the best advantage from the service... Sometimes it is and sometimes it will work very well, but often people who are in the target population are people who will need at some point to see a physician also because they have addiction problems or they have chronic conditions, or there's nutrition problems, yes. ...They're not necessarily the healthy normal –
> **Meta:** Right, right, exactly.
> **Participant 9:** That we're supposed to be specializing in, so.

Further, many participants were concerned that these priority populations had to be in place at all because all of the women who wanted it could not yet have access to midwifery services, and the midwives were turning women away. Many expected that middle class educated consumers would be angry and demonstrate against this priority being offered to other populations and not them. However this has not occurred as much as was expected:

> **Participant 12:** The midwives assured me that they are achieving good rates of clients from priority populations being cared for.
> **Meta**: OK. So that hasn't been a problem for them?

Participant 12: No and it, I expected it to be more of a problem.
Meta: Yes.
Participant 12: Not so much from the people that we're serving, that would fit into these priority populations, but from these, call them the middle class yuppies which were the ladies that petitioned and lobbied for it.
Meta: Yes, right.
Participant 12: Now you've done all this work, and now you want to have a baby and we're saying, 'no, sorry'.
Meta: Right.
Participant 12: So that hasn't happened, but that's what I've been anticipating would happen.

A number of reasons for this may include the fact that women who had a midwife's care before legislation are a priority population as previous clients and are not being turned away. As this population completes their families, women like them who are strong midwifery advocates but starting their families post regulation and thus have no priority status will increasingly be turned away and may begin to organize. It has also been only a few years, and most consumers expected that originally demand would outstrip supply, but as time passes, expectations about being able to access midwifery may increase. Further, initially many of the midwifery practices were not reaching 50% priority populations, but now that they are, there are fewer spots left for non priority population women. People's patience around access may be running thinner, and advertisements about creating new midwifery consumer groups (Women's Health Clinic and Prairie Women's Health Centre of Excellence 2004 and 2005) may indicate that advocacy around expanding the service to be available to more women is developing.

6.2.3 Community Clinics

The Manitoba Health Human Resource Strategy for Midwifery Implementation Committee (1998) report also recommended that midwifery practices in Winnipeg should

be located where the priority populations are most commonly found including the inner city, North end, and West end neighbourhoods:

> **Participant 10:** So the decision was made to locate the midwives in community areas that had the highest numbers of priority populations … So part of the [RHA] plan was to place midwives physically in a geographical area where there were the highest numbers of families that belong to the priority populations.

The report further suggested that midwives should be in community clinics which target these socially at risk groups, and which have certain programs designed for their extra needs. The three clinics identified in this report for having these programs became the first three clinics to offer midwifery services. Most participants stated that having the midwives in the clinics was working well to improve access to the service. In Winnipeg, where demand for midwifery is much higher than the small numbers of midwives can provide, the physical placement of the midwives in inner city and north end clinics may have been key to facilitating access for disadvantaged groups. The midwives at one clinic have also made a particular commitment to serving women from priority populations, and a number of mechanisms were put in place to make this happen:

> **Participant 8:** …That was an explicit goal of their program, that was an explicit goal of the midwives who came here, they came here to do that…One of the differences, I think, for us is that our midwives for some time now have only been taking people that they are otherwise mandated to take, so returning clients and other sort of specific people. And clinic clients. And clinic clients because we have a specific geographic area, our clinic clients are, because of our own accessibility guidelines, that's a limited group so that means that all of their intakes are one of those two groups. We don't have another stream into that… But we also specifically, with our prenatal nurse, she will identify people who might specifically benefit from midwifery, and then she will make a stronger case to say, 'why don't you guys help this one', not because she wants it more, but because we think she needs it more. She's younger, more isolated, whatever. And the midwives have been very open and also agree with that priority. But I'm not sure that all of the Winnipeg midwives share that same zeal.

Many participants also believed that community clinics were a good location for midwives caring for a disadvantaged population because they could draw on the wider social services and targeted programs offered at the clinics for their clients:

> **Participant 13:** I think so yes. The idea of midwives, back to the strengths and pluses, midwives being part of the primary [healthcare] focus, the latest [community] clinic opening up with social workers down the hall and a physician and public health, I think is good because in life there are very few of us that can, I think, go through things easily and if you have a target group for midwifery clients, that means granted there will be other issues. And a midwife, she can't do it all. If there are resources that are close by I think that's really, really important.

Until the spring of 2004, one of the midwifery practices in Winnipeg was not located in a clinic. It was thus not getting internal referrals and was to some extent more open to women throughout the city. However, this practice has since been incorporated into a community clinic such that all of the practices now have geographical catchment areas combined with an internal referral system from the clinic (Manitoba Hansard, 26 April 2004). As these practices fill up entirely with women from their geographical catchment areas, and as demand and referrals increase, this leaves 9 of the 12 health regions in Winnipeg without any midwifery service:

> **Participant 9:** ...So we will get full with our own community area and have less space available for women from areas that don't have services... In some ways I look forward to that, but the other thing is there's no plan anytime in future to expand the services.
> **Meta**: Right.
> **Participant 9:** Women in St. Vital will not have any clinic attached to them. There's lots of areas of the city that don't. St. James. Where are these people supposed to go to get services?
> **Meta**: Yes.
> **Participant 9:** Unless they can find their way into what are always very full practices, they just won't have access to services, which is not fair really.

This means more and more women from those neighbourhoods, generally the higher income areas of the city, will not have access, and their increasing frustration about this may lead to more organizing in the near future.

6.2.4 Overcoming Geographic Barriers

Another area of advocacy for the introduction of midwifery services was around the ability of midwives to offer maternity services in rural and northern communities which currently have difficulties recruiting health professionals. This means that women must travel long distances for care, have very little choice of birth place, and often receive fragmented care (Manitoba Government 1993). Manitoba tried a number of initiatives to increase the number of midwives in northern and rural areas, and many of these were partially successful. However, because of the small numbers of midwives, midwifery services are only available in small areas of the province. The flexibility of midwives to travel around the province is also made worse by regionalization, which puts boundaries on the midwives' practices. Many participants spoke of geographic barriers as one of the last hurdles for Manitoba when it comes to accessibility:

> **Participant 19:** ...we have geographic restrictions. We have had a lot of problems with that. I think that's one of the main areas that I have concerns about.

> **Participant 16:** Access in rural and northern areas continues to be an issue. It requires a long term plan and a long term policy framework. A lot of variables need to come together if this is to happen. The political will has to be there as well.

The commitment to reinstituting midwifery in northern and rural Manitoba goes back to the first reports recommending legislating midwifery. This issue was becoming increasingly exacerbated with the continuing loss of family physicians doing obstetrics in rural and remote communities (Manitoba Advisory Council on the Status of Women,

1987; College of Physicians and Surgeons of Manitoba and Manitoba Association of Registered Nurses 1991; Manitoba Government 1993). During the 2nd reading of *The Midwifery Act*, Manitoba Legislators also based a great deal of the support for the *Act* on the need for midwifery in rural and remote areas and the importance of ensuring the service is accessible throughout the province (Manitoba Hansard, 18 April; 15 May 1997; 12 June 1997):

> "Mr. Stan Struthers (Dauphin): I am pleased to be able to stand today in the House and talk, a little bit anyway, about Bill 7, *The Midwifery and Consequential Amendments Act*...I think it is important in this particular recommendation to note as well that in rural and remote areas, the ability of midwifery to be available in a variety of different settings is very important... Now, if it is not available to all women, then I would suggest that is an unfair situation for whatever reason...We as legislators, I think, have a responsibility to ensure that those services be made available to all women, no matter where the families and the women happen to live" (Manitoba Hansard, 8 May 1997).

The MIC responded to this focus by carrying out extensive consultations with rural women. The Equity and Access Committee was committed to ensuring midwifery services were available throughout Manitoba in rural and northern communities (MIC Minutes, 10 January 1995). In the fall of 1995 and the winter of 1996, Committee members began to travel across the province to over 20 rural and northern towns for public information nights and consultations which were attended by approximately 225 people. The turnout to these meetings was small, and the people attending were mostly community midwifery consumers who wanted to ensure that their access to midwifery and the model of midwifery they were used to would be preserved with regulation. Many consumers expressed concerns about how implementation would intersect with regionalization and whether the RHAs would be required to have midwifery services, or

how it would work in the RHAs that did not have midwifery services (Haworth-Brockman 1996 and 2002).

The MIC also tried to make changes to the standards of practice so that they would facilitate midwives offering the full model of care in rural and northern communities. The principle of non midwife second attendants was supported from the first meetings of the MIC, with the expectation that this would enable midwives to offer their full scope of practice, including home birth, in low population areas which could not support that many midwives (MIC Minutes, 29 September 1995; 22 July 1995):

> **Participant 2:** Also, and equally important, thinking in terms of anybody working outside of Winnipeg, Thompson or Brandon, whom would she call on and could that mean that women simply couldn't get midwifery care because they're waiting for a second midwife to show up? And even if a second midwife did show up, thinking of working conditions, who gets a break? When? What is reasonable? How many hours is she meant to be on-call? So we began to look at the evidence for who should be a second attendant. When we had established the criteria for having someone competent to deal with both maternal and/or neonatal emergencies, then we set those as the criteria, as the competency that will be needed. That opened the possibility for a physician or a nurse or an emergency medical person to reach their competency and get their certification and thus make him or herself available to midwives as a second attendant under the responsibility of the midwife.

However, despite the intentions of the Midwifery Implementation Council, it was determined that the MIC did not have the authority to regulate second attendants who were not from registered health professions, and so the assistance available to midwives in rural and northern communities is limited (Transitional Council of the College of Midwives of Manitoba, 15 March 1999).

Manitoba also altered the standard for planned out of hospital births. Although midwives in Ontario and other provinces are required to be within 30 minutes of a tertiary medical facility when attending home births, this was not seen as appropriate for

Manitoba to allow midwives to attend births in nursing stations, and protect choice of birth place for women throughout the province. Instead, the onus is on the midwife to assess each situation and to ensure good back up care is available if a transfer were to become necessary (Haworth-Brockman 2002; College of Midwives of Manitoba 2003a). Further, with the decision to extend midwives' practices into more remote areas came a recognition that they would also need more extensive emergency skills. Thus, neonatal intubation was added to the scope of practice (College of Midwives of Manitoba 2003c).

Another issue was the location of the assessment and upgrading. Initially the Education Committee had wanted to offer the assessment and upgrading throughout the province, especially with a northern location. However, the assessment and upgrading ended up only being offered in Winnipeg (MIC Minutes, 15 March 1999). This created large barriers for rural and northern women who wanted to register, but could not afford to without financial assistance for travel, billeting and childcare. While assessment and upgrading candidates who wanted to practice rurally and in the north were given priority status, only a very small number chose to apply (Haworth-Brockman 2002; MIC Minutes, 21 September 1998):

> **Participant 18:** ...We of course had to pay to do the upgrading, which was quite expensive. Also we had to live in Winnipeg for two, three or sometimes four days a week. This of course meant that you could not work. So I would take holidays or give my shifts away and take unpaid leave. Not everyone could afford to do this, so it became difficult for people to afford this program.

These extra barriers for rural and northern women with midwifery training to attend the assessment and upgrading meant that some were lost to the profession. A consequence of this pointed out by one participant was that later this left many rural RHAs without resident registered midwives looking for employment, which made it less feasible for the

RHA to then implement a midwifery service because it would have to recruit the midwives from other communities (Participant 11). The importance of resident midwives for the implementation of midwifery was also recognized by the Human Resource Strategy for Midwifery Implementation Committee (1998) in their report.

Despite the limitations created by the urban assessment and upgrading, Manitoba Health did try to support rural and northern RHAs in introducing midwifery services by targeting funding for 10 of the first 26 midwifery positions for rural and northern RHAs (Manitoba Hansard, 14 June 2000). Participants also noted that rural midwifery practices might not have survived without the employment funding model which allowed RHA managers to support integration into what were sometimes close-knit medical communities which might not otherwise have been welcoming (Participant 23). Employment also allowed small rural practices to develop a client base slowly:

> **Participant 11:** ...I mean I couldn't have started out on a contract kind of model because we wouldn't have been able to survive financially while we were building the client base.
> **Meta**: Right.
> **Participant 11:** It would have been very hard. I'm not sure we would have been able to continue. And so it's actually been good...

However, while midwives are available in 5 of the rural and northern RHAs in the province, this of course means that there are 5 RHAs where midwifery services are not available:

> **Participant 13:** What I don't understand is how a service can be described as a publicly funded service, but currently, if you're in half of the RHAs in Manitoba, you will not have access to a midwife. It is a contradiction.

As well, in one of the three rural RHAs with midwifery services, the midwives can only do home births and home visits in a portion of that RHA (Haworth-Brockman 2002). In the two northern RHAs, midwives offer in-hospital care in two towns. When there are

two midwives practicing, they can also attend home births in these two towns, but this has rarely been available since for the majority of the time since proclamation there has only been one midwife in each town (Participant 23, Participant 6). There is one independent registered midwife who is not hired by an RHA and is willing to travel to northern and rural RHAs to attend out of hospital births (Participant 19).

For rural and northern women in the RHAs without midwifery services, or who are in areas of RHAs which are not covered, this is their worst fear about the impact of regionalization come true:

> **Participant 11:** We were really annoyed because a lot of effort had been put into accessibility. There was a whole Committee of the Council that was devoted to accessibility.
> **Meta**: Right.
> **Participant 11:** And the whole thing has basically fallen by the wayside except for two regions. There really were no teeth to that Committee in the end. All that work that was done around accessibility, and then really in the end, I don't think it meant that much.
> **Meta**: Why? Why do you think --?
> **Participant 11:** I think it was the intersection with regionalization.
> **Meta**: Okay, it was that.
> **Participant 11:** The impact of regionalization wasn't taken into account. Many of the women who had supported the regulation of midwifery were rural women.
> **Meta**: Yes.
> **Participant 11:** In the end, it was a slap in the face to say, 'sorry. Yes we're going to regulate it but you guys can't have it'...

Many of these women expressed their anger and frustration about this situation to the College of Midwives of Manitoba:

> **Participant 2:** I think that the tragedy is that there are Regional Health Authorities that have no midwives at all and women who feel completely cut off from a service that they had grown to expect or had advocated for. Now their numbers aren't huge but it's dismaying, and for those of us receiving daily calls, of course, it became an issue that you're coping with a lot. We would be seen as the bad guys. That was depressing.
> **Meta**: And you were getting daily calls?

> **Participant 2:** Oh yes. And you know people who were feeling, very, actually feeling very passionately about not being served now at all.

Fuelled by this frustration, many participants noted that the area of continued consumer advocacy has primarily been around improving geographic access:

> **Participant 19:** There's a pocket of consumer activity.
> **Meta**: Yes.
> **Participant 19:** The parents who are motivated because they don't have midwifery services in their Region.
> **Meta**: Right.
> **Participant 19:** Those are the people who are quite political. You know, it feels very unfair to them…

Despite these challenges, given the changes to the scope of practice made by the MIC, and the government's commitment to rural and remote communities through targeted midwifery positions, it would seem that these final barriers to geographic access could be overcome with an education program which produces more midwives to practice in rural and northern communities.

6.3 Summary

Manitoba's commitment to improving access to midwifery services created substantive results. The extensive consultations which were carried out by the Equity and Access Committee of the MIC led to a professional structure which has incorporated the revitalization of Aboriginal midwifery into regulated midwifery and includes a Standing Committee, Kagike Danikobidan, which works to keep the profession responsive to the needs of Aboriginal women. The results of this commitment to Aboriginal midwifery is that Kagike Danikobidan along with the CMM and the provincial government are now working together to develop an Aboriginal midwifery education program which will attempt to combine Western and traditional Aboriginal midwifery competencies. Graduates of this program will be able to register with the CMM. Manitoba also publicly

funds midwifery services, which combined with prioritizing the service for disadvantaged women and targeting the midwifery practices in community clinics in low income areas, has been successful in making the service accessible to a more representative sample of the Manitoba population. Midwifery practices have also been targeted for rural and northern regions. While a practice structure has been put in place which facilitates practicing in more remote areas, the small number of midwifery positions in the province means that the majority of communities in Manitoba still do not have access to publicly funded midwifery services. This level of directing the midwifery practices and who they would serve would not have been possible if they were not salaried employees, and northern and rural practices may not have survived without employment funding. Thus, at this point with only a little more than 25 midwives practicing in the province, the primary access issue appears to be simply increasing the numbers of practicing midwives so that they can serve more women and open more practices throughout the province and the neighbourhoods of Winnipeg.

Chapter Seven: Integration into the Existing Health Care System

7.0 Introduction

Smooth integration of midwifery into the existing health care system is important both for the midwives' working conditions, and for the care they can offer their clients. In Manitoba, a great deal of effort was put into this aspect of the introduction of midwifery services, and many integration initiatives were implemented. This focus on integration began during the tenure of the Midwifery Implementation Council (MIC). The MIC held numerous consultations with health professionals and health administrators, designed the midwifery practice and regulatory structures with integration concerns in mind, and formed working groups to address certain integration details. Manitoba Health then followed up on this attentiveness to integration issues following proclamation of *The Midwifery Act.* Manitoba Health developed integration initiatives including requiring each Regional Health Authority (RHA) with midwives to create a Midwifery Implementation Committee to work on local integration issues. The decision to fund the midwives as salaried RHA employees also attempted to facilitate a commitment to integration initiatives from both the RHAs and the midwives. With this groundwork in place, the general consensus from participants was that integration with the existing health care system, including physicians, hospitals and nurses, has been successful and smoother than anticipated. However, despite this success, many participants noted that provincial government support for the program has been declining, and were unsure whether midwifery would have the political stamina to grow beyond a small add on service.

7.1 The Midwifery Implementation Council

The work of integrating midwifery into the healthcare system began long before midwives started practicing. One of the priorities of the Midwifery Implementation Council's Practice Committee was strategizing on how to ease the midwives' integration. Their first effort in this regard was the development of the *Standard for Consultation and Transfer of Care* which in many ways lays the foundation for the working relationships midwives will have with other health professionals in the care of clients. The Practice Committee also created three subcommittees to focus on different aspects of integration. The Midwifery/Hospital Working Group worked on aspects of integration with hospitals. Two issues which were particularly difficult to work out were integration with the nursing staff and anesthesiology. The MIC also had to work out how midwives would get hospital admitting privileges. The Midwifery/Public Health Working Group worked on the protocols and orientations that would be necessary to facilitate midwives and public health nurses working collaboratively in the care of women during the postpartum period. The third subcommittee was on integration with the emergency medical services(EMS), which mapped out the necessary guidelines for how midwives and EMS would work together during transfers from home to hospital. These efforts laid the groundwork for a smoother integration once the midwives starting practicing, and they also initiated the focus on integration in the province which would be taken up by Manitoba Health and the Regional Health Authorities later.

7.1.1 Standard for Consultation and Transfer of Care

The *Standard for Consultation and Transfer of Care* defines the boundary of the midwifery scope of practice, and guides how midwives will interact with other health

professionals when a client's status falls outside that boundary. Because of its foundational role in defining the profession, writing this standard was confrontational, and the MIC consulted with many stakeholder groups as a part of trying to create a standard which was acceptable to everyone. In practice, it appears that this standard has worked to smooth interactions between midwives and other health care providers in the care of clients.

The first draft of this document was created by the Working Group (Manitoba Government 1993), and it was closely based on the Alberta midwifery standard for consultation and transfer of care (Midwifery Services Review Committee 1992). In their final report, the Working Group wrote that they believed that the guideline would be short lived to ease integration, and then midwives should be able to decide when to transfer primary care based on their professional judgment: "We therefore anticipate that following the initial stages of the introduction of midwifery, there will be no further need to maintain lists of specific conditions which will indicate the necessity to transfer the primary care of the individual" (Manitoba Government 1993: 75).

When the Practice Committee of the MIC began to look at this document in 1995, they looked again at this issue of whether the transfer of care decision should be made based on the midwife's professional judgment, or required based on a practice standard. The decision whether or not transfers would be mandatory was debated within the MIC between views that a required list would ease integration, and views that such a list was insulting to the midwives' professional judgment. In Ontario, midwives are required to transfer care when clients show the risk factors and complications listed, and a 1994 visit from midwives practicing in Ontario indicated that mandatory consultation and transfer

standards had been invaluable for integration, giving midwives a firm basis for defending their practice decisions when questioned (Haworth-Brockman 1995). The MIC decided that the integration benefits made mandatory consultation and transfer the better option (MIC Minutes, 29 January 1996):

> **Participant 16:** ...We needed to have those things written down, not so much for the midwives but for other professionals who were concerned about the safety of midwifery care. It was important to communicate that midwives would be required to consult or transfer if situations were clearly outside their scope of practice. This document outlined the standards which came from a regulatory body that stated 'You are required to ask for a consult or to transfer care in these cases – this is clearly outside the scope of normal and therefore within the realm of another healthcare provider'...Having this written down was very reassuring for some and helped with implementation.

The guideline itself then went through many revisions. The Association of Manitoba Midwives (AMM) and the Manitoba Traditional Midwives Collective were consulted on the list throughout 1996 and numerous changes were made based on the advice from these groups (MIC Minutes, 6 May 1996; 25 November 1996). Creating the list was a difficult task for the midwives who had been trained within different parameters for consultation and transfer, including nurse midwives who had worked in close consultation with physicians, and community midwives who really only had transfer of care available to them:

> **Participant 16:** ...We had Ontario's document to start with. We weren't reinventing the wheel from the start, but there were differences among the midwives. There were some midwives who would say, 'I would just wait and see' and there were others who would say, 'No, I would consult.' And again there was a lot of give and take between the midwives who participated in this aspect of the practice framework. It was a very important process for the midwives to participate in.

The College of Physicians and Surgeons of Manitoba (CPSM) was also consulted about the document many times (MIC Minutes, 6 May 1996; 10 September 1998; 5

October 1998). The majority of the CPSM recommendations were in the area of newborn care and many of these were incorporated. Physicians were also concerned about midwives caring for women who had a history of previous obstetrical problems which could repeat in the subsequent pregnancy, such as premature labour or cesarean section delivery, and whether midwives would be allowed to deliver babies that were breech or twins (Participant 7).

The September 1998 draft of the *Standard for Consultation and Transfer of Care* (MIC Minutes, 18 September 1998) follows the equivalent Ontario standard closely, although it is generally a more detailed list, especially in the area of newborn care (Bourgeault 1996). The Ontario guidelines also have a list of conditions for which discussion with a peer or other health professional is required. The MIC transformed this list of conditions into a list where consultation may be required depending on the woman's condition, but was not mandatory. The addition of this section creates a middle ground which relies more heavily on the midwife's professional judgment. The final College of Midwives of Manitoba (CMM) (2003b) standard follows this draft almost identically. While this standard was difficult to create, the high level of consultation involved in producing it may have influenced the general support it has gotten from all stakeholders. Many participants also noted that the intended benefits for integration from a required list for consultation and transfer have indeed paid off:

> **Participant 7:** Yes, there have been confrontations, and there have been times when people objected to things. My only recourse is to say, 'OK, well let's go back to the scope of practice. Was she or was she not within her scope of practice. If she wasn't then that goes to the Midwifery College for discipline'.
> **Meta:** Right.
> **Participant 7:** 'And if she was, then what are you arguing about?'

7.1.2 Preparing the Hospitals and the Midwifery/Hospital Working Group

The MIC and its Practice Committee also began to lay the groundwork for midwifery integration in hospital very quickly after they began meeting, including having midwives attend teaching rounds in hospitals, because they knew this work needed to be done before the midwives began practicing (MIC Minutes, 13 March 1996):

> **Participant 7:** ... I think we have avoided some of the head-to-head conflicts that some hospitals have because I had seen that kind of conflict in Ontario, with anesthesia for instance.
> **Meta:** Right.
> **Participant 7:** Or pediatrics.
> **Meta:** Right.
> **Participant 7:** So I knew that we had to develop the climate before the legislation came out, and before midwives found themselves in these confrontational situations.

A large proportion of the MIC consultations around the province were also with hospital staff. In the briefing information the MIC submitted to the Minister of Health in 1997, they listed 16 consultations with hospital staff including physicians; 6 consultations with medical organizations; 7 consultations with nursing organizations, and 5 consultations with community clinics (Anonymous 1997a).

Early on in its tenure, the MIC also began the processes of consultation, education and negotiation which were required to implement the Working Group recommendation that midwives receive hospital admitting privileges. Hospital admitting privileges were seen as essential to giving midwives' clients choice of birth place, and for making home birth safer, since it would ease transfer to hospital (Manitoba Government 1993). This process began in 1996, and most of the early consultations were in Winnipeg, where there did not seem to be that much resistance to midwives getting admitting privileges within the RHA (MIC Minutes, 29 August 1996; 12 June 1997). However, while the MIC had

hoped that midwives could have their own independent reporting stream in hospitals so that midwives would be supervised by and report to other midwives, it was determined in the winter of 2000 that midwives would go through the same route to getting privileges as physicians, and would receive hospital admitting privileges through Family Medicine once they began practicing (Transitional College of Midwives of Manitoba, 20 January 2000).

The MIC also identified the need for a distinct hospital implementation working group (MIC Minutes, 4 July 1996), and in the fall of 1996 the Midwifery/Hospital Working Group was formed and an initial implementation framework for facilities and professionals was developed. An invitation was sent out to all hospitals with a labour and delivery department to send a representative. Three hospitals in Winnipeg and the hospital in Brandon responded and made up the working group representatives (MIC Minutes, 25 October 1996; 16 December 1996). The working group began writing an implementation guide in winter 1997, and this process included meeting with hospital and Regional Health Authority staff. They used the hospital integration document developed by the Ontario Hospital Association (1994) as a model. In their implementation guide, the Midwifery/Hospital Working Group recommended many strategies to assist hospital staff with midwifery integration including orientations for midwives to learn hospital routines and meet hospital staff, educating hospital staff about midwifery, and appointing midwives to hospital committees. The report also recommends an orientation to record keeping for midwives, especially finding a new way for combining hospital records with those started at home (MIC Minutes, 15 September 1997; College of Midwives of Manitoba 1999).

One difficult issue which the hospital working group had to address was how midwives' clients would receive epidurals. Epidurals have become a fairly standard part of hospital birth, with more than 40% of women in Manitoba having one during labour in 1998 (Manitoba Health 2000). The first core competency profile of the MIC included managing epidurals as part of the scope of practice of midwives because it was felt to be an unnecessary duplication of services if the nurse was managing the epidural while the midwife managed labour (MIC Minutes, 16 March 1998). Discussions with Ontario and British Columbia however, indicated that this was a challenging area for midwives practicing in hospital because they were not usually trained in it and rarely used epidurals. Midwives generally transferred care to a physician to order the epidural, a nurse managed the epidural once started, and the midwife took a supportive role through the rest of the labour and birth (MIC Minutes, 16 March 1998; 27 March 1998; 19 June 1998). There was thus some discussion in Manitoba whether managing epidurals should be a part of the midwifery scope of practice or shifted to advanced practice (MIC Minutes, 6 April 1998). The Practice Committee was clear that they wanted midwives to be able to refer directly to anesthesiology for an epidural, but it was not that certain this would be possible (MIC Minutes 21 January 1998).

The epidural issue continued to be discussed without resolution throughout 1998, and in December it was decided to form a working group on anesthesiology (MIC Minutes, 14 December 1998). However, a year later, the anesthesiology working group had still not decided whether midwives would be allowed to refer directly to anesthesiology for epidurals or how epidurals would be managed (Transitional College of

Midwives of Manitoba, 17 January 2000). Thus, although effort was put into working out this issue, it was not resolved when the midwives began practicing (Maize 1999).

Integration with hospital nursing staff was also a broader issue which was of central importance to the Midwifery/Hospital Working Group. From the first meetings of the MIC, there was an expectation that nurses would act as second attendants for midwives in hospital. This was seen as an important measure for easing integration with hospital nursing staff, because nurses would become familiar with both the midwives and midwifery practice through routine interactions (Participants 1 and 2; College of Midwives of Manitoba 1999). However, many of the hospital representatives on the working group who had some experience with midwifery integration in hospital from the two hospital based nurse midwifery pilot projects in Winnipeg knew that the biggest implementation issue would likely be nurses who saw others gaining greater autonomy as a demotion, and were hostile to the program (MIC Minutes, 21 February 1997). A great deal of preparatory work was then put into addressing the details which might make it challenging for nursing and midwifery to work together cooperatively:

Participant 7: We spent a lot of time with the nurses on the labour floor.
Meta: Yes.
Participant 7: Sorting out roles.
Meta: Sure.
Participant 7: For example, if you have an IV running, who runs the IV?
Meta: Yes.
Participant 7: If a patient comes in and a midwife is with her, who does what?
Meta: Yes, yes.
Participant 7: How do you get a Demerol order for a midwife patient. Using the hospital papers.
Meta: Yes.
Participant 7: Who writes on what page. Kind of, that sort of stuff.
Meta: Sure.
Participant 7: You really have to do it step-by-step, and you really can't leave it to the occasion. You have to think it out beforehand.

Following these consultations and meetings, the final report of the Midwifery/Hospital Working Group included a section detailing the roles of nurses and midwives when working together in the care of a client (College of Midwives of Manitoba 1999).

7.1.3 Midwifery/Public Health Services Working Group

The need to work towards facilitating integration with public health nurses was also recognized early by the MIC, and the Council held a consultation with 25 public health managers in the fall of 1996. The managers were generally supportive of the introduction of midwifery, especially for high risk groups and remote communities, and were interested in creating a referral system to ensure care would not fall in the cracks between midwifery and public health (MIC Minutes, 25 September 1996). They were willing to participate in an integration working group, and a working group representing urban and rural public health nurses along with members of the MIC began meeting in the spring of 1998 (MIC Minutes, 23 March 1998). They completed an integration document detailing roles, responsibilities, and the process of referral for midwifery and public health which was combined into a provincial midwifery implementation document (College of Midwives of Manitoba 1999).

The report recommended that midwives attend an orientation to public health in the region they would be practicing in, and that midwives may refer to public health any families which need more care than the midwife can offer in the first six weeks postpartum (College of Midwives of Manitoba 1999). Following these integration guidelines, extensive orientation and education sessions were carried out with public health in the RHAs as the midwives began practicing. While participants acknowledged

that integrating with public health had its own challenges, none felt that these raised any long standing issues.

7.1.4 Midwifery/Emergency Medical Services Working Group

Smooth integration with emergency medical services is essential to improve the safety of reintegrating home birth into the Manitoba health care system. In a consultation with Ontario midwives, the MIC learned that the midwives they spoke with did not believe that they had done enough liaison with EMS prior to the initiation of midwifery practice. The MIC began meeting with representatives from EMS in Manitoba in the spring of 1997 (MIC Minutes, 21 April 1997). At the first meeting, it was recognized that midwives would need to understand the variation in EMS skill across the province, and that the EMS would need to know more about midwifery because they are used to being the most competent persons at the scene when they are called, and usually take over care. These consultations led to a recommendation for forming an EMS working group which began meeting in Spring 1998 (MIC Minutes, 16 March 1998). The working group was made up of representatives from the paramedic's association, rural and urban communities, Manitoba Health, members of the MIC, and practicing community midwives (MIC Minutes, 23 March 1998). The group wrote an integration framework document for EMS which was incorporated into the provincial midwifery implementation manual (College of Midwives of Manitoba 1999).

One of the issues that the committee identified it needed to address was to figure out how the fact that EMS are under a transfer of function from the College of Physicians and Surgeons would affect their taking orders from midwives. It was determined that midwives keep responsibility for client care within their scope of practice, and that the

midwife directs the EMS crew as to who they are to care for and what they are to do to assist her (MIC Minutes, 16 March 1998; 15 May 1998). If anything should happen outside of the midwife's scope of practice, such as a seizure, the EMS would then be responsible to direct and provide medical care (MIC Minutes, 12 June 1998). Numerous continuing education presentations were given for EMS staff on midwifery through the fall of 1998, and midwives were also oriented to the details of how emergency medical services worked in the different health regions (MIC Minutes, 29 September 1998).

The working group also looked at whether EMS could be second attendants at home births, and whether home births should be registered with EMS prior to the birth to facilitate any transfers. It was determined that while EMS can be second attendants based on skills, they cannot take on this role while they are working, but only on their own time (MIC Minutes, 13 August 1998). The committee decided that it would be recommended that a home birth be pre-registered with the EMS at 37 weeks if the home is more than 30 minutes from a hospital or difficult to access, but this would not be required (College of Midwives of Manitoba document 1999). It appears that these education meetings, consultations, and the subsequent follow through on the recommendations which came out of the Midwifery/Emergency Medical Services Working Group have worked to successfully integrate midwifery services and the EMS (Participant 12).

7.2 Health Care Administration: Manitoba Health and the RHAs

Once implemented as a publicly funded service, midwifery has become intimately intertwined with the provincial government at all levels, but particularly Manitoba Health and the Regional Health Authorities. The provincial government was supportive of

introducing regulated midwifery, and it is clear that this political support has been crucial to the successful introduction of the profession. Manitoba Health eased the introduction of midwifery by using their funding control to ensure the model of the profession implemented across the province was uniform, and facilitated the Regional Health Authorities in working closely with their staff and facilities to ease the initial integration. Many participants noted that this has led to increased support for midwifery in the Regional Health Authorities, and a desire on their part to expand the program.

7.2.1 Manitoba Health

Following the passage of *The Midwifery Act*, Manitoba Health became much more involved in planning how the midwifery service would be offered. In 1998, a human resource planning report for midwifery from Manitoba Health was written which focused on the payment model for midwifery and created a detailed plan for service delivery since these issues were outside the scope of the MIC. The report was written based on the assumption that midwifery would be a service offered by the Regional Health Authorities (Human Resource Strategy for Midwifery Implementation Committee 1998).

Once the funding model was agreed on in 2000, Manitoba Health then took an active role in assisting the RHAs to introduce the service. A Midwifery Implementation Coordinator position was created and filled by the previous Legislation Chair of the MIC whose function was to assist with interpreting the midwifery legislation, prepare the template for the RHA proposals for midwifery services, and help set up the RHA midwifery programs (Transitional Council of the College of Midwives of Manitoba Minutes, 17 May 1999). She was joined by a Midwifery Consultant, a registered

midwife who, along with members of the MIC, educated the RHAs on the shape midwifery was taking in Manitoba and worked with them to write their proposals for funding. Once an RHA was approved for a midwifery program, she also assisted them in developing and integrating a midwifery service (Transitional Council of the College of Midwives of Manitoba Minutes, 19 April 1999 and 17 January 2000). In many ways, the work of Manitoba Health during the initial integration period was to standardize the integration process across the RHAs through integration initiative requirements, and to put the necessary supports in place so that the RHAs could reach these integration goals. While the details of these initiatives will be discussed below, many participants commented on the importance of Manitoba Health's leadership during this period in the success of midwifery integration in the province (Participants 3, 6 and 12).

7.2.2 Regional Health Authorities

The health care system in Manitoba was becoming regionalized at the same time that midwifery was being implemented, and it was at first unclear how this new organizational structure would affect the introduction of the profession (MIC Minutes, 11 September 1995; 23 October 1995). Both the MIC and Manitoba Health had to work creatively to find a way to obtain the benefits of midwives being funded as RHA employees without this hindering the growth of the profession. This process began in 1995 as the MIC learned more about what regionalization entailed. Once they had a better picture of the changes that were coming, it became apparent to MIC members that if Regional Health Authorities had to fund midwifery services out of their global budgets, which did not include costs for physicians, then they would opt not to hire midwives.

Concerns about this became heightened by the situation in Alberta, where the province set up a similar situation and no RHAs chose to fund a full midwifery service (James and Bourgeault 2004). The Manitoba Health Human Resource Strategy for Midwifery Implementation Committee (1998) recognized this problem and recommended that a designated midwifery fund be created which would be distributed to RHAs in exchange for midwifery service deliverables. The report continued to support midwifery being offered as a regional service because of expectations that this would facilitate midwives serving community areas, reduce transportation costs for consumers, and could facilitate local midwives working in their own communities to reduce recruitment and retention problems in rural and remote areas. Manitoba Health agreed with this recommendation and gave midwifery its own global budget following proclamation (Haworth-Brockman 2002).

Once it was clear that midwives would be funded as employees of RHAs in January 2000, it became a priority to support as many RHAs as possible in introducing the service so that midwifery would be available to women throughout the province (Haworth-Brockman 2002). Since the RHAs were newly formed, many had done recent needs assessments for their regions. In some RHAs, the introduction of midwifery had come up repeatedly during consumer consultations, and this influenced the decision to introduce the new profession (Participant 12). Despite this goal of full provincial coverage, Manitoba Health did not make offering midwifery mandatory, but instead determined that initially it would be better for the program to be voluntary so that the RHAs which chose to offer it would work harder to illustrate that it could be implemented successfully (Haworth-Brockman 2002):

> **Participant 3:** I think part of what we considered was how RHAs, with the right supports, could take the lead in implementing regulated midwifery. We really wanted RHAs who were keen to take the lead so that they could show their neighboring RHAs just how safe and effective midwifery could be. That is, there wasn't a higher risk of babies dying; and midwives were trained and competent to handle emergencies. Unfortunately, some RHAs have had a few bad experiences with unregulated midwifery. This has made them very leery, and sometimes, uninterested in introducing midwifery into their RHA. It is important for Manitoba Health to continue to provide information that reassures such RHAs that regulated midwifery now means that midwives must follow standards and laws and be accountable to their governing body.
> **Meta:** Right.
> **Participant 3:** So our method was to first focus on those RHAs who were interested and willing to invest the time in implementing midwifery in their region. We tried to divide the available funding among all interested RHAs.

At the time of proclamation, 3 of the 12 Regional Health Authorities submitted proposals which were approved, and soon hired midwives (Maize 2000). Soon after, three more RHAs submitted proposals which were approved and began to offer midwifery services (Moon 2001; Friesen 2001; Anonymous 2002b).

As required by Manitoba Health, each of these RHAs developed a Midwifery Implementation Committee made up of health professionals, including physicians and nurses, midwives, consumers, RHA administrators, and other individuals who would be involved with the midwifery program (Human Resource Strategy for Midwifery Implementation Committee 1998; Manitoba Health 1999). The committees looked at issues of hospital admitting privileges, emergency transport from home to hospital, orientation to RHA and hospital policies by midwives, and orientations to midwifery for other health professionals (Haworth-Brockman 2002). Many participants noted that the Midwifery Implementation Committees which were required for each RHA were invaluable in the successful integration of the program into the RHAs.

The Manitoba Health Midwifery Consultant traveled to all of the RHAs to help them with setting up the midwifery implementation committees, and initially was also a member of the committee where she assisted with problem solving, educating, and facilitating discussions:

> **Participant 12:** ...We pulled together a group of people to be on our Midwifery Implementation Committee. We had a consumer on the committee, people from hospital, RHA administrators, midwives and Public Health and so on. And we worked through a lot of the integration.
> **Meta:** Oh good.
> **Participant 12:** Now we had a lady by the name of [Midwifery Consultant] who came out from Manitoba Health...And she was really instrumental in helping us to avoid a lot of the silly landmines that would have stopped, or maybe not stopped but made things more difficult.

The first initiatives of these committees was to organize extensive orientations for midwives, medical staff, public health, nurses, pharmacists, mental health, lab technologists, and hospital staff (Irvine-Wallace 2000):

> **Participant 6:** So, integration. I think it was very well planned out and details in place.
> **Meta:** Yes.
> **Participant 6:** Before we were even set loose...We did presentations to the medical staff, to the staff of public health, to the dieticians, to the labor and delivery nurses, to the EMS. We even did a little thing with the people in records because now, it was a joint effort. 'This is what we do as midwives, and what do you want us to do as midwives? How do you want us to keep track? Teach us your system.'
> **Meta:** Yes.
> **Participant 6:** So it was, it was very thorough. Which was really, really important because we had the support, and we felt like we had the support of the system. When we knew everybody was on board, and introduced and orientated. Not everybody agreed with us, not everybody was pleasant to us, but we had a right to be there and they knew it because they already had that information from the orientation. That was good.

Thus, most aspects of integration were able to be worked out before the midwives began practicing, and once they did begin, the Midwifery Implementation Committees created a

non confrontational forum where problems could be discussed and resolved in a timely manner (Participant 10).

The decision to let the RHAs voluntarily offer midwifery services combined with the integration support offered by Manitoba Health appears to have worked to create successful models of the program, which then increased interest in the program from other Regional Health Authorities. A recent meeting of Manitoba Health and Regional Health Authority administrators on midwifery in winter 2004 was attended by representatives from almost all of the RHAs. This appears to indicate that the RHAs which have midwives want to expand their programs, while RHAs which do not yet have midwives are interested in offering midwifery services as well:

> **Participant 3:** ...we just had a roundtable of the Regional Health Authorities and the midwives last Friday. My impression is that, in general, RHAs are very pleased and enthusiastic about their midwives. They are supportive and value the work of midwives and definitely view them as colleagues...We invited all of the RHAs to the midwifery roundtable. A majority of RHAs attended. Those that didn't were unable to attend because of the extreme cold and the risk of driving long distances. Those which did attend all indicated an interest in midwifery. No one said they were opposed to midwives. The main issues are the availability of funding and the availability of midwives looking for work...What's the change? I think it's as I said earlier, they see other RHAs and they've seen how absolutely committed the RHAs are to the midwives. They see the benefits and the good work that they do.

7.3 Employment and Integration

Midwifery in Manitoba is distinguished from the other provinces not only because it has been made a regional service, but more importantly because the midwives are salaried employees of the RHAs. The decision to fund them this way was made partly because of the perceived benefits for integration. In practice, employment status does appear to have improved both the speed and the ease with which midwifery has been integrated into the existing health care system. Three attributes of employment appear to

have influenced this: the presence of an RHA supervisor, midwives getting paid for integration work, and co-location with other health professionals. Together, these attributes appear to have contributed to the easier integration of midwifery experienced in Manitoba.

The decision by Manitoba Health to want midwifery funded through the employment model was primarily supported because it was believed it would ease integration:

> **Participant 3:** ...We began our negotiations by considering a variety of payment options. Should it be an independent contract, fee for service or an employment contract?...We quickly decided not to go with a fee for service model. As well, generally speaking most of the Regional Health Authorities and Manitoba Health became increasingly uncomfortable with an independent contract model for a couple of reasons.
> **Meta:** OK.
> **Participant 3:** Two main reasons I guess. One is, we were concerned about being able to ensure integration of midwives into the health care system. We didn't want midwives working on the fringes...And maybe now today there wouldn't be that kind of problem. but we knew from the experiences of other provinces that if you don't have midwives rubbing shoulders with doctors and other health care professionals, as well as RHA officials, that it is likely that there would be misunderstandings and problems with acceptance of midwifery.

The other benefit of employment was that midwives would not have to start a business:

> **Participant 1:** For those of us on the Council outside the midwifery world, what we were hearing from Ontario is that it was a nightmare to be self-employed. Because it was hard enough to be out there starting up your practice, just trying to provide good care, trying to fit in with the physicians and nurses and everybody else, and on top of that to be a small-business woman and be paying the bills and hiring staff and making sure that everything keeps going.

In practice, many participants stated that having the midwives be employees of Regional Health Authorities has been fundamental to the successful integration of midwives with other health professionals and health institutions:

> **Meta:** What do you think has influenced the generally positive integration you're describing? With hospitals, with public health, with physicians and nurses?...
> **Participant 9:** I think that, what has influenced that? I think there has been a lot of ground work done. A lot of communication with the different professions. Attempts to sort of pave the way and then people have continued to work on those aspects, like once it became sort of something that was happening it seems like things were handled. Maybe that, maybe that was partly [RHA Midwifery and Antenatal Services Manager] and the work that she did with the various, you know, integration initiatives. That they had someone who was in the position of implementation coordinator. Did they have that in other provinces where they didn't have an employment model? I don't think so. We're employees of Manitoba Health, of the government. So it's like, we've got a little badge that says we're employees, we're allowed to be here. That might be a part of what it is, the employment model that we follow probably made a big difference.

Participants noted three aspects of employment which aided integration. The first was the presence of a supervisor whose job was often focused around successful integration:

> **Participant 10:** ...And we have to provide a description of what we are doing and where we are heading with integration. We have been extremely successful in [RHA]. I think the advantage for us being the support of the Regional people. Being able to have someone in a position like mine where implementation and integration was my job.
> **Meta:** Right.
> **Participant 10:** My focus every single day was working on integration with the midwives.

The person in this position could also often act as a bit of facilitator in professional disputes without appearing too biased towards the views and interests of one professional or another (Participant 23).

The second aspect of employment is that the midwives are not paid solely for attending births, so they can spend more energy and time on integration initiatives and meetings without the time for this having to come on top of their already full work lives, and without this affecting their income because it is not based solely on offering care:

Meta: That was part of the goal of having the employment, right?
Participant 9: Yes.
Meta: That it would ease integration?
Participant 9: Yes...Because otherwise it would be another one of those things that if you were a private practice midwife, it's like, 'there's my clients, my family, my overhead, and oh right, I also was supposed to go talk to public health'.
Meta: Right.
Participant 9: It would be another one of your jobs that maybe would be pretty far down on the list of things that you were able to accomplish.

The third aspect of employment is that the Regional Health Authorities had control over the location of the midwives practices, and could require that they practice in co-location with other health professionals. This allows for the everyday interactions which minimize suspicion and make midwifery practice familiar. Having midwives co-located with other health professionals in community clinics to support integration was first recommended by the Manitoba Advisory Council on the Status of Women *Midwifery* report (1987), which consulted with a number of clinics in the city and found them supportive. In discussion papers, the Working Group (1992a) also viewed clinics as good locations for midwives which would ease integration. This perception that community clinics are a good site for midwifery was also expressed by the clinics themselves. In 1998, 11 clinics in Winnipeg had expressed interest in offering midwifery services (Human Resource Strategy for Midwifery Implementation Committee 1998). In 2000, midwifery practices were introduced in three of these clinics, while a fourth group of midwives was first located in a public health office before being moved into a new community clinic opened in 2004 (Irvine-Wallace 2000; Manitoba Hansard, 26 April 2004). Many participants felt that having the midwives practicing out of community clinics was very beneficial for integration:

> **Participant 1:** I think the plus side to it was that within the clinics they've had to work with other professionals and other professionals have had to work with them. There's some support there that is developing over the years. And some understanding and some comfort…
>
> **Participant 10:** …So what we're finding in all of the clinics is that hallway consultations happen often. And if you need a dietitian or if you need some advice for a client, you can knock on a dietitian's door or a physician's or a social worker's or you can get advice on what community resources and services are out there. So the midwives are learning about the different services that are available to their clients.
> **Meta:** Right.
> **Participant 10:** And because they are working together with public health nurses, they are learning. I think that has been really crucial to integration in the community areas and with other professionals. And you know if you are working in the same office, you get to know people.
> **Meta:** Right.
> **Participant 10:** And over time trust develops. And then if you have a question you know who to ask…And I definitely think its been a good thing to have the midwives co-located in offices with other professionals. I think that we've only seen positive benefits from that, for sure.

Being located in community clinics also means that midwives get referrals from the other professionals in the clinic, indicating their support for the midwifery practices. In one clinic, the midwives primarily accept clients as referrals from the clinic (Participant 8). Integrating into the clinics was not easy, and involved quite a bit of work on the part of the midwives, but all participants who discussed the clinics indicated that this has occurred successfully.

In the two northern RHAs the midwives are also co-located with other health professionals in the town community health centre or hospital. Of the three rural RHAs, the midwifery practices in two are stand alone, while the last shares a building with other health professionals. In the two rural RHAs where midwives have stand alone practice locations, the feeling appears to be that the communities are small enough that integration

and day-to-day interactions happen without the continued support needed in larger communities:

> **Participant 6:** Outside of Winnipeg we're a pretty small community.
> **Meta:** Yes.
> **Participant 6:** So we walk over to the doctors office to give them a release of information request. And we might ask the doctor that is standing at the desk a question about a blood result we just got back. You know, 'would you like to do something about that', or, 'I don't have experience in that, so should I be worried about that', you know.

Together, these three attributes of employment: the presence of an RHA supervisor, participation in integration initiatives as part of the job description for midwives, and co-location with other healthcare professionals, appear to have contributed to an easier integration of midwifery services with the existing health care system, including medicine, hospitals, and nursing.

7.4 Medicine

Integration with physicians was taken very seriously and started early in the implementation process. The MIC consulted extensively with medical organizations to educate them about the developments in midwifery, and take into consideration their concerns and suggestions before the midwives started practicing, so that consults and transfers would be able to occur in a collegial manner. Obstetricians and family practitioners also had different issues which had to be addressed. At present, it appears that the number of midwives remains small enough that they can mostly limit their contact to supportive physicians, which makes practicing easier.

Physicians, as represented by the College of Physicians and Surgeons of Manitoba and the Manitoba Medical Association (MMA) have recommended and been cautiously supportive of the introduction of midwifery since the mid-1980s, although they supported

a model of midwifery different from the one which was introduced (Manitoba Advisory Council on the Status of Women 1987). Released in 1991, the joint report of the College of Physicians and Surgeons of Manitoba and the Manitoba Association of Registered Nurses recommended the introduction of hospital based nurse midwifery pilot projects only, with no acceptance of direct entry or community trained midwives. The general consensus among participants was that the negative views held by physicians on midwifery was based on experiences they had with unregulated midwifery:

> **Participant 7:** ...Those physicians who have had experience with unregistered midwives in Canada usually thought it was a very traumatic and confrontational experience because those midwives came only to the hospital when disasters happened. So physicians always found that midwives were associated with disasters. They usually thought that the care had been substandard prior to coming to hospital.
> **Meta**: Right.
> **Participant 7:** Which you know, that was a pretty strong bias.

> The conception of midwifery in Manitoba was influenced by incidents of lay midwives bringing patients with obstetrical problems to the hospital at the last minute. Obstetricians believed that they were forced to 'fix the mess' midwives got their patients into and therefore resented midwives (**Participant 22**).

Those who were familiar with midwifery in other countries or in northern Canada were more likely to be supportive (Human Resource Strategy for Midwifery Implementation Committee 1998).

Although the MMA, as well as other medical organizations, had representatives on the Manitoba Working Group on Midwifery which recommended autonomous midwifery in 1993, the MMA continued through 1997 to support a midwifery model which circumscribed midwifery to hospital based practice under physician supervision for labour and delivery only, with no responsibly for the newborn. The MMA argued that demand for midwifery would be lower than estimates, and were concerned about the

liability insurance a midwife would carry (Anonymous 1997b). Financial issues, including payment for midwives, the cost to the system of offering midwifery, and consultation fees were central to most conversations between the MMA and the MIC on the implementation of midwifery (MIC Minutes, 20 April 1997). When the MMA was consulted on the *Midwifery Regulation* by the MIC, the MMA responded with a number of criticisms about how midwifery was being regulated, and a warning that if physician liability and payment concerns were not addressed, midwives would find that there were few physicians willing to work with them (Manitoba Medical Association 1998). In 1999, the Manitoba Association of Midwives (MAM) reported that as they were facing regulation, anesthesiologists were refusing to take consultations from midwives, and so were many other physicians (Maize 1999). The Transitional Council of the College of Midwives of Manitoba continued to consult with physicians through 1999 in hopes of negotiating a framework so that the two professions could collaborate (MIC Minutes, 22 January 1999).

Finally, in the spring of 1999 there was a bit of a breakthrough when fees for midwifery consultations with physicians were approved (MIC Minutes, 17 May 1999). This eased a lot of concerns about integration, and has also worked to make consultations smoother in practice:

> **Participant 9:** Doctors in Manitoba, I think Manitoba was the first place that actually paid for consultations.
> **Meta**: Right.
> **Participant 9:** So that was a big deal.
> **Meta**: Right.
> **Participant 9:** It means that you know, 'if I do a consult with you, you are going to get a paid for it' and it's a very professional relationship.

Once the midwives began practicing, a number of information meetings, participation in medical rounds, and orientation sessions began to be held with physicians (Scurfield 2002):

> **Participant 6:** In [RHA] one of us was invited to the MAC, Medical Advisory Committee. The doctors meetings, basically.
> **Meta**: Yes.
> **Participant 6:** And we had a voice and we disseminated information there or explained situations there. We also go to rounds with the doctors so that we have a collegial situation there to sit around the table with a presenter. You know, and there's two or three midwives and there's maybe eight doctors. So it's not a big group and we can converse. 'This is what I think,' or 'it was good you did that.' 'No, I wouldn't do that.' 'This is what the women are saying,' or whatever the case is.

While participants did not play down the importance of this preparatory work, they also discussed how issues about when midwives consult and transfer really had to be worked out in practice, and that as the professionals became more familiar with each other, consults and transfers have become smoother (Participant 23):

> **Participant 5:** The only complaint I've had, or heard about relates to issues of transferring too late, or 'why wasn't I involved sooner?', 'why the hell is this mess getting dumped in my lap now?'.
> **Meta**: Yes.
> **Participant 5:** That kind of thing. And in all honesty it hasn't happened very often.
> **Meta**: Yes.
> **Participant 5:** I would attribute most of it, just to inexperience as to when to transfer. Not that it was deliberately hoarding a patient or, you know, just inexperience.
> **Meta**: Yes. I guess since we're three years in, and that's something that really takes time.
> **Participant 5:** There's a testing curve here, MDs/obstetricians/nurses have to work with them and realize they are doing things OK…I think anyone who has some doubts and concerns about it has to spend some time working with them. Then they'll realize that things are OK. It seems to work out fine.

A number of the midwives interviewed stated that physicians have been more supportive than expected, and that a physician giving a midwife a hard time is the exception rather than the rule (Participants 21 and 9).

Partly it is clear that this is because there is still only a small number of midwives, so for the most part they are able to limit their contact with physicians to those who are supportive or at the very least not hostile to midwifery:

> **Participant 16:** I would be one of the first people to say that I think one of the reasons that it's gone quite well is that we have had the good faith and goodwill of some physicians. Not all physicians, some have been quite negative. But a self-selection process has occurred. Midwives don't generally consult with non supportive physicians unless they have to.
> **Meta:** Right.
> **Participant 16:** But there are enough physicians available who understand that they have a professional responsibility to accept and facilitate consults from midwives (despite what they may feel about midwifery itself) in the interest of maintaining the best possible care for women and babies.

While the general consensus seems to be that integration issues have been worked out and the concern about midwifery competency held by physicians has waned, the safety of home birth remains an issue, and as long as they disagree on its safety, full integration based on respect between the two professionals will probably not be able to take place.

While smooth consultations and transfers are important for midwives' working conditions and the care they can offer their clients, the Manitoba Working Group on Midwifery had initially hoped that family physicians and midwives could work together even closer in smaller communities based on a similar philosophy of care (Manitoba Government 1993). However, it was recognized by the Manitoba Advisory Council on the Status of Women (1987) that family physicians were quite resistant to the introduction of midwifery because even though the majority are leaving obstetric practice, those who remain doing obstetrics are very committed. They also feel under appreciated, and have to make extensive lifestyle sacrifices to attend births on call:

> **Participant 1:** ...Often they didn't want to hear this. For many of them it was insulting. Midwifery was insulting. It was hard to walk that line with them. Talking to the obstetricians who are working really hard because there's not

> enough of them. They are up night after night. Their family lives were ruined because they devoted their lives to this job. Now we're walking in and saying 'you're doing a crap job and we're bringing in someone else to do it. And the midwives say that birth is normal and use informed choice' and now 'what do you think I've been doing for the last 30 years?,' the obstetrician thinks.
> **Meta:** And that would be true for family physicians, too, right?
> **Participant 1:** Sure. Especially for them because they were feeling, you know, this is coming in at a peer level. And they haven't earned it as far as the physicians were concerned, a lot of them. It was hard because there was a lot of resistance to hearing this...

The MIC did hold consultations with the College of Family Physicians to facilitate the kind of working relationships envisioned by the Manitoba Working Group on Midwifery though (MIC Minutes, 1 April 1996; 21 April 1997; 23 March 1998). These consultations appear to have mostly involved educating family physicians about midwifery so that they would be more comfortable with it. These efforts and the efforts of the midwives once they began practicing appear to be having some effect however, because in some smaller communities midwives and family physicians have begun to work together more closely. Participant 23 noted that in her RHA, general practitioners have taken responsibility for the care of the midwife's clients when she requires some time off call. Thus, integration with obstetricians and family practitioners was perceived as moving ahead quite well.

7.4.1 College of Physicians and Surgeons of Manitoba

While consultations with physicians as a whole were important for smoothing interactions in the care of midwifery clients, integration also needed to occur with the College of Physicians and Surgeons of Manitoba. The CPSM had initially advocated for their playing a substantial role in regulating midwifery. Their argument was that all obstetric care should be overseen by a single regulatory body (Manitoba Advisory Council on the Status of Women 1987; College of Physicians and Surgeons of Manitoba

and Manitoba Association of Registered Nurses 1991). Through discussions between the MIC and the CPSM, compromises were reached which kept the CPSM involved in the regulation of midwifery-provided obstetric care, but also protected the autonomy and self regulatory nature of the new profession. In the summer of 1996 a midwife was invited to join the CPSM Perinatal and Maternal Welfare Review Committee (MIC Minutes, 4 July 1996). With the introduction of a midwife, it was agreed that this committee would review and make recommendations around all births in the province with poor outcomes, including those attended by midwives, but it also meant that the review of all physician births would be influenced by the perspective of midwifery. A midwife began to sit on the Perinatal and Maternal Welfare Review Committee of the CPSM in February 1998 (MIC Minutes, 24 February 1998).

The CPSM was also given opportunities to comment on the proposed midwifery legislation in the fall of 1996. These comments were taken into consideration and many changes were made (MIC Minutes, 25 October 1996). Although the CPSM was still not entirely happy with the midwifery legislation, the CPSM did not attend when the midwifery bill went to Manitoba Legislative Assembly Committee of the Manitoba Legislature. The CPSM then asked that their submission be entered the next day after the fact. While all of the presenters at the Manitoba Legislative Assembly Committee meeting had been supportive of the new bill, the CPSM's submission was the only one which requested changes (Manitoba Hansard, 12 June 1997). In their submission, the CPSM requested that midwives not be allowed to attend home births, that there be formalized education requirements for midwives in the Act, and that the list for mandatory consultation and transfer include more conditions and factors (Manitoba

Hansard, 12 June 1997). When this submission was discussed by the Manitoba Legislative Assembly, it was agreed that it was too late to consider these changes because the bill had already passed in Manitoba Legislative Assembly Committee. It was also recognized that the CPSM had been consulted extensively, and that their views had been taken into consideration in the writing of the bill (Manitoba Hansard, 13 June 1997).

In the summer and fall of 1998, the CPSM was then consulted on the proposed *Midwifery Regulation*, and many of their suggestions were incorporated (MIC Minutes, 19 October 1998). The CPSM was also consulted on the standards of the CMM and on the development of the structure of the CMM itself:

> **Participant 5:** Yes, it is going back a ways. They got involved with our committee and approached us in terms of A) wanting to bring this in, and B) once the process was initiated, run some of their rules and regulations by us, some of their structure. Things of that nature.
> **Meta**: Oh really?
> **Participant 5:** Some of their involvement with us went past the [Name 2 Committee] in terms of what, how to, what we thought standards should be. Such as, they looked at the organization of the College, how we were structured, how we set up Standards committees, things of that nature. So people outside of our Committee were also working with that working group for example.

The fact that the College of Midwives of Manitoba's structure is modeled on the Colleges of the other health professions also eases integration, making it easier for other health professionals to trust the competency of the midwives. The two Colleges continue to interact in the regulation of maternity care in the province, and many participants stated that these interactions are smooth (Participants 5, 16, 9 and 13).

7.5 Hospitals

A number of participants perceived that the work that went into easing integration into hospitals from the Midwifery Implementation Council, the Midwifery/Hospital

Working Group, the Regional Health Authority Midwifery Implementation Committees, the Regional Health Authority administrators, midwives, and other health care professionals has been effective. Most discussed how integration into the hospitals had been unexpectedly smooth. While research out of British Columbia and Ontario have discussed the challenges midwives have faced with integrating into the hospital, similar problems were not seen as common in Manitoba.

One of the first things newly practicing midwives needed to do was obtain hospital admitting privileges. While hospital admitting privileges are a gatekeeping symbol which prior to this were only held by physicians and dentists, midwives received hospital admitting privileges in Winnipeg with ease following the extensive negotiations and advocacy of the MIC:

> **Meta:** What about hospital admitting privileges? How did that work?
> **Participant 1:** We were so lucky. (Laughter.) I tell you. Hospital admitting privileges were an issue right?
> **Meta:** Sure.
> **Participant 1:** In some provinces – Quebec is only just getting them I think. In Ontario it was a huge struggle. Here it was a snap. I'm trying to think of what the history was. We did a lot of work. I always sold it as 'Well, if you don't want them doing home birth then you're going to have to give them hospital admitting privileges'. … Midwives filled out their applications and there's supposed to be a meeting to consider them. There was such apathy that they canceled the meeting. The Chair sent out a note saying that anyone having any concerns about these people, if so let him know by Friday otherwise they have their privileges. So they got their privileges. There wasn't even a meeting.

The fact that midwives acquired hospital admitting privileges in Winnipeg easily created an expectation that it would go smoothly everywhere in the province, but this was not always the case. However, while physicians sometimes tried to challenge midwives getting privileges, their status as RHA employees and the support this garnered from

RHA administrators eased this process, and midwives were able to get admitting privileges in all RHAs:

> **Participant 11:** And so it's actually been good and it's also been good in the way that we didn't have as much resistance about getting hospital privileges. Because we were part of the organization now.
> **Meta:** Right.
> **Participant 11:** They couldn't just say no and stick to it. Although they did say no at first, but then we got them [privileges].
> **Meta:** In [town 1]?
> **Participant 11:** Probably because they felt they had to refuse one time anyway, right? (Laughter). But then we ended up getting them. I think that was because we had the support of the organization and management to say 'there are certain groups and organizations that have problems with midwives, but hey, get over it, because they are part of the organization, and this is what is going on. This is what we're working towards so it needs to be done'.

While the midwives in the smaller RHAs generally had only one hospital to integrate with which could be done as part of the general RHA integration and orientation process, the Winnipeg Regional Health Authority (WRHA) put a particular focus on smoothing hospital integration into the three hospitals that the midwives in Winnipeg would practice in. Following proclamation, the first 13 midwives spent their first few months taking part in a number of consultations and orientations with labour and delivery floor staff to familiarize the hospital staff with midwifery and learn hospital routines and policies (Irvine-Wallace 2000):

> **Participant 10:** OK well, the main integration issues. I think probably the biggest one in all areas was people not understanding what midwives do…So what we did that was really, really effective was we did many, many, many presentations to different groups about midwifery.
> **Meta:** I see.
> **Participant 10:** We started in the hospitals, and the midwives did the presentations…So I think it's been helpful that we did lots of presentations. It helped to increase others' understanding of how midwives practice.

Further, for the first year and a half, there was also a review of every single midwifery attended hospital birth in Winnipeg:

> **Participant 10:** ...And one of the other things that we did that was effective in the first, I think it was about year and a half, was that for every midwifery birth in the hospital, we had a debriefing meeting around each birth.
> **Meta:** Yes.
> **Participant 10:** And it was very time-consuming, but it was a really good investment to aid integration with hospital personnel.
> **Meta:** Yes.
> **Participant 10:** We would have a meeting that included myself, the manager at the Hospital, the midwives involved in that birth, and nurses involved if that worked out. We then reviewed the birth, what went well, what didn't. How could we have made it better? Was the client happy? That was really, really effective in developing the relationships with the hospital.

As the midwives began working and attending births in hospital, many have had to adjust to following hospital policy. While it is recognized that these policies were often quite different from the standards of the CMM, and were not created with midwives in mind (MIC Minutes, 23 March 1998), midwives have been supported in sitting on and influencing any committees that make decisions about perinatal health policy at both the regional and hospital level to make them more midwifery friendly (Participants 11 and 12). One hospital protocol which remains an issue though, is how midwives can order epidurals for their clients. While the MIC tried to have it work out that midwives could refer directly to anesthesiology for an epidural, in practice, direct referrals to anesthesiology for epidurals are not accepted, and midwives must transfer care to a physician first:

> **Participant 1:** ...And epidurals. And that was still being worked out, that issue. The final decision was that those would be a transfer of care to a physician. Now some of the nurse midwives didn't like that. Because they have been doing these things, they felt they could do them better than a physician.

However, the guidelines of the CMM state that midwives who train in epidural management and obtain full epidural certification can manage the epidural and remain the primary caregiver, but midwives without this certification must transfer care to a

physician and can provide supportive care. This training has been made available to midwives in Winnipeg, and some midwives have upgraded to full epidural management. This certification and expanded scope is recognized by the Winnipeg Regional Health Authority (Winnipeg Regional Health Authority 2003).

Another challenge discussed by many participants was developing good working relationships with labour floor nurses. Participant 22 noted that some of the biggest challenges for nurses with midwifery is when they disagree over when a midwife should transfer care to a physician, or when they observe a midwife having a disagreement with an obstetrician over patient care. Other participants had not seen that this was an issue:

> **Participant 12:** It was very much once you got to know the midwives, then your level of stress tended to go down…'She was, she did know how to handle that. She did know when to refer'.
> **Meta:** Yes.
> **Participant 12:** 'She did know when to seek a consultation'.
> **Meta:** I've heard of that being an issue. Yes.
> **Participant 12:** So that was something that has never been an issue here. Never had a complaint. Never had a concern.

Another issue for integration with hospital nurses which was identified was when midwifery clients chose to stay in hospital for the initial postpartum period to receive routine postpartum care. It was noted that to some nurses this looks as if the midwife is not offering continuity of care, but the same care a client would receive from a physician (Participant 22). However, another participant pointed out that the transfer to postpartum care appears to be an area where the nurses in hospital are particularly sensitive to the fact that midwives can give them orders similar to a physician (Participant 18). For labour and delivery, the midwife's role in many ways overlaps more with a nurse than a physician, but for postpartum care, it is more similar to a physician.

While many participants felt that it was initially challenging for midwives and nurses while everyone worked out their roles and responsibilities, they also said that with time things have begun to run more smoothly. Most participants were in agreement that the preparatory work and the continued integration efforts from all parties had been successful in fostering good working relationships between nurses and midwives (Participants 1, 16, 21 and 23):

> **Participant 5:** They had some significant problems with nursing, too. Significant problems.
> **Meta:** Do you want to talk about that at all?
> **Participant 5:** Well, I don't know much about it, but I've heard about where nurses who would come out of a room, you know, 'who the hell does she think she is. She's pushing me around, she's giving me orders'.
> **Meta:** Yes.
> **Participant 5:** Doing things which nursing felt to be inappropriate.
> **Meta**: Right.
> **Participant 5:** So they had to, over time, evolve some sort of cooperation, set some ground rules. Now it seems to be working fine.
> **Meta**: Oh good.
> **Participant 5:** I don't hear anything about that anymore.
> **Meta**: So it was sort of a, sort of a working it out kind of thing.
> **Participant 5:** Yes. People needing to feel themselves out, that sort of thing.

All of these integration initiatives on top of learning the hospital routines and policies, and developing working relationships with other professionals meant that midwives spent a great deal of time and energy working on integration in the first years:

> **Participant 16:** It was really incumbent upon that first group of midwives to really learn on the job.
> **Meta:** Yes.
> **Participant 16:** It was really tough for them…And they had to become implemented into the system. They had to learn things associated with being part of the health care system. It was really, it was a huge transition over the last three and now almost 4 years now. I have tremendous respect for that first group of midwives who really were at the front-lines in terms of integration as practitioners. They were under scrutiny at all times and it took a lot of courage, but they obviously believed in themselves and the value of midwifery care. But it could not have been easy especially for those who had

> never worked in the mainstream system before. They deserve a lot of credit, they paved the way for others.

Many participants stated though, that all of this effort was largely successful in easing midwifery integration into hospitals:

> **Meta**: How has integrating into the hospital gone?
> **Participant 9:** I think it's gone pretty well. I think it's gone very well. I personally have had good experiences for the most part. A couple of conversations with doctors have been less than professional but really I mean like two in three years.
> **Meta**: Yes.
> **Participant 9:** I think it's been very good. I've always felt pretty well received...

> **Participant 10:** So the hospital piece I think was what worried us the most at the beginning before we even started. And then it really wasn't that hard. Because we really had the opportunity to develop things ahead of time and deal with issues as they arose.

7.6 Nursing and Dual Registration

The integration with nursing goes beyond developing working relationships with the staff nurses in hospital. It involves integration of the two professions as a whole, especially with the creation of dual registration in nursing and midwifery. As was true of nursing organizations across the country, The Manitoba Association of Registered Nurses initially supported the regulation of midwifery as a specialty of nursing only (Manitoba Advisory Council on the Status of Women 1987; College of Physicians and Surgeons of Manitoba and Manitoba Association of Registered Nurses 1991). While the benefits of this model were considered seriously by the Manitoba Working Group on Midwifery (1992b), it did not recommend nurse midwifery in its final report (Manitoba Government 1993). MARN was then one of two nursing organizations which recorded their opposition to this recommendation and stated that it would only support the introduction of nurse midwifery (Manitoba Government 1993).

Then, as the MIC began to implement autonomous midwifery, MARN brought up concerns about Manitoba replicating the way that Ontario decided to implement direct entry midwifery, which excluded nurses with midwifery training from the profession. The MIC assured MARN that the profession would be open to registered nurses with midwifery training during consultations held in the fall of 1996, and stated that they were hoping it would be possible for women to register as both nurses and midwives in Manitoba (MIC Minutes, 16 December 1996). The MIC then began discussing how dual registration would work in practice in the fall of 1996, both in terms of how the philosophies of the professionals could be mixed, and how an individual could work part time at both professions and be responsible to two governing bodies (MIC Minutes, 28 October 1996). The registered nurses with midwifery training in the province were very supportive of the possibility of dual registration so that they could register as midwives without having to give up their nursing registration. In the spring of 1997, the MIC and MARN began discussions on how dual registration would be implemented (MIC Minutes, 22 April 1997).

Soon after, a MARN representative announced its support for the model of midwifery the MIC was implementing at the Manitoba Legislative Assembly Committee public hearings for *The Midwifery Act* in 1997. She stated that while MARN still supported nurse midwifery as the best option for the midwifery profession, MARN supported the passage of *The Midwifery Act*, the regulation of midwifery, and she stated that they had the mechanisms in place to allow for dual registration between the two professions (Manitoba Hansard, 12 June 1997).

At present, there do not appear to have been any issues with applicants choosing to register with both the registered nursing and midwifery colleges, and a number of midwives have done so (Participant 20). In practice though, dual registration has not been used by practitioners in isolated communities as was initially envisioned by the Manitoba Working Group on Midwifery, but has been used primarily by women who have chosen to continue practicing as nurses, but wanted to register with the CMM for recognition of their midwifery training. Dual registration also created a kind of safety net for nurse midwives who wanted to try out autonomous midwifery but were not entirely certain about it. For those nurse midwives who have not chosen one profession or the other, but work in both, one participant noted that this can create confusion for other health practitioners as a single individual moves between an autonomous and non-autonomous role within the same institution:

> **Participant 19:** ...And role confusion, it's like, I mean, there are midwives who are working weekends as nurses in the hospital where they also have privileges as a midwife.
> **Meta**: Really?
> **Participant 19:** Now talk about role confusion.
> **Meta**: Yes.
> **Participant 19:** That could be very confusing.
> **Meta**: Yes.
> **Participant 19:** Even for the staff working in the hospital, 'today I'm a nurse. Tomorrow I'll be here as a midwife'. You know, the same person. Same week.

The potential benefits of nurse midwifery practitioners in remote communities thus has not yet been explored and remains an area of possibility for the future.

7.7 Loss of Leadership from Manitoba Health

At the same time that participants spoke of the successes of midwifery integration in Manitoba, and gave Manitoba Health much credit for facilitating this because of the

integration initiatives it spearheaded, they also expressed frustration at how Manitoba Health's support appears to be lessening. With the untimely deaths of two midwifery consultants in the first few years of midwifery integration (College of Midwives of Manitoba, 2004a; College of Midwives of Manitoba, 2004b), and no long term plan from the Health Minister for the further growth of the program beyond the current cap at 30 positions, the impetus behind midwifery has come to stall, and there have been few voices to advocate for it within Manitoba Health. In it's 2002-2003 annual report, the College of Midwives of Manitoba (2004) stated that they received assurances from the government that it wants midwifery programs in all RHAs, yet there remains no long term plan to expand the program and reach that goal.

Considering the amount of energy and financial support that went into implementing this new program, many participants seemed surprised at the government's apparent apathy towards it, keeping it at a level which leaves half the programs on the brink of closing. It appears that the potential danger associated with midwifery, unregulated practitioners attending home births, has been addressed, and the improved political images from midwifery, enhancing consumer choice and targeting services for socio-economically disadvantaged women and remote communities, can be offered with a small token service:

> **Participant 5:** One of the things about this is that for a very large part this was a political process. It was a political, all of this was in the media, it was a political move. It was a feel good, look good kind of program, 'so we'll [government] set up a midwifery program'. They've met the public's agenda now. So they're perceived as good guys. They've lost interest...Governments run right now on a crisis basis.
> **Meta:** Right.
> **Participant 5:** We answered the crisis. At that time there was a crisis. They answered the crisis.
> **Meta:** Right.

Participant 5: There's no pressure on them.

Midwifery must now compete with all of the many health care services in need of funding, and for the time being, any substantive short and long term benefits are not getting the opportunity to show themselves. Many participants perceived the government as only focused on cost saving measures, although at its small add on size, midwifery is currently plagued by issues of economies of scale and the cost of integration initiatives which will only be profitable investments if midwifery is maintained over the long term. Instead of taking such an approach, participants spoke about a lack of long term thinking on the part of the government, a focus on short term savings, and high scrutiny to determine if the midwifery program is worthy of public funding:

> **Participant 16:** I am very disappointed in the current government at this point. They have been very tentative in their support and the long term sustainability of the program is not certain. The official view is, 'oh yes we support midwifery but' it has to be within the context of everything else, health-care cuts and transfer payments etc. The government has taken a lot of credit for the success of midwifery in this province but the irony is that we have made it happen here is spite of the tepid support from government. I thought at the beginning the major obstacles would have been organized medicine or nursing or the health care bureaucracy but all of those groups have been so supportive. In the end, it has been the government who has been the biggest obstacle to growth and sustainability. What an irony!

> **Participant 9:** But I keep also hearing this same thing coming from anybody who's interacting with the government about how they want some proof that it's cost effective. You can't do that at this stage.
> **Meta:** Right.
> **Participant 9:** It's impossible to do that when you've got this few number of people who are working.
> **Meta:** Right.
> **Participant 9:** You can't see it as a big program.
> **Meta:** Right.
> **Participant 9:** You can't see what the impact is of this profession.

Many participants mentioned that they feel that the tenets of midwifery, in terms of continuity of care, accessibility, and empowerment, are not as supported by the present

government as expected. This lack of support for the philosophy of midwifery meant that they were being evaluated inappropriately with no consideration of the extra prenatal and postpartum support they had been hired to offer:

> **Participant 6:** Another unfortunate situation is the way we keep track of our stats. So it's called Midwifery Implementation Statistics, MIS. And we write down our activities every month, or every day and then we document on their monthly sheet every phone call, every contact we've had directly with a client in her home or in a clinic or in a hospital...And we spend time doing that and then we discovered they're counting 'ticks'. One tick at a home visit or a client visit gets the same weight as a tick for a 28 hour labour in a hospital setting. Or a one hour visit if you take them to the hospital and give them a tour, you know.
> **Meta:** Yes.
> **Participant 6:** So it's not accurate. There are Manitoba Health employees who are more involved in what midwives do and then there's the bean counters, who aren't getting the picture because they are getting those kinds of statistics. So they aren't noticing for example, that teen mothers are keeping their babies and being responsible to breastfeed them with great success...And so it's the soft issues that don't get the proper weight in a statistical rating, right. It's very frustrating.

They also believe that at this level, their impact will only be felt in soft individual outcomes which are not being measured in any way:

> **Participant 3:** It's very hard to measure at this time all of the benefits of midwifery. It's difficult to actually measure the long term benefits of giving a particular woman a few extra hours of care, providing good nutritional counseling, teaching parenting skills, accessing rehab programs, supporting women to deal with situations of violence, encouraging breastfeeding, etc. I believe that in the case of breastfeeding there are some studies reporting on its long term benefits. But aside from breastfeeding, it is difficult to quantify hard tangible results of the extra care provided by midwives.

> **Participant 16:** I'd like to demonstrate the cost savings of the benefits of preventing one fetal alcohol syndrome, or one child battery case. It is very difficult and again it takes time. In order to show results such as that, a program like midwifery needs to be valued and supported. It is an investment that will reap results in the long-term.

Thus, a number of participants noted that while Manitoba has made a number of initiatives in offering care to higher needs clients, this work is not being measured, valued

or supported by the government which they find very frustrating. The lack of support for growing the program is also frustrating in light of the support and expansion of the midwifery programs in British Columbia, Quebec and Ontario (Participant 16). At the same time, the fact that midwifery is not funded in Alberta, and the decline of the profession in that province, acts as a warning to practitioners here about what could happen if government funding and support is not sustained:

> **Participant 6:** My dark side is that the bean counters don't see the big picture and look at those inaccurate stats and say 'this program isn't paying off and so we're cutting the funding.' And then we're in trouble. And there's no funding, there's no midwifery program, and women/families are not benefiting from midwifery care.
> **Meta:** Yes.
> **Participant 6:** I can't see it happening but there's sort of this, almost a threatening rumble.
> **Meta:** Yes.
> **Participant 6:** Your know, 'mind your Ps and Qs or we can just pull the funding.'

To many participants, it appears as if Manitoba Health and the Manitoba government have lost sight of many of the reasons why midwifery was implemented, and the perception of a number of participants seemed to be that they had moved from offering leadership to becoming the barrier blocking the growth of midwifery in Manitoba.

7.8 Summary

In only a few short years, Manitoba has clearly made substantial advances in the integration of midwifery into the health care system. Integration issues were at the forefront of the introduction of midwifery services in Manitoba, and following a great deal of work and negotiation, it appears that the integration initiatives developed in the province have been largely successful. The integration manuals and role documents created by the MIC's working groups, the extensive consultations and information

meetings with health professionals, and the RHA Midwifery Implementation Committees seem to have worked successfully to bring stakeholders together, open communication channels, and allow problem solving around integration to occur in a timely and more cooperative atmosphere. The employment funding model created a role for RHA administrators who appear to have been integral to smoothing the integration process both in the community and in the hospitals. Employment also meant that midwives worked more closely with other health professionals, and could put extensive time into integration efforts for the first few years without this affecting their income. The decision to make offering midwifery services voluntary by the RHAs has also worked to create successful models of the service for the other RHAs to replicate. An appropriate fee for midwifery consultations with physicians has improved relations with medicine, and the possibility for dual registration with the College of Midwives of Manitoba and the College of Registered Nurses of Manitoba (formerly the Manitoba Association of Registered Nurses) has enhanced mutual respect between these two professions. However, despite these accomplishments, participants discussed midwifery as if it were in a stall because there is not continued leadership from the provincial government for continued growth. This points to the important role that the support of government bodies played in implementing midwifery, and the central role they also have in determining its future. On the other hand, the appearance of a stall may partly be reflective of the incredible speed with which midwifery has moved in these first few years, and how quickly a strong foundation was developed for the continued growth of the profession. With this foundation of successful integration in place combined with a return of provincial support, midwifery should be able to grow easily in Manitoba.

Chapter Eight: Access to the Midwifery Profession

8.0 Introduction

This chapter looks at the processes through which regulating midwifery is creating midwives as a new professional group in Manitoba. Three attributes of this process will be explored. The first is the impact of the design of the initial assessment and upgrading on the training backgrounds, experiences and philosophies of the first group of midwives who have been able to register. In Manitoba, the emphasis which was placed on accessibility extended to strategies to try to make the assessment and upgrading as inclusive as possible for competent community midwives, nurse midwives, and immigrant midwives with direct entry training. Participants reflected on the outcomes of these strategies, and discussed the implications of both their successes and their failures on the further development of the profession. The second attribute which will be explored is the development of internal cohesion among the registered midwives. The historical development of this internal cohesion will illustrate both the strengthening aspects of inclusive principles, and the challenges operationalizing these principles create because of the greater differences that exist between the midwives. Finally, this chapter will look at the midwifery education initiatives which have been developed in Manitoba, the commitment to maintaining multiple routes of entry to midwifery which they signify, and the importance of supporting them for the future development of the profession.

8.1 Creating an Inclusive Assessment and Upgrading: Successes and Challenges

Manitoba did not just focus on improving access to midwifery services for clients, it also attempted to address equity issues in who could be assessed and register as a midwife. The form of the assessment determines the training backgrounds and

experience required of midwives to register, which then determines what models of midwifery will be available in the province. Addressing issues of equity and access for midwifery practitioners was one of the terms of reference of the Midwifery Implementation Council (MIC) (Scurfield 2002). Because of this goal, many participants noted that Manitoba developed a number of initiatives within the assessment and upgrading which were designed to make midwifery registration accessible to all Manitoba women found to be competent practitioners. However, participants also pointed out that some of these initiatives were not successful, and that making the profession more inclusive was more challenging than expected.

Equity principles for education programs, and therefore the assessment and upgrading program, were a high priority for the Midwifery Implementation Council, and an education equity document was first developed in the fall of 1996 and completed a year later (Midwifery Implementation Council 1996a; Garvie 2001). This equity policy stated that any program the College of Midwives of Manitoba (CMM) would approve would need to take tangible steps to prevent discrimination against historically oppressed groups, provide multiple locations, and reach out to cultural and visible minorities. It also stated that part of this outreach would have to include specific measures such as holding seats, having childcare available, offering language support, and diversity and equality training. The qualifying criteria for the program should also see a woman's diverse background as meritorious for entry, and it supported this based on a belief that a diverse midwifery profession would be more attractive to clients from diverse backgrounds (Garvie 2001). The MIC tried to create an assessment and upgrading program which was true to these principles, and they were partially successful.

A survey in the 1987 *Final Report of the Task Force on the Implementation of Midwifery in Ontario* determined that women with midwifery training in Ontario who were neither nurses nor practicing community midwifery made up the largest group of women in the province who wanted to practice midwifery, and had the greatest amount of experience. Nurses with midwifery training made up the second largest group of women interested in the profession. However, very few of the women from these training backgrounds ended up being allowed to practice midwifery in Ontario because of the requirement that applicants had to be actively practicing midwifery in the province in the years before regulation and had to have home birth experience. The MIC discovered that the breakdown of women with midwifery training was similar in Manitoba (Kaufert and Robinson 2004; Human Resource Strategy for Midwifery Implementation Committee 1998). When the MIC began meeting in the spring of 1995, they discussed the situation in Ontario and determined that they would try not to create the same situation here (MIC Minutes, 3 April 1995).

8.1.1 Strategies for a More Accessible Assessment and Upgrading Process

Towards this equity goal, the Education Committee first determined that the assessment would be competency based, which would mean it could accept women from any training background as long are they were found to have the required education and experience. This would also ensure that all of the registered midwives had surpassed a minimum level of skill and experience based on hands-on testing, rather than relying on their academic credentials alone. The form of competency based assessment chosen for Manitoba was the North American Registry of Midwives exams (NARM) (MIC Minutes, 19 October 1997). Part of the MIC investigation into the NARM exam was to look at

how accessible it would be to women from multiple educational and national backgrounds. It was determined that while the NARM was designed to assess the education of women received through multiple routes including apprenticeship training, it had very little experience with confirming the credentials of women trained outside of North America and would have to contract this out. On the other hand, the exams only required an eighth grade literacy level, aside from medical terminology, which would make it more accessible to women for whom English is a second language. The NARM was also a cheaper process than developing unique Manitoba exams, which would lower the cost of the process for candidates (MIC Minutes, 25 November 1996).

To determine the competencies that would be included in the model of practice, a two day process for developing the midwifery core competencies was held in early winter 1995 with 12 community and nurse midwives (Garvie 2001). A survey was also distributed to members of the Manitoba Traditional Midwives Collective and the Association of Manitoba Midwives (AMM) so that the midwives could identify which competencies they felt would need upgrading (MIC Minutes, 9 December 1996). The assessment and upgrading was then partly designed based on the information received from the midwives in these two organizations (Garvie 2001).

In the winter of 1997 following further consultations with the Manitoba Traditional Midwives Collective and the Association of Manitoba Midwives (MIC Minutes, 2 December 1996), the MIC determined that changes to the NARM entrance requirements were needed in Manitoba to increase access to the assessment and upgrading. With the decision to allow midwives to limit themselves to practicing in one birth location, women with experience only in hospital births would be registering.

While the NARM normally required documentation of ten out of hospital births to be eligible for their process, they agreed that they would assess women without home births for Manitoba. Manitoba also did not want to exclude midwives who had not practiced in the last five years as the NARM required. It was particularly important that currency not be required if the MIC wanted to include immigrant midwives, since their practice experience was often in their country of origin and many had immigrated more than five years ago. The NARM agreed to count enrollment in the Manitoba assessment and upgrading program as currency of practice (Kaufert and Robinson 2004). Candidates also had to document only three cases of offering continuity of care, which is much lower than other provinces. This was seen as an essential part of opening up the profession to women trained in models where midwifery care was fragmented, but the woman had all the necessary skills:

> **Participant 1:** ...Three continuity of care, it's not a lot. It might have been five, somewhere in that neighborhood. And if you go to some other provinces they were rigid, absolutely rigid. To the point where we had a woman come here to register because it was going to take her two years to register in B.C. This is a woman who had hundreds of births but needed 15 or 20 continuity of care for B.C. right? So she was having to work for nothing for another midwife. Because it's not like continuity of care you can get that overnight, right? You have to be there for the year it takes for the woman to go through it. So we certainly understand that it wasn't necessarily something that should cut people right out. We tried to find people for them to work with or get them a way to get that continuity of care if that's all they required. And there were some where that's all they required. Some with many, many births and lots of experience.

The MIC used equity principles as part of determining who they accepted into the assessment and upgrading. They tried to get an equitable representation of Aboriginal and immigrant midwives, and a balance between those trained in direct entry programs, and those who had trained in nursing first. A candidates' proficiency in another language

was valued. Seats were also given preferentially to women who stated they planned to practice in rural and northern communities (Garvie 2001). The assessment and upgrading was much shorter than the process in Ontario, and offered flexibly in both a longer and a compressed format to assist women who had employment responsibilities (Participant 2). Thus, the MIC worked to find a method of assessment which would be low cost for candidates, and would be accessible for women who were apprenticeship trained, trained in hospital, and who had trained and practiced in other countries.

8.1.1a Immigrant Women

With the focus on the two midwifery organizations, few immigrant women with midwifery training were consulted in the early midwifery consultations, but outreach to them gradually built over time, and many identified themselves to the MIC at public consultations after the passage of *The Midwifery Act* in 1997 (Garvie 2001). In the summer of 1997, the Education Committee then invited an immigrant midwife to join them and help with making sure that the assessment and upgrading program would be appropriate for the large number of women who had come forward with training and experience from the same country (MIC Minutes, 29 August 1997). By the spring of 1998, ¾ of the 30 women who attended a public meeting on the assessment and upgrading were identified as immigrant midwives (MIC Minutes, 9 June 1998). The Manitoba Health Human Resource Strategy for Midwifery Implementation Committee (1998) reported that women from Yugoslavia, the United Kingdom, East and West Africa, Central and South America, the Caribbean, China, the Philippines and other Southeast Asian countries had all expressed an interest in having their training recognized and registering as midwives. The Filipino community alone was identified as having 40-

50 potential registrants, and offered as an example of a larger immigrant population in Manitoba which, like others, could support culturally bilingual midwives.

With the decision to try to facilitate immigrant women entering the assessment and upgrading, there was a great deal of debate about English language requirements (MIC Minutes, 21 November 1995; 9 January 1996; 5 February 1996; 25 February 1997; 12 January 1997; 17 March 1997, 1 April 1997; 8 January 1998; 22 January 1998; 8 February 1998). While it was recognized that a certain level of proficiency in English is required to successfully complete the assessment and communicate with other health professionals and clients as part of midwifery practice, there was concern that all language testing must be midwifery specific. There was also a preference for including a program to upgrade the English language skills of applicants whose language proficiency was not sufficient, rather than using language as a gatekeeping mechanism to keep women out of the assessment and upgrading. In the winter of 1998, the MIC discovered that the Adult Language Skills Branch of the Department of Citizenship, Culture and Heritage developed profession-based language benchmarks. They also found that the Adult Language Skills Branch required that these benchmarks be combined with an English language upgrading program which they would also create (MIC Minutes, 10 March 1998). The MIC immediately began looking for funding to implement this program (MIC Minutes, 23 March 1998). The communications skills assessment began to be offered in the summer of 1998, and the *English for Midwives* language education program began to be offered in the winter of 1999 (MIC Minutes, 6 July 1998; 14 December 1998). All candidates were required to pay for and undergo the communications testing, but the language upgrading was offered free of cost to those

determined to need it (MIC Minutes, 20 April 1998; Garvie 2001). The *English for Midwives* program was well received and other provinces soon became interested in it (Transitional Council of the College of Midwives of Manitoba Minutes, 15 March 1999, Participant 13).

Another concern was that the NARM assessment was based on a North American training and practice model which would not be able to appropriately assess the competencies of women who trained and practiced in non-European countries. Strategies were therefore considered to make the assessment and upgrading better suited to this challenge (MIC Minutes, 22 April 1997). Plans for a midwife mentor to assist candidates through the assessment and upgrading process was first mentioned in the summer of 1997 (MIC Minutes, 16 June 1997). It was hoped that such a person could offer academic support, but also assistance with dealing with paperwork and bureaucracy. A non midwife mentor was hired for this role in time for the last run of the assessment and upgrading. This assistance was found to be quite beneficial by midwifery candidates surveyed following the assessment and upgrading (Garvie 2001).

8.1.2 Diversity in Midwifery

The results of these accessibility initiatives meant that 7 of the 39 successful midwives trained in non English speaking countries (Haworth-Brockman 2002). 11 of the first 26 registered midwives were not Canadian born, and 2 self identified as of Aboriginal descent. The training of the first 26 midwives was also diverse: 6 were trained in direct entry programs, 6 were trained as nurse midwives in Europe, 12 were trained in the community (of which two were also nurses), and 2 were trained in another

related health profession. None of the midwives who initially registered to actively practice in Manitoba had a university degree in midwifery (Scurfield 2002).

Many participants stated that this has meant that recently immigrant women are able to get midwifery care in their first language, which one participant noted is important to women from her country of origin because they appreciate having someone who can explain prenatal tests, which are often a foreign aspect of Canadian prenatal care. However, she also noted that she believes she can serve the needs of Canadian women equally well (Participant 21). Many participants appreciated the benefits which came from having a more diverse group of midwives practicing:

> **Participant 10:** I personally feel that diversity in the midwives' backgrounds is really a strength in our group.
> **Meta**: That's actually one of my questions, so please go ahead.
> **Participant 10:** Yes, yes. I think that because they come from different backgrounds, different countries, different perspectives, and training -
> **Meta**: Yes.
> **Participant 10:** that they all have something very unique to offer...And they can bring different perspectives, and different clients are looking for different things in a midwife.
> **Meta**: Yes.
> **Participant 10:** And so we have more ability to match, although we don't always because we have limited numbers of midwives. But if we have a client who is looking for a particular style we can try and match them up...

8.1.3 Challenges

Despite the best intentions of the MIC, many participants also noted the barriers some groups of women faced to entering the assessment and upgrading. They also discussed patterns in who was not able to successfully complete the assessment and upgrading. Many of these barriers were recognized by the MIC's *Education Equity Policy and Plan* (Garvie 2001), but the assessment and upgrading was not able to meet these principles because of time and economic constraints. This includes a lack of

financial assistance for candidates and a highly medicalized assessment and upgrading which was intimidating and foreign to women trained in more traditional midwifery models. Further, it was determined that for many immigrant midwives who had not practiced in many years, a more extensive refresher course was necessary.

As part of supporting their equity principles, the MIC looked into methods of financial assistance for candidates in the assessment and upgrading process. However, because the process was training in a profession not yet regulated and was not a full time program, candidates were not eligible for student loans, and other forms of financial assistance were not found (MIC Minutes, 9 June 1998; 15 March 1999). Without financial assistance, many women could not apply to the assessment and upgrading:

> **Participant 17:** ...Then we had a meeting and they said, you know, 'we're implementing it. This is what we are going to do.' So we put down our name. But there were so many requirements that some of us thought, 'oh I can't do it, it's too much.' It's always the money.
> **Meta**: Yes.
> **Participant 17:** It's always the money. The money is the barrier.
> **Meta**: Yes.
> **Participant 17:** You think to yourself, 'OK I have three young ones, three kids to raise, if I stop working for six months, six months is a lot of money to lose.'

The Education Committee also ideally wanted the assessment and upgrading offered through a community college, since they are generally perceived as more accessible than universities (Participants 1 and 14), but the assessment ended up being at one of the tertiary teaching hospitals. This is probably the most medical location in the province, and the upgrading modules were developed and taught primarily by nurses and physicians which participants noted made some students feel intimidated, inappropriately evaluated, and did not respect the differences between midwifery, nursing and medicine. In focus groups with both successful and unsuccessful candidates from the assessment

and upgrading, the general feeling expressed was that the assessment and upgrading was too medicalized and did not adequately reflect the midwifery model. The literature used was also often medical rather than midwifery literature, and the instructors could not always answer midwifery specific questions (Garvie 2001; Participant 17). The module on hospital birth was also given more emphasis that the home birth module, and thus some community and immigrant midwives felt that their experience and knowledge was not recognized (Garvie 2001).

This medical perspective partly reflects the location where the assessment and upgrading was held, but it also indicates the general sense that the upgrading components were for the community midwives who needed enhanced education about medical care, and not the nurse midwives (Participant 11). A letter sent out to potential midwives in late 1996 for determining areas of upgrading only included options for clinical skills, except for herbology, and once the upgrading was running most modules were on medical skills (MIC Minutes, 9 December 1996; June 1997). Some participants noted that while the women with nursing training had little trouble with the medicalized upgrading, it did not really prepare them for practicing, and once practicing, many have had trouble adjusting to midwifery practice:

> **Participant 1:** ...But the nurse midwives had different gaps...what is it like to do continuity of care? What is in like to be on call? Taking on responsibility as a primary care provider. That was something that many of the nurses had never done...And plus the nurse midwives needed more information about alternative kinds of therapies. You know, like homeopathic remedies, herbs and stuff...

8.1.3a Immigrant Women

However, it is immigrant midwives which have been identified as having the most difficulty with the assessment and upgrading. In fact, despite the intentions of the MIC,

none of the first midwives to practice were midwives trained in a non-European country (although physicians from non-European countries were successful) (Garvie 2001).

> **Participant 16:** Unfortunately the loss from that whole process was midwives from the immigrant community.
> **Meta**: Yes.
> **Participant 16:** All of those women who initially went through the assessment and upgrade program with the exception of one, I think, were not successful. That really spoke to the complexity of what we were trying to do. To be inclusive of both direct entry midwives and nurse midwives was tricky enough, but to be able to create some process that would integrate the immigrant midwifery community and have them have the same standard of knowledge, and practice in the same model was just too complex at the time. It was a very big disappointment. I think a lot of people silently went away realizing that they would have to wait until another time.

> **Participant 19:** ...It was harder for immigrant midwives. In fact I don't know if any of them did get through and get registered.
> **Meta**: Right.
> **Participant 19:** That was a real shame because I really, really enjoyed their input into the classes. They had a lot of home birth experience... So yes, that was too bad. I mean Manitoba tried to be very inclusive.

One factor is that during the early consultations with midwives which defined the competencies of the profession, the practice guidelines, and the legislation, immigrant midwives had not yet been reached, and did not participate (Participant 17). Thus, the MIC knew the least about the immigrant midwives' training, skills and philosophy as a group and what upgrading they needed (Kaufert and Robinson 2004).

Many of these women also had not practiced for a number of years and the decision to not have currency of practice requirements for the assessment was done primarily for them (Kaufert and Robinson 2004). However, many of the women also knew that they needed some sort of refresher course. Many immigrant midwives talked to members of the MIC about possibilities for apprenticing with a practicing midwife or other health professional to refresh their skills, get recent experience and/or increase their

birth numbers. No organized system of doing this was available, so it was the responsibility of the woman to find her own way to refresh her skills which required personal contacts with other providers or the money to travel to other countries (MIC Minutes, 15 December 1997; 22 January 1998). Community and nurse midwives also recognized their need for a refresher or greater education for themselves prior to the assessment and upgrading, and many took university courses, worked with physician colleagues (Participant 5) or traveled internationally to work in midwifery training programs:

> **Participant 14:**...Some of them went and trained with other midwives if they were missing a couple of births.
> **Meta**: Right.
> **Participant 14:**Or if they were missing a whole piece they went down to a clinic in [the United States]. A lot of people took partial courses and so on.
> **Meta**: Yes.
> **Participant 14:**It was up to midwives to gather that experience and present it in order to get through. That's how they did it. But it wasn't easy.

Not being able to finance or organize this personal refresher hindered many women from taking part in the assessment or successfully passing it. The fact that so many midwives needed a refresher or further training seems to indicate that not requiring current experience without offering a refresher for women who have not practiced in many years may not increase accessibility as much as expected. Many participants discussed the benefits of offering a more extensive upgrading and refresher program which might yet tap into a large number of midwives trained in significantly different models of midwifery (Garvie 2001; Participant 17):

> **Participant 2:** ...Ideally a refresher program where a woman could spend much more time side-by-side with somebody who has already registered would give her a chance to become more familiar with our system, and the midwife to really assess whether this person has a decent set of knowledge or happens to be book savvy.

> **Participant 3:** ...What we really need is a really good refresher course that enables all midwives, no matter where they are trained, to become registered in Manitoba. Such a refresher program within a formal education program might enable more midwives living in Manitoba to become registered and available for work.

The evaluation of the assessment and upgrading further identified that the process had difficulty with validating international credentials which often took longer than expected and caused significant problems for candidates. It was also noted that as mature students, often educated in quite distinct educational models, many of the immigrant candidates also required more support to assist in developing Canadian education study skills and becoming familiar with Canadian teaching styles such as self directed learning and multiple choice tests (Garvie 2001):

> In (Her Country of Origin), education is taught in different formats, modules were an alien form of teaching. Further, knowledge is tested in different formats. Some of the testing appeared to unnecessarily focus on testing English language skills, such as multiple choice **(Participant 17)**.

> **Participant 1:** ...Even issues around -- issues in the upgrading program around, being able to ask for help. There are some communities where you don't say you don't understand. You know, or you never say no. If somebody asks, 'do you understand that?', you always say yes. Even if you don't understand it. It became very challenging to meet their needs. And/or to get them to buy into the Manitoba model. So that they could work within it. Many of them were very experienced midwives where they came from, with hundreds of births.

Finally, despite the positive response to the *English for Midwives* program, many immigrant midwives were not able to pass the assessment because of language barriers:

> **Meta**: Yes. Did the assessment, I know that looking at the other provinces Manitoba seems to have done some things to try to make the assessment more open to people from a number of different training backgrounds...
> **Participant 11:** I don't think they were very successful. There were certain groups even though they tried didn't work, and that has a lot to do with language.
> **Meta**: Yes.

> **Participant 11:** And maybe not enough realization that the language support would need to be in place sooner rather than later.

Feedback from registrants was reported as indicating that rather than spreading resources thin by testing all of the candidates in English, resources might have been used better by targeting language training for those most in need (Garvie 2001).

8.2 Midwives and Internal Cohesion

Despite these challenges, the first group of midwives registered in Manitoba were still quite a diverse group, including women who had trained in midwifery programs from across the world, as well as some who trained in other complimentary professions such as medicine and nursing. These women also came from separate midwifery organizations in Manitoba which had supported different ideas about how midwifery should be practiced. The journey towards unifying into a cohesive profession thus occurred slowly as the processes of implementation and integration unfolded, and it was not without its setbacks. This section will detail the historical development of midwifery cohesion in Manitoba, and some of the factors which both facilitated and hindered this process.

Midwifery implementation in Manitoba began with the groups of different midwives fairly polarized. The midwives practicing as nurses were in one organization, community midwives were in another, and direct entry trained midwives from non-European countries were unorganized and largely unaware of the midwifery implementation process starting in the country (Kaufert and Robinson 2004). The Manitoba Traditional Midwives Collective, and the Nurse Midwives Association of Manitoba (NMAM) were formed in the 1980s entirely separate from each other and with little contact between them (Participant 16; Scurfield 2002). The first formal contact between these two groups was during the development of the Manitoba Advisory

Committee on the Status of Women report (1987) *Midwifery,* which brought together representatives from nurse midwifery and community midwifery. This report also recommended a model of midwifery which could act as a compromise between the models of the two groups. However, the 1990-1992 inquest into the intrapartum death of a second twin transported to hospital from a home birth polarized emotions about home birth in the province (Conner 1992; Grant 1993), and worked to divide the two midwifery associations. The midwifery report of the College of Physicians and Surgeons of Manitoba (CPSM) and the Manitoba Association of Registered Nurses (MARN) (1991) recommended nurse midwifery without any consultation with the community midwives organization. This report created further divisions between the two groups (Participant 11).

Steps to end this divisiveness were made during the tenure of the Manitoba Working Group on Midwifery which acted as a forum to bring nurse midwives and community midwives together. An important symbolic step in this move towards unity was when the Nurse Midwives Association of Manitoba chose to change its name to the Association of Manitoba Midwives as part of becoming more accepting of direct entry midwifery (Kaufert and Robinson 2004). The vote for the name change was unanimous within the nurse midwives organization (Driedger 1993).

When the MIC began meeting in 1995, both midwifery groups went into the process with some amount of trepidation. Community midwives were always a small minority on the Working Group and on the MIC, and were concerned that their model would be over-run by the more medical model of the other stakeholder groups. Nurse midwives were concerned seeing what was happening in other Canadian provinces that

they might be left out of the new profession altogether (Kaufert and Robinson 2004). However, the MIC appears to have worked hard to bring the midwives together and to foster respect for all of their practice models and training. Participants noted that one of the breakthroughs in trust and unity between the two organizations was the consensus model of the MIC (Participant 1). As well, the process for developing the midwifery core competencies was perceived by multiple participants as a moment which brought the community and nurse midwives closer together (Garvie 2001; Participant 11).

The MIC continued to work towards uniting the profession into a single whole. They consulted with both midwifery organizations, and brought direct entry trained midwives from non-European countries into the process (Kaufert and Robinson 2004). The consultations with women of Aboriginal decent were also an attempt to bring women practicing traditional Aboriginal midwifery into the profession (Garvie 2001). It was within this inclusive atmosphere that the midwives came together to form the Manitoba Association of Midwives (MAM) (MIC Minutes, 17 November 1997). The bylaws were written together by members of the Manitoba Traditional Midwives Collective, the Association of Manitoba Midwives, and the newly formed Filipino Association of Midwives in the spring of 1998 (MIC Minutes, 23 March 1998). Their first Annual General Meeting was in the fall of 1998 and held at the offices of the Manitoba Association of Registered Nurses (MIC Minutes, 21 September 1998).

With unity continuing to build between the midwives, the assessment and upgrading process which ran from 1999-2001 strengthened this as the midwives from different organizations worked together, learned from each other, and found that their

competencies, philosophy of practice, and model of practice overlapped more than they expected:

> **Participant 18:** Right, you're talking about us going through the upgrade and assessment? It was really good. There were a lot of dynamics in that too.
> **Meta**: Yes.
> **Participant 18:** Some of the nurse midwives had not met with or had much to do with the lay midwives.
> **Meta**: Right. Yes.
> **Participant 18:** I think once the midwives started sharing there views it made people realize that there are more similarities than differences. I thought it was really good, the sharing of points. And I think it really helped to bind us in the sense that we were all heading in the same direction. We all wanted to practice as midwives, we wanted to do it legally, and wanted to do it collectively.

> **Participant 6:** There was a sense of camaraderie that was happening among the women in there. We were welcoming women who were new to Canada or new to midwifery in Canada. Women with midwifery training from [Asian Country] and one woman from [European Country 1]. Some women did their training in [European Country 2]. There was a mesh happening, the traditional midwives were learning more of the clinical skills that we hadn't been allowed to do in the past, and the medical midwives were learning more of the traditional midwives art. (Laughter). So it was a nice feel of 'let's be open and honest and learn from each other'.

However, as the assessment continued and non-European trained immigrant midwives systematically failed to be eligible to register, they were excluded completely from the new profession and this growing area of unity lost:

> **Participant 17:** I hope I can call the midwives, 'let's make a noise this 2004. And say here we are, we are midwives, what do you want us to do? Help us.' They don't, they stay quiet.
> **Meta**: Yes.
> **Participant 17:** They're very quiet now…Yes. Practicing midwives. But you know. That's one thing. The practicing midwives, they should also always make noise. 'OK, those midwives who are not registered yes, come, let's work together. Let's see what we can do for you, as our sisters in our profession.'
> **Meta**: Yes.
> **Participant 17:** 'If you can help us, let's help you. If you are not registered, okay. Be a part of it too, come and join'...You don't open arms? Just because now you're registered? Don't forget they are your sisters in your profession.

Even among the midwives who were able to register, almost all of these steps towards unification started to disintegrate when Manitoba Health decided that midwifery would only be funded through one funding mechanism which they wanted to be employment. The split within MAM on whether or not to accept this funding model followed the old nurse/community midwife divide, with nurses who were used to working as employees in hospital comfortable with the employment model, and community midwives more worried about autonomy issues with an employee model, and supportive of a contract funding model. While MAM initially tried to reach consensus on this issue, internal conflict began to be unmanageable in the fall of 1999, and consensus proved impossible even with the introduction of trained facilitators in the spring of 2000. Ultimately this issue came to a vote in April 2000. The vote was very close but favoured the employment model which was subsequently accepted (Anonymous 2000). Many participants spoke of how divisive this vote was within the midwifery community, and mentioned hard feelings which have yet to completely heal:

> **Participant 18:** ...There was a lot of controversy when MAM negotiated the very first contract.
> **Meta**: Right.
> **Participant 18:** There was a lot of unhappiness about our negotiations.
> **Meta**: Within the midwives, among the midwives, too, right?
> **Participant 18:** Yes. There was a lot of animosity because people had been paid privately when working as a lay midwife. So these midwives did not want a salary like the nurse midwives did.
> **Meta**: Right.
> **Participant 18:** They wanted to be self-employed. And people who were salaried wanted it to be salary.
>
> **Meta**: I was asking you about the issues around the employment model...
> **Participant 6:** Yes. It was quite hostile. Lots of people had their own ideas about how it was going to be.
> **Meta**: Yes.

Participant 6: Like integration hadn't happened yet. Integration of the midwives let alone integration with the other professions…So the vote actually was 14 to 15 for the employment model.
Meta: Oh God.
Participant 6: And there was one woman who came to the voting meeting who hardly ever came to previous meetings whose vote made the difference. Otherwise it would have been a tie, and there would have been more negotiation…

Further, once this funding model was settled on and the midwives began to practice, the tension within the profession grew as community midwives found many of their autonomy concerns about employment coming true, while nurse midwives generally had a much easier experience of integration than their community trained peers. Many participants noted that midwives without a nursing background were scrutinized much more closely, especially those who practiced pre-regulation, than the midwives with a nursing background (Participant 23):

Participant 11: …But I think we were, and even now I think we are watched a little more closely.
Meta: Yes. I wondered that. Whether, particularly because you were so public before and people knew who, sort of, the lay midwives were, whether that kind of followed you, how long that followed you in terms of being watched.
Participant 11: Well I think it still does…I know there's been scrambling going on about wondering what I'm doing and people checking the regulations, checking that I'm practicing within the guidelines.
Meta: So highly scrutinized.
Participant 11: Yes.

Participant 10: And I think because of that, there was some resentment between, you know, the midwives with different backgrounds.
Meta: Right.
Participant 10: Because you know what, 'why do they just accept you?' It was because the midwife had been working as a nurse in the hospital for 15 years or whatever.
Meta: Yes.
Participant 10: They know her or trust her already. Even in the other hospitals, 'oh, she has been working as a nurse at that hospital. So she must be okay.'
Meta: Right. So – I have heard some of that.

Participant 10: So it was not really valid, but understandable, because you trust what you can understand.

However, despite their easier integration, it was also noted that a large number of dually registered nurse midwives have chosen to go back to nursing:

Participant 19: ...One of the things I've seen as an evolution, that I've found quite interesting, is that a lot of the nurse midwives when we were doing the negotiations with MAM, I think there's only one that's practicing.
Meta: People have said that.
Participant 19: They were so passionate about what should be done and how it should be done, and that this is the best for midwives and they're not even working as midwives now. You know so that I found quite interesting. Maybe it was the on-call thing.

Participant 5: It's interesting to see, I don't know if you're pursuing this or not, but what happened with them [nurses with midwifery training] in terms of working as midwives, too.
Meta: Yes.
Participant 5: It's kind of come and gone. Many of them.
Meta: Oh really?
Participant 5: Yes. They had some significant issues.
Meta: You mean in terms of practicing and choosing not to practice?
Participant 5: Yes. For various reasons.

The primary reasons participants gave for women choosing to go back to nursing were not liking the amount of on call time midwifery required, and the fact that they could make the same salary without the on call time as nurses:

Participant 18: It is only now that people are complaining that they get a straight salary, but they're realizing that that salary is not going as far as they thought. I would make almost the same money if I had stayed in my previous job and I would be off call a great deal more.
Meta: Yes.
Participant 18: I had hardly any call, in my previous job compared to now.

Participant 16: I think the call issue was very important, and having a predictable life.
Meta: Yes.
Participant 16: And whereas midwives, community midwives in the past were used to doing that, they built their lives around being available when women needed them. That was the essence of their model of care.

It appears that the salary was not set at a level such that it compensates for the greater responsibility and commitment midwifery requires compared to nursing in a hospital shift. Initially, the plan was that the midwifery salary would be set in between the income level of registered nurses and family practitioners (Human Resource Strategy for Midwifery Implementation Committee 1998). However, once implemented, the higher nursing salary levels were used to set the salary for midwives instead (Manitoba Hansard, 31 July 2000). Nurses may be less likely to consider the profession if they are going to earn an equivalent salary but have to work longer hours and take on more responsibility. It should remembered that as nurse midwives, many of the nurses who went into registered midwifery were well educated and experienced, and compensated for this accordingly in nursing in terms of remuneration at the higher salary levels. With dual registration possible in nursing and midwifery, registered nurses had the chance to try out midwifery and return to nursing if they did not like it.

For the midwives who have chosen to continue practicing, a few participants noted that while it has not been easy, being forced to work with differently trained midwives and having this work out successfully has greatly enhanced cohesion within the profession:

> **Participant 6:** It was an especially good step because we had to work together. We weren't independent practitioners all over. Now we were 'the midwives' and we worked in teams of midwives. And the teams were not always our choice, it was who was available.
> **Meta**: Right.
> **Participant 6:** So there were some people that maybe would have chosen a different partner but because they got paired up with this partner, it set up a whole new area for communication and integration amongst ourselves.
> **Meta**: Really? That's an interesting point.
> **Participant 6:** Yes, because now we had to work together. And now we had to try really hard at understanding each other. You know, coming from two different philosophies and styles of practice and we were trying to mesh. And

> so 'I want to do things my way but I'll listen to why you do things your way', and 'let's find a happy medium', or 'let's agree to be different on some points'.

Some participants also noted that now that the midwives have all practiced within the same model for a few years, they have become united in their practice of Manitoba midwifery:

> **Meta**: But you see it sort of getting more cohesive? In terms of what is midwifery in Manitoba?
> **Participant 9:** Yes, yes. Because the people that are coming from different professions, that are coming from everywhere, from obstetricians to nurse midwives, to apprenticeship based training.
> **Meta**: Right, right.
> **Participant 9:** And varying lengths of involvement with that.
> **Meta**: Right.
> **Participant 9:** But we've all now been working for, you know, two or three or four years as midwives in Manitoba.
> **Meta**: Right.
> **Participant 9:** This is becoming our experience now and I think that's moving people away from their differences and their backgrounds.

Thus, it is clear that this developing unity has come from a combination of: key events which have brought the midwives together, a reduction in the amount of variation among the midwives because of who was able to attend and pass the assessment and upgrading and who was not, and self selection as those midwives who are not comfortable with the model have chosen to stop practicing. However, many participants noted that unity within the profession is not yet complete, but that a unifying education program which created midwives who are neither community nor nurse midwives could end this lingering divisiveness.

8.3 Midwifery Education Available

The future of the midwifery profession in Manitoba lies in an education program. Reports of the Working Group and the MIC expected that midwives would attend 50% of

normal births in the province, which would require approximately 150 midwives (Haworth-Brockman 2002; Human Resource Strategy for Midwifery Implementation Committee 1998). Relying on midwives educated in other countries and other provinces will never allow the number of midwives to reach a sustainable level which is at a scale to be cost effective, available to women throughout the province regardless of their area of residence, and can meet demand. A local midwifery education program can also foster unity within the profession, and give it greater legitimacy with other health professionals. On the other hand, multiple educational routes in the province may not as easily foster this cohesion, but it will continue the commitment to access to the profession by increasing Manitoba women's options in how they want to train in midwifery.

With the successful implementation of the new profession, all of the RHA managers spoke of the need for more midwives in their regions and the difficulties they are having recruiting for open positions with no new midwives being trained in the province (Participant 23; participant 12):

> **Participant 10:** And it comes down to human resources. What we really need is an education program, which I'm sure you have heard again and again. And again.
> **Meta**: Yes.
> **Participant 10:** I have empty positions and I can't fill them. And I'm trying to recruit across the country.
> **Meta**: Right.
> **Participant 10:** And that's really frustrating because we have lots of work for midwives.
> **Meta**: Right.
> **Participant 10:** We really have lots of great opportunities in this region for the midwives to come to start working with us. And it's a vicious circle: we can't get funding for more positions if we can't fill them.

While many early reports indicated that a public education campaign would be necessary for women to accept midwifery care and for demand to grow, it has been noted that

demand grew across the province faster than expected (Haworth-Brockman 2002). Midwives in many regions found a warm welcome from consumers without an extensive public education campaign (Friesen 2001; Thiessen 2001).

Many participants also expressed concern that the number of practicing midwives in Manitoba is already starting to drop. Most of the initial midwives were registered after having already practiced in their profession for many years, and are older and closer to retirement age than graduates from a formal education program would be. As a profession made up entirely of women in Manitoba, midwifery also has to address practitioners going in and out of practice because of family responsibilities and maternity leave without this putting practice groups in jeopardy. Without an education program, real fear was expressed by participants about the future of the profession in Manitoba. The fact that a profession is desired by consumers, cost effective and meets service needs does not guarantee that it will remain funded and grow. The decline in the nurse practitioner profession is clear evidence of this (Angus and Bourgeault 1999). Many participants expressed concern that the time to start an education program is now, before the number of midwives deceases further, leaving fewer to act as clinical preceptors.

The commitment of the members of the MIC and the registered midwives to an education program can be seen in the number of education initiatives which they have worked on. A baccalaureate midwifery program has been developed and approved but has not yet been funded to start. A process for recognizing the competency of women trained in other jurisdictions, the Prior Learning and Experience Assessment (PLEA), has been run three times. Guidelines for approving independent studies and mentorship programs in midwifery (MEPA) is about to start, and as discussed earlier, a proposal for

an Aboriginal Midwifery Education Program (AMEP) is in the beginning stages (College of Midwives of Manitoba 2004c). In light of the need for more midwives, the option of buying midwifery program seats in other provinces or offering midwifery education from other provinces here through distance education with local preceptors has also been explored.

8.3.1 A Baccalaureate Education Program

As each consecutive report came out recommending midwifery in Manitoba, they also similarly advocated for a formal training program (Manitoba Advisory Council on the Status of Women 1987; College of Physicians and Surgeons of Manitoba and Manitoba Association of Registered Nurses 1991; Manitoba Government 1993). Members of the MIC Education Committee and the education professionals they worked with put a great deal of effort into developing an accessible, rigourous and culturally appropriate baccalaureate midwifery program. It now sits ready and waiting for funding (Haworth-Brockman 2002). The work that went into negotiating and developing this program are extensive. The first issue which had to be addressed was how the midwifery program would intersect with nursing education. The Working Group considered many options for integrating nursing and midwifery training (Working Group 1992b). While some supported a model of nurse midwifery, it was agreed that the majority of those on the Working Group saw midwifery as an independent profession which should have direct entry training and be taught primarily by midwives. Support for this model was greatly enhanced when Ontario chose to start a direct entry baccalaureate of midwifery training program. In their final report, the Working Group recommended a direct entry baccalaureate midwifery education program, because they thought it was most

appropriate for an autonomous professional, would allow reciprocity with other provinces, and could include refresher and challenge mechanisms (Manitoba Government 1993).

Further support for a baccalaureate midwifery education program came from a paper on the cost effectiveness of midwifery commissioned by Manitoba Health (Kilthei 1993). This paper pointed out that a three year direct entry midwifery education program was the most cost effective way for the province to train maternity care providers. Since the province pays the majority of the costs of post secondary education, a three year midwifery program is much cheaper than a seven year medical program, especially since the majority of family physicians and increasingly obstetricians/gynecologists are not likely to actually practice obstetrics. Further, nurse midwives are also less likely to practice midwifery since they have other practice options within nursing.

Developing a baccalaureate midwifery education program was one of the top priories of the Education Committee of the MIC. They held joint discussions in 1995 with the other provinces in the process of regulating midwifery to learn more about the education programs they were developing and whether a western consortium, as there is for veterinary science, could be developed (MIC Minutes, 28 May 1995). However, Alberta was the farthest ahead on this in 1995, with a baccalaureate midwifery program already developed and approved. When the Albertan government chose not to fund their education program along with not funding midwifery (James and Bourgeault 2004), plans for the western consortium appear to have fallen apart.

The Education Committee then looked at the possibility of offering the program jointly between a community college and a university as is done in Ontario, which would

offer the theoretical strength of the university with the increased access initiatives of a community college (MIC Minutes, 9 January 1996). By the summer of 1996, the Education Committee had put together a proposed 3 year intensive baccalaureate program which would be an independent school of midwifery within another faculty, and would accept 20 students a year. It was hoped that it would be graduating students at the same time as the initial assessment and upgrading so that baccalaureate trained midwives would always be the majority in the province (Midwifery Implementation Council 1996b). The Education Committee and the MIC held numerous meetings with community colleges and the Faculty of Nursing at the University of Manitoba about this program, and the institutions were investigating developing and offering it (MIC Minutes, 12 August 1996; 30 September 1996; 21 April 1997; 29 April 1997; 22 May 1997; 16 June 1997). These meetings continued until the fall of 1997, when it became clear that the community colleges would not be able to play a part in offering the program, and the plan was discarded (MIC Minutes, 27 October 1997).

However, six months later the Faculty of Nursing expressed an interest to the MIC in putting together a proposal for a freestanding School of Midwifery on its own (MIC Minutes, 11 May 1998). That summer a member of the MIC was contracted to write a proposal for the program which was completed the following fall, and gained the support of the Council of the Faculty of Nursing and the MIC (MIC Minutes, 9 June 1998; 19 October 1998; Transitional Council of the College of Midwives of Manitoba Minutes, 18 January 1999). In the spring of 1999 the proposal went to the Council of Post Secondary Education (COPSE) for approval. By the summer of 2000, everything was in place, and the proposal was approved by COPSE, the Transitional Council of the

College of Midwives of Manitoba, and the University of Manitoba. Further, a community college had been brought back in to collaborate and make the program more accessible. The curriculum was based on Ontario, all of the course work for the program was laid out, and only three new courses needed to be created exclusively for midwifery. The program also had a challenge component, such that candidates could be assessed for competency and eligibility to register at any point in the program. Collaboration with other health professionals was expected to create enough clinical placements for the 20 students expected each year (Faculty of Nursing, University of Manitoba 2000). Student interest in the program was and remains high. The College of Midwives of Manitoba (2003i) states that the program is ready and awaiting funding. In the meantime, they keep a list of interested students:

> **Participant 18:** We do have actually a four-year degree program. That's been ready to run, but of course we don't have the finances to run it. That becomes another problem.
> **Meta**: Yes.
> **Participant 18:** We have people who are really keen. They love the idea of being a midwife but we don't have any access for them to get into the system at the moment. That's the hard part.

Almost all participants stated that it was important to get this program funded and running as soon as possible. Many participants also noted that it was the lack of a long term plan for how the midwifery service was expected to develop which was hindering the initiation of this baccalaureate program:

> **Participant 13:** Historically the Education Committee of the Transitional Council was working on the baccalaureate program with the high hopes that it would receive funding because the *Act* passed, so you know, the program would be. But through years of meeting with the Department of Advanced Education and Manitoba Health, to me it synthesized down to how could you rationalize funding for an entire baccalaureate program when there does not seem to be a long-range plan for midwifery written down anywhere. So do you mount a program for three students? Or ten students?, or… and because

> the number of jobs is capped by Manitoba Health, it's not like there are a hundred vacancies in Manitoba to come and work...We haven't been able to say in 2004-2005, there's going to be 15 new midwifery positions in Manitoba and in 2005-2006 there's going to be another 15. So it's kind of this circular thing.

Without funding to start this program, the College of Midwives of Manitoba has looked at other ways of attaining more practicing midwives for the province.

8.3.2 The Prior Learning and Experience Assessment (PLEA)

Without an education program of its own, at present the only way for Manitoba to gain more midwives is to assess and register women with midwifery training from other jurisdictions through the Prior Learning and Experience Assessment. The PLEA also allows women who have trained through apprenticeship in Manitoba to register because it focuses on assessing whether the midwife is competent in areas of midwifery care rather than determining eligibility based on credentials (College of Midwives of Manitoba 2004b). Maintaining an assessment process was seen as particularly important for allowing international recruitment in the north, which has been the primary strategy for hiring health care professionals in these communities (Human Resource Strategy for Midwifery Implementation Committee 1998). It was also a process which would be important to support midwifery having multiple routes of entry (College of Midwives of Manitoba 2004b). In the winter of 1999, Manitoba Health commissioned research on methods of foreign credentialing and assessment. The recommendation of the report was for Manitoba to develop its own assessment process (Mathae 1999).

The PLEA model introduced in Manitoba in 2003 follows the PLEA model which had already been developed in Ontario and then replicated in British Columbia (Participant 24). The PLEA uses trained assessors from the CMM, who first determine if

the woman applying has the appropriate education and experience. Training in all aspects of the scope of practice in Manitoba is required because the PLEA process has no upgrading capabilities. The PLEA process then begins with 4 written exams taken over 2 days followed by two days of objective clinical structured exams (OCSEs). If she successfully passes these exams, the candidate is eligible for registration following a four day orientation program. She will then be required to practice under supervision for six months to one year. The process costs $3500 paid in stages as the stages are passed. While the process is seen as long and expensive for women with midwifery training coming to the province, it is also seen as necessary to protect the Manitoba public (College of Midwives of Manitoba 2004b).

The first round of PLEA was held in the winter of 2003 and had two candidates. Both were successful and are now practicing in rural Manitoba (College of Midwives of Manitoba 2004a). The second run of the PLEA in 2003 had seven candidates, of which six were successful, although 2 were done for the Northwest Territories. The third run of the PLEA in 2004 had 3 candidates (College of Midwives of Manitoba 2004c). A fourth round of PLEA is scheduled for 2005 (College of Midwives of Manitoba 2005). As the only present source of new midwives in the province, the PLEA is critical to the growth of the profession, but without an upgrading component, and in a province without a great deal of immigration, it is unrealistic to expect that an assessment process alone can fill the current and future need for midwives in Manitoba (Participant 24).

A midwifery reciprocity agreement signed between all of the provinces with regulated midwifery in 2001 does mean that midwives who are registered in other provinces do not have to go through the PLEA to register in Manitoba (College of

Midwives of British Columbia *et al* 2001). As the midwifery training programs in other provinces become more open to women from other provinces, this reciprocity agreement may become more important for recruiting midwives to this province. Participants noted that a few midwives have already registered in Manitoba through this agreement (Participant 24).

8.3.3 The Midwifery Education Programs Approval (MEPA) Process

One educational route is about to become available in Manitoba. The Midwifery Education Programs Approval (MEPA) process allows the College to approve midwifery education programs for eligibility to register, whether those programs are institution based, self study, or a mentorship with a midwife. This approval process respects and facilitates multiple routes of entry to the profession in Manitoba (College of Midwives of Manitoba 2003i). The desire to protect the apprenticeship education model in midwifery was first mentioned in discussion in the MIC in 1995 (MIC Minutes, 5 March 1995), but put aside while the Education Committee worked on the formal baccalaureate program and the assessment and upgrading. The idea of an apprenticeship program for the north and rural areas was supported by the Manitoba Health Human Resource Strategy for Midwifery Implementation Committee (1998) in their report as a supplement to a baccalaureate program.

In the winter of 1999, a committee of the Transitional Council of the College of Midwives of Manitoba was formed to work on developing a process which could approve all different types of midwifery education programs (Transitional Council of the College of Midwives of Manitoba Minutes, 15 February 1999), and the first guidelines were developed in the spring of 1999 (Transitional Council of the College of Midwives of

Manitoba Minutes, 19 April 1999). This document offered guidelines for approving midwifery education programs that are institution based, an apprenticeship program within a midwifery practice, or an independent study with a midwife mentor (College of Midwives of Manitoba 2000). Programs of self study with a midwife mentor would also require the candidate to complete the PLEA to be eligible to register (College of Midwives of Manitoba 2003i). Thus, the project had to be put on hold while the PLEA process was completed because the two needed to be congruent (College of Midwives of Manitoba 2004a). The CMM began working on the MEPA documents again in 2003 once the PLEA was up and running, and it was in the process of being finalized in the summer of 2004 (College of Midwives of Manitoba 2004c).

The commitment of the CMM to preserving multiple routes of entry brought back some tensions within midwifery, since the form of training, whether apprenticeship or formal, had been one of the issues identified that made it difficult for the community and nurse midwives to unite in the province. One participant opposed the approval of mentorship education programs because it creates too private a teaching relationship between the mentor/midwife and the student, such that regulation of education standards is forced to be based on the honour system. There would also be less theoretical training and less chances to benefit from learning from the perspectives of multiple midwives and other health professionals (Participant 22). Others were not sure how someone would be respected who had come through an independent study as opposed to having baccalaureate training:

> **Participant 16:** There are more opportunities for people in Manitoba, we have preserved that route for people who want to put together a program themselves.
> **Meta**: Right.

> **Participant 16:** So we have honored that, and it is now incorporated as an important principle. But will graduates of this process be viewed the same as somebody who went to a university in Ontario? Probably not.

Many participants were supportive of the MEPA process though, because it could be community based and allow midwives to train students in their Regional Health Authorities (RHAs) rather than requiring them to all come to a central institution (Participants 13 and 6). With very recent approval of the MEPA at the time of writing, it is not clear what form the midwifery education programs approved through it will take, nor how many students will be able to enroll in these programs.

8.3.4 Buying Seats in Out-of-Province Programs

Another option which was mentioned by participants was that Manitoba could buy seats in the midwifery education programs in other provinces, with the midwives in Manitoba approved as clinical preceptors (Participant 13). This would be at a lower cost to the province, and less of a burden to the midwives in the province because they would not have to come out of active practice to teach in a formal program:

> **Participant 24:** One option might be to "buy seats" in Canadian midwifery education programs. Perhaps an arrangement could be made with those programs to allow some Manitoba students to be accepted with the understanding that their clinical preceptors would be Manitoba midwives practicing here. That might be a strategy that could assist Manitoba women who are aspiring midwives. However, I would see that as only a temporary measure until Manitoba has its own program. I doubt that either Ontario or BC would have much room to accept students from out-of-province. There has been a lot of cooperation and collaboration amongst the provinces as regulated midwifery has been implemented – perhaps this is another area where we can help each other.

The idea of buying seats was first mentioned by the Working Group (Manitoba Government 1993). A Manitoba Health paper costing the education of midwives also recognized that the most cost effective strategy would be to buy seats in other provinces

since it reduces capital and start up costs. The report noted that Manitoba Health already has inter-provincial training agreements with British Columbia, Alberta and Ontario for other specialties (Anonymous 1996). Buying seats in another province was also the recommendation of the Saskatchewan Midwifery Advisory Committee (1996) report on midwifery as the most cost efficient way to fund midwifery education. The Saskatchewan report further recommends attempting to offer midwifery training through distance education from another province. When the MIC looked into this in the fall of 1996 it was not an option because there was only the one program in Ontario and it had a three year waiting list (MIC Minutes, 10 June 1996). However, there are now three provinces with baccalaureate programs increasing the possibility of buying seats in another province.

8.4 Summary

In this chapter, facets of the development of midwifery as a new professional group in Manitoba have been explored. The impact of the changes made to the initial assessment and upgrading process to make it more inclusive and thus to make the first group of registered midwives more diverse were discussed. The assessment and upgrading appears to have been successfully able to recognize the training of both community and nurse midwives, as well as women trained through some other routes through the use of a competency based assessment process, and entrance requirements which did not require that experience be current, gained in a particular model of midwifery practice, or have occurred in Manitoba. As well, Manitoba was the first province to create a midwifery specific English language test and an English language upgrading program for candidates. However, many participants noted that even with

these supports in place, language barriers, financial barriers, the need for a more extensive introduction to midwifery in Canada, and cultural/medical biases in the assessment and upgrading combined to unevenly exclude immigrant women. Despite these challenges, the many successful accessibility initiatives in the assessment and upgrading did mean that the first group of midwives registered in Manitoba were fairly diverse. Combined with the inclusive atmosphere created by the MIC, this was gradually developing into professional unity until differences in the integration experience split the midwives along old lines. For those who remained practicing past this point, internal cohesion appears to be strengthening again as the midwives work together within the profession. Implementing a baccalaureate midwifery education program would work to further foster unity within the profession, but the lack of provincial support for such a program has led the midwives to work towards other education and assessment options. These include a competency based assessment and a process for approving local self study/midwifery mentorship programs. These other programs may work to extend the province's commitment to professional inclusiveness into the future, but will likely also extend the challenges which come with that goal.

Chapter Nine: Conclusions

9.0 Introduction

This chapter will summarize the dissertation by providing an overview of the research objectives and design, and offering a synopsis of the initiatives in midwifery services that were implemented in Manitoba. This will be followed by an holistic evaluation of these features which brings together the insights gleaned from looking at the Manitoba experience through the lens of each research topic. This discussion will concentrate on the initiatives which were a part of trying to create a more inclusive midwifery profession, and on the implications of funding the midwives as salaried employees of the Regional Health Authorities (RHAs). Recommendations will be provided about these initiatives for other provinces considering the implementation of midwifery. This will be followed by a discussion of potential strategies for the future development of the midwifery profession in Manitoba. While these sections will attempt to be pragmatic in their recommendations, a reflection on how this study can contribute to our understanding of some of the theoretical and conceptual constructs which guided this project will also be done. The chapter will conclude with a consideration of the significance of the research project, its limitations, and suggestions for future research.

9.1 Research Problem

This project looked at the case of midwifery implementation in Manitoba, the factors which shaped its development, and how it has continued to evolve during its integration into the health care system. It looked in depth at how four topics central to the implementation of midwifery care were dealt with in Manitoba: 1) how the midwifery model of care was implemented and has worked out in practice; 2) what was done to

facilitate access to the midwifery service by clients; 3) how midwifery was integrated into the existing health care system; and 4) how access to registering as a midwife in the province was regulated. The three objectives of this project were first, to describe how the issues within these four topics were defined and negotiated. Second, based on a review of documentary sources, to describe how agreement on these issues was translated into the regulatory framework and the structure of midwifery care. Finally, to describe how these issues are now seen by members of different stakeholder groups including what they see as having worked well, as partly successful or in need of major revision.

9.2 Research Approach

A critical, feminist theoretical methodology guided this study. Critical theory involves recognizing inequities in society and attempting to use the research project as a tool for social change (Thomas 1993). As a feminist project, this study views the repression of midwifery and the medicalization of birth as forms of sexism which the midwifery movement tries to address (Ulin *et al* 2002). Feminist research can be limited by a one sided view of women as only oppressed though, when many of the women who implemented midwifery in Manitoba more closely resemble elites in society. Thus, a research methodology for studying elites was used (Kezar 2003). To understand the midwifery movement as both a feminist movement and an example of the way elite power shapes the social world, an interlocking methodology of power was employed. This approach recognizes that individuals can be both subordinate and dominant, and that systems of oppression rely on and strengthen each other (Nestel 2000).

This research project used a qualitative, case study design. It combined documentary data from reports, position papers, newsletters, provincial hansards, and

minutes of the Midwifery Implementation Council (MIC) meetings with data from open ended interviews with 26 participants who had been involved with the midwifery implementation and integration processes. These participants were selected to represent 5 stakeholder groups: midwives, women as maternity care consumers, other health care providers, government representatives, and individuals who had been a part of the midwifery implementation and regulatory bodies. Subgroups within these 5 stakeholder groups were identified and participants were selected to ensure that all of the subgroups were represented. The data from this project was analyzed using content analysis. The ethics of the project was assured by following University of Manitoba Health Research Ethics Board guidelines for informed consent, keeping the identities of all participants anonymous, and using reflexivity to outline the way the biases and values of the researcher affected the project.

9.3 Conceptual Framework

The history of midwifery in Canada was reviewed to discuss how the health care system was historically able to develop without a role for midwives, to identify the many movements to get midwifery recognized in this country, and to highlight some of the factors which have influenced the more recent developments towards regulating midwifery. From this review, it became possible to conceptually divide the midwives now interested in practicing into four groups: Aboriginal women, nurse midwives, community midwives and immigrant midwives (Kaufert and Robinson 2004; Carroll and Benoit 2004; Nestel 1997). The concept of medical dominance was then used to explain the historical trajectory of the Canadian health care system where physicians have had almost total control over the system, and used this power to exclude other health

occupations such as midwifery. The concept of a decline in medical dominance was utilized to explain why the Canadian health care system has recently become more receptive to creating a role for midwives. Finally, the concept of biomedicalization was employed to tie this decline in medical dominance in Canada to larger structural and philosophical shifts in Western health care systems around the world (Clarke *et al* 2003). It was argued that the theory of a decline in medical dominance combined with the concept of biomedicalization offers a cohesive framework for understanding how the new focus on rationalizing costs, risk populations, and customizing care creates seemingly paradoxical support for growth in both new complex medical technologies and more autonomous non physician health care providers such as midwives.

9.4 Manitoba Initiatives: Midwifery Implementation in Manitoba

As the fifth province to implement midwifery, the midwifery implementation process in Manitoba was influenced by the decisions made by the provinces which came before it, but it also followed its own unique trajectory. While the model of practice is roughly identical to the earlier provinces, the initial assessment and upgrading program used in Manitoba attempted to be more inclusive so that competent midwives from a wider variety of training backgrounds could register. Manitoba also did not make an exemption for Aboriginal midwives in their midwifery legislation. Instead they attempted to include Aboriginal midwifery within the provincial regulatory structure through a *Standing Committee on Issues Related to Midwifery Care for Aboriginal Women* at the College of Midwives of Manitoba (CMM). Once midwives began practicing, the provincial government chose to fund them as employees of the Regional Health Authorities rather than finance the program directly. This was done to facilitate a

better geographical distribution of the midwives, introduce access initiatives for midwifery clients, and to put a greater focus on integrating the midwifery service into the existing health care system. The present status of midwifery in Manitoba is also influenced by the fact that there is currently no midwifery education program, there is a cap on the number of funded midwifery positions in the province, and there is presently no plan for increasing the number of positions. The following three sections will review the implications of these decisions, and suggest recommendations both for other provinces considering implementing midwifery, and the province of Manitoba as it moves forward in the development of the midwifery profession.

9.5 The Midwives: Creating an Inclusive Profession

The emphasis which was placed on trying to create a midwifery profession which was accessible to all competent midwives in the province distinguishes Manitoba from earlier provinces which focused on midwives from certain philosophical and practice model backgrounds. This was done both as part of trying to create an equitable professional structure, and as a way to include within the regulated service many of the different care options which different groups of Manitoba women wanted and needed. The diversity of the midwives who are currently practicing in Manitoba reflects the success of these efforts, but the patterns in who has not been able to practice reveals the difficulties of realizing this goal as it faced different challenges during the implementation, assessment and registration, and initial practice phases.

The Midwifery Implementation Council was initially formulated to have members who were familiar with a number of different midwifery models. This representativeness assisted the MIC in addressing the issues of many different groups of

midwives, consumers, and other health professions, but it was limited by the fact that some members were paid a stipend while others were not. This meant that members representing certain stakeholder groups differentially participated in the process based on the amount of volunteer time they had to offer. Concerns were raised by MIC members that certain viewpoints, experiences, and midwifery models were not as well represented as others because of this. In future it is recommended that midwifery implementation bodies continue to try to represent all of the stakeholder groups who will be affected by midwifery regulation, but that they also value all of the members' contributions by paying them a stipend.

As part of its commitment to inclusiveness, the MIC also made a concerted effort to reach out to and hear from Aboriginal, Métis and First Nations women and communities throughout the province, and tried to incorporate their ideas and needs into the developing profession. These consultations with Aboriginal women and community representatives fostered trust and openness, and were done with enough time to formulate a way for Aboriginal midwifery developments to be incorporated into regulated midwifery. The *Standing Committee on Issues Related to Midwifery Care for Aboriginal Women* (now referred to as Kagike Danikobidan) distinguishes Manitoba as a strategy for including the revitalization of midwifery traditions in Aboriginal communities within regulated midwifery. The presence of this committee is a testament to the work of the MIC and its Equity and Access Committee to create confidence that the midwifery profession would strive to prioritize the issues of Aboriginal, First Nations and Métis communities and hear their voices.

In the provinces where this bridging work did not occur, Aboriginal midwifery services and education program projects outside of the midwifery legislation tie the midwives to the pilot projects and communities they are trained in without credentials that are recognized to move between provinces and programs. This may create real barriers in the future as more Aboriginal midwives are trained in these programs and wish to expand their practice options. On the other hand, there are real risks to incorporating the Aboriginal midwifery movement into the provincial profession, particularly in terms of losing control over the direction of developments, and becoming a token consultative body. From the Aboriginal consultations of the MIC it is clear that the idea of the Kagike Danikobidan Standing Committee included identification that it needed to have the funding, support and participation which would allow it to identify and drive its own agenda. At present, two meetings a year does not allow work on a self directed agenda, and real results from the participation of Aboriginal women is important at this stage to make the inclusion of the Aboriginal midwifery revitalization movement meaningful.

The Aboriginal Midwifery Education Program (AMEP) creates the tangible results that the midwifery profession needs to be pursuing to honour the spirit in which Kagike Danikobidan was created. It is an Aboriginal midwifery training program which follows the desires of many Aboriginal women consulted by the MIC to combine Western and Aboriginal knowledge and skills. It will be community based and aimed at producing practitioners for northern communities (which many participants noted have been mostly left out of the midwifery service at present), and graduates of the program will be able to register with the province of Manitoba and therefore practice throughout most of the country. AMEP has the potential to be an innovative way to address provider

shortages in the north, and dissatisfaction with the maternal evacuation policy. The development of the AMEP combined with the presence of the Kagike Danikobidan Standing Committee suggest that meaningful inclusion of Aboriginal women and midwifery traditions in regulated midwifery is possible. Other provinces and territories may want to conduct their own consultations to determine how Aboriginal issues in midwifery could appropriately be incorporated into the profession in their jurisdiction.

The MIC also consulted widely with organized midwifery and consumer groups, and tried to reach out and hear from individual women about the midwifery models they were familiar with or desired. The two most organized groups were supporters of the community and the nurse midwifery models, and they initially played the largest roles in shaping the developing profession. There was also attempts to reach out to women who had trained and practiced midwifery internationally, but were peripheral to the Canadian health care system and the midwifery organizations. These women were largely unorganized which made them more difficult to reach early on in the process, but the MIC became increasingly successful throughout its tenure. Based on what was learned from these consultations, the MIC tried to limit the barriers to the assessment and upgrading which could turn away competent midwives unnecessarily.

The assessment and upgrading used a competency based process which could accept for consideration candidates regardless of how they got their training, whether it was vocational, baccalaureate, graduate or self study/apprenticeship. It also accepted candidates who received their training in other health professions, such as medicine or nursing. By not requiring any practice experience in Manitoba or in the previous five years, the assessment and upgrading became open to midwives who had only practiced in

other jurisdictions. Following the creation of the birth place exemption, which allowed midwives who registered in the first three years to limit their practices to one birth location (in or out of hospital), candidates were not required to have out of hospital birth experience to apply to the assessment and upgrading. The birth place exemption was put in place based on nurse midwives concerns about having to offer home birth services. The MIC also limited the requirements for continuity of care experience to open up the assessment and upgrading program and registration process to midwives who had gained their skills in more fragmented practice models. The Midwifery Implementation Council had a communications testing and language upgrading program developed solely for midwifery, the *English for Midwives* program. Over time this program began to include teaching Canadian study and test taking skills, and was supplemented by a mentor position who aided candidates with study skills, time management, and dealing with the bureaucratic aspects of the process. These supports were put in place for candidates who had the necessary midwifery skills and experience, but needed some assistance upgrading their English, becoming familiar with Canadian evaluation styles, and working within Canadian bureaucratic systems. These initiatives appear to have increased access to the assessment and upgrading process for midwives who had practiced in the community, had trained and practiced in direct entry models in other countries, and had trained in midwifery as a specialization of nursing.

The assessment and upgrading program also accepted candidates wanting to practice in rural and northern regions on a priority basis to try to improve the geographic distribution of the midwives once they began practicing. This support for rural and northern candidates appears to be key to having midwifery practices outside of Winnipeg

because the health regions which had resident midwives wanting to be hired were more likely to start a midwifery program after proclamation than those which did not. To further support this goal of having midwifery practices in rural and northern areas, recognition of the greater difficulties rural and northern women have for participating in the assessment and upgrading is also important. While a distance component for the assessment and upgrading would be ideal (though difficult to organize and execute), some recognition in the form of financial support for rural and northern candidates might have allowed more candidates from these areas to travel to the urban centre for the assessment and upgrading. Billeting, childcare, lost wages and time away from family for up to a year can more than double the cost of the assessment and upgrading for rural and northern women.

Financial barriers are also an issue for low income women regardless of their location of residence. For midwives trained in direct entry programs in other countries who could neither practice here as nurses nor as community midwives, the employment options available to them were often low paid and marginal, and women in this situation may be particularly unable to enter the assessment and upgrading because of financial barriers. The MIC tried to find a form of financial assistance for candidates of the assessment and upgrading in Manitoba, but were unsuccessful. Creating a method of financial assistance is recommended as an important facet of facilitating access to the assessment and upgrading program by competent immigrant midwives with direct entry midwifery training.

Like the entrance requirements, the content of the assessment and upgrading was also influenced by the MIC consultations with the midwifery organizations. The

assessment and upgrading primarily focused on enhancing the candidate's medical skills and familiarity with the healthcare system, two issues which community midwives identified as their greatest weakness. It also used the NARM exam, which is an American community midwifery assessment process. Because of these considerations, competent community midwives were not identified as having difficulty with the assessment and upgrading. Since the assessment and upgrading was in a large teaching hospital, offered training in clinical skills, and was largely taught by physicians and nurses, the process was not intimidating for candidates who had worked within the health care system either. These candidates appear to have had little trouble entering and successfully completing the assessment and upgrading program.

However, a pattern of women who had not practiced in Canada either as community midwives or as nurses having greater difficulty with the assessment and upgrading did emerge. This points to the need for some changes to the assessment and upgrading process to assist candidates from this group with completing it successfully. Many participants identified that what may have been helpful was a refresher program for midwives who had not practiced in many years and who needed an opportunity to become more familiar with the Canadian health care system and the Canadian midwifery model. The fact that so many community and nurse midwives also sought refresher or upgrading experience before entering the assessment and upgrading indicates that by separating this from the official process, this refresher component was basically privatized. A woman's ability to get refresher experience became reliant on her ability to travel to another country, or her personal connections with community midwives, family physicians or obstetricians to meet this need. Cutting this component out of the

assessment and upgrading to make it shorter and cheaper for participants may not therefore be the best way to facilitate registering the greatest numbers of competent midwives. Instead, a separate organized refresher program before the assessment and upgrading might have increased the success of all candidates, but particularly women who had only practiced in other jurisdictions or who had not practiced midwifery or a related profession in many years.

Retaining this focus on inclusiveness is also important after the midwives begin practicing. Despite the variation in the midwives training and experience, participants described the initial integration experience as having challenges for all registered midwives. Midwives who had practiced in the community faced challenges because many were unfamiliar both with working as employees within a large healthcare bureaucracy, and with the protocols and policies of the health care system. The decline in their autonomy from practicing unregulated to practicing within the much more tightly proscribed boundaries of an employment model was very challenging. The steep learning curve which they were on to learn about and integrate with the hospitals, community clinics and other health professionals was exacerbated by the fact that other health care providers and administrators often treated them with greater suspicion and hostility than some of their midwifery colleagues. While these issues represent huge challenges for practicing community midwives, the employment funding model has reduced the differences in their practices from mainstream healthcare providers, and given them added legitimacy through their close association with the Regional Health Authorities and Manitoba Health which worked to ease their integration. At the same

time, they have still been able to provide care which closely resembles the philosophy and model they were trained in.

Midwives who have practiced as nurses on the other hand, faced few difficulties integrating into the health care system since they were already largely familiar with its protocols and settings and were more welcomed by other health professionals who were more familiar with their training and approach. The employment funding structure was also a closer match to how they had worked before. Nurse midwives were more challenged however, in offering the model of care, particularly the on call time that is required to offer continuity of care when the midwifery practices are small, and the amount of time each midwife is on call is extensive. Many nurse midwives in Manitoba have also been wary of midwifery training from non formal programs, and participating in a regulated midwifery profession without a formal midwifery education program may not be comfortable for many of them.

The primary issue for both groups of midwives appears to be burnout from the high stress and long hours which these women have faced during this initial integration period. The difference is that in response to these practice issues, midwives who practiced in the community have few other employment options, and are more likely to work for change within regulated midwifery, while midwives who are dually registered in nursing have another viable career option in nursing. This option looks more appealing because the midwifery salary was set commensurate with the upper levels of the nursing pay scale, such that it does not compensate for the added responsibility, overtime, commitment, and flexibility that midwifery requires in comparison to working nursing shifts. For this reason, and certainly many individual ones as well, participants

described a pattern of nurse midwives registering, practicing, and then choosing not to practice. What we see with Manitoba's attempt to incorporate nurse midwives into regulated midwifery is that dual registration allows nurses to get recognition for their extra training and expertise as midwives, but if the pay schedule is equivalent, only those women who have a philosophical commitment or a very flexible lifestyle will choose to practice as midwives rather than as registered nurses. It is thus recommended that the midwifery salary should be set between that of nursing and general practitioners to compensate for the extra responsibilities, longer hours and increased commitment of midwifery compared to nursing.

9.5.1 Recommendations

The following recommendations are for provinces which are considering implementing midwifery services or currently in the process of implementing the midwifery profession:

1. A representative midwifery implementation body is recommended as an important part of creating an equitable midwifery profession. It is also important that all of the members' contributions are valued by paying them a stipend.
2. The extensive consultations with Aboriginal, Métis and First Nations women and communities, the formation of the Kagike Danikobidan Standing Committee at the College of Midwives of Manitoba, and the development of the Aboriginal Midwifery Education Program (AMEP) indicate that meaningful inclusion of Aboriginal women and midwifery traditions in regulated midwifery is possible. Other provinces and territories implementing midwifery may want to conduct a similar process to

determine how Aboriginal issues in midwifery could be incorporated into the profession in their jurisdiction.

3. Entrance to the assessment and upgrading process used to evaluate midwifery candidates can be made accessible to midwives from many training and practice backgrounds by: i) using a competency based process which recognizes training received through many educational routes; ii) recognizing experience gained in any jurisdiction; iii) not requiring that experience be current; iv) recognizing experience in both community and hospital based models, and not requiring that the initial midwives attend births out of hospital. The *English for Midwives* program developed in Manitoba to upgrade candidates' English, combined with supports to familiarize candidates with Canadian study skills and evaluation styles, can also improve equitable entrance to the assessment and upgrading.
4. A form of student loan targeted for candidates from rural and northern communities to assist them in entering the assessment and upgrading could increase the number of midwives available to practice in northern and rural communities. These student loans should also be available to low income candidates.
5. While not needed by all candidates, a separate organized refresher program before the assessment and upgrading may increase the success of candidates who have only practiced in other jurisdictions and who have not practiced midwifery or a related profession for many years.
6. Once practicing, midwives who are also registered as nurses are more likely to return to nursing if the salary is not set at a level which compensates for the extra responsibilities, longer hours, and increased commitment of midwifery. It is

recommended that the salary for midwifery should be set between that of nursing and general practitioners.

9.6 The Health Care System: Employment and Integration

While the assessment and upgrading worked to ensure that all of the midwives were safe and competent health care providers, the inclusiveness of it meant that they came from a wide range of backgrounds. This would have led to a diversity of midwifery practice styles were it not for the standardizing effects of the employment funding model. While multiple funding options would have followed the inclusive and accommodating values of the MIC, it is possible that if there were two funding mechanisms instead of one, the majority of community midwives might have chosen contract funding while the nurse midwives chose employment. This seems likely because of the way the vote to accept employment funding appears to have split between nurse and community midwives. This could have increased the differences in the integration experiences of the midwives and exacerbated long-standing tensions within the profession, rather than fostering unity as employment appears to have done because midwives from diverse backgrounds had to learn to work together.

The benefits for integration of the RHA employment model combined with a designated midwifery budget from Manitoba Health are also reasons for choosing employment as the sole funding mechanism. The benefits of having the midwives as Regional Health Authority employees rather than paid directly by the province is that the Regional Health Authority can coordinate integration of midwifery services with all aspects of the health care system in that region. This includes hospitals, other health professionals, emergency medical personnel, pharmacists, public health, and diagnostic

services. This support and close association with the RHAs from employment also gives added legitimacy to these integration initiatives, which the midwives would otherwise have to organize on their own. As employees, the RHAs can also have some control over the midwives' practice locations. Having the midwives' practices located in community clinics as they are in Winnipeg means that they are co-located with other healthcare providers. This facilitates growing familiarity between the professions, and the development of relationships with other health care providers outside of consultations and transfers. However, RHA employment runs the risk of leading to no midwives being hired by RHAs if they must pay for the service out of their global budgets while the costs of physician services are covered by the province. It also runs the risk of different RHAs hiring midwives to perform different deliverables, limiting their scope of practice or altering the model of care. These problems with RHA employment can be overcome if the provincial health organization creates a funding mechanism for midwifery services which requires the RHAs to offer the full model of practice in exchange for financing as was done in Manitoba.

Creating this distinct fund for midwifery services which RHAs could access as long as they meet certain program requirements can also be used to require that all RHAs implement initiatives to improve access to the program. Manitoba Health created a priority populations policy which requires that RHAs work to ensure that 50% of their midwives' clients come from identified disadvantaged groups. This policy has led to an association of these populations with midwifery which is important so that other professionals who may have first contact with women from these groups will now refer clients to midwives. It has also influenced the midwives' behavior in terms of who they

accept first as clients. Finally, it has influenced the RHAs, especially the decision of the Winnipeg RHA to locate the midwives' practices in inner city community clinics which are a common point of first contact with the health care system for pregnant women from the identified priority groups. These actions appear to have increased the diversity of midwifery clients in Manitoba. Without these efforts, midwifery would remain a service which would only be found by those who are well informed about their childbirth options and willing to put extra energy into seeking out a midwife.

Targeting positions for rural and northern regions also works to improve geographic access, and the employment funding model was identified as important for the initial development of practices in these less populated regions. However, regional employment can also work against improving geographic access when midwifery services are not in every health region, and women in large parts of the province are left without access to the service. Therefore, to support geographic access, regional employment must be combined with a commitment to have midwives in all RHAs. Before there are enough midwives to make this possible, a flexible practice system needs to be implemented which allows midwives to cross RHA boundaries, or makes their practices responsible for multiple regions even if it is the women who continue to have to travel.

Manitoba Health also made the development of Midwifery Implementation Committees a requirement of funding, and assisted the RHAs with developing these committees. The Midwifery Implementation Committees were made up of RHA managers, physicians, nurses, consumers, midwives, public health, community clinic and hospital representatives. These committees created a forum for open communication

between stakeholder groups to identify and address integration issues in a cooperative atmosphere. Committee members also organized education and orientation events which smoothed the introduction of midwifery services.

These integration efforts of the Midwifery Implementation Committees partly reflect the fact that employment created a close association between the midwifery program and the RHAs which were then more committed to making the program work. This is particularly true because of the province's decision that the RHAs could voluntarily choose whether or not to offer midwifery services. The decision to make this voluntary appears to have worked in terms of improving RHAs' commitment to integration, and it also appears to have worked in terms of these RHAs creating successful midwifery programs which the other RHAs now want to replicate. The diversity of the professionals on the Midwifery Implementation Committees also meant that the midwives could be aided in the integration process by people, especially the RHA manager in charge of the program, who were familiar and respected within the existing health care system.

9.6.1 Recommendations

The following recommendations are for provinces which are considering implementing midwifery services or currently in the process of implementing the midwifery profession:

7. When implementing a midwifery service, one funding mechanism should be chosen for the program to foster unity within the profession, rather than exacerbate professional divisions. The regional employment model combined with a designated

provincial midwifery budget is recommended because it offers benefits for integration while maintaining the model of practice.

8. The priority populations policy instituted as a funding requirement by Manitoba Health is recommended because it offers tangible results for increased access to midwifery services by pregnant women who are socio-economically disadvantaged.
9. Midwifery services should be targeted for rural and remote regions to reduce geographic barriers to the profession and reduce provider shortages in these areas. However, regional employment can initially limit geographic access before all RHAs are offering the service. Therefore, a system of geographic targeting should also include protocols to allow midwives and consumers to cross RHA boundaries during early implementation, and a long term strategy for working towards having midwifery services available in all RHAs.
10. Midwifery Implementation Committees in each Regional Health Authority improve midwifery integration into the health care system and should be replicated. Allowing RHAs to initially implement the midwifery services voluntarily eases integration because the RHA is more committed to assisting the growth of the program. Together, these efforts increase the likelihood of creating successful midwifery models which other RHAs then become interested in offering.

9.7 Conclusion: Potential Strategies for the Future

The employment funding model used in Manitoba created a certain level of standardization in the midwives' practices. This standardization is a facet both of the successful integration process which is happening, and the internal cohesion which is growing within the diverse midwifery profession. This standardization has costs though,

and led to some restrictions on the midwives' practices and their autonomy. The initial focus on improving integration and involving stakeholders from many professions means that administrators and other health care providers have been closely scrutinizing the midwives' practices, both in terms of the care they offer their clients, and the way they use their time and their budgets. This has been difficult for the midwives because they are constantly being evaluated by non midwifery standards. Budget decisions for administrative and practical support, travel and equipment have also been out of their hands in many regions. They have not had control over who they practiced with, or where they practiced in some RHAs. While this standardization of the midwifery practices appears to have played a part in the successful initial integration stage, this level of scrutiny and control of an autonomous primary caregiver becomes less appropriate as the profession matures, and should be addressed as the profession grows. Many participants recommended that in the near future, the midwives should be given more flexibility in how they offer the service:

> **Participant 19:** But I think a lot of the midwives now are starting to get more interested in being able to practice in different ways and in different groups. Moving around, doing locums, things like that. And I think that, you know, eventually the midwives will probably try to expand what's possible for their practice…I think we have a pretty standardized midwifery practice right now here in Manitoba… The other thing that I always felt was very key was that midwives were able to set up a practice, you know, in a creative way. The way that they wanted to. They set up their own practices.
> **Meta:** Yes.
> **Participant 19:** That hasn't happened. And I think that if we did that, we would see some really neat stuff…I mean can you imagine it if a couple of midwives got together and decided, 'hey why don't we do this in a mall'. 'Why don't we do this on the edge of Reserve land. We can help all the women'. You know, like so much would be possible that's not getting moved on…So I think in that sense the employment model is holding people back.

Movement towards this added flexibility can already be seen in Winnipeg where the management of the midwives' practices is moving from the RHA to the community clinics. This may allow the clinics to be more responsive to the midwives' practice needs in terms of equipment and support, and may also allow the midwives to move between community clinics more easily to better match the philosophies of the clinics and their midwifery colleagues.

This added flexibility also needs to include some system of making it possible for midwives to work with non midwife second attendants in the community. This is so that midwives in rural and northern areas can attend out of hospital births when there is only one midwife in the region. It is also important for offering continuity of care so that when there is less than four midwives in a region, they can spread their on call time between them in a more sustainable way. These midwifery second attendants would also be important in Winnipeg so that the midwives could come closer to meeting the greater demand for midwifery services in the city. It could also be seen as a possible alternative for Regional Health Authorities which presently want to expand their midwifery services, but cannot recruit any more midwives because of the cap on positions. It is now possible for these midwifery second attendants to be registered nurses and emergency medical services personnel when they are on their own time. However, allowing the CMM to regulate midwifery second attendants who do not belong to a health profession as the College of Midwives of British Columbia do in their *Policy for Second Birth Attendants* (College of Midwives of British Columbia 1998) could increase the options available for this position. An individual trained in emergency medical services could also be hired by an RHA to primarily offer midwifery second attendant services.

The movement towards greater flexibility for midwifery practices should also consider some form of extending the well woman care scope beyond the reproductive year in rural and northern areas. In these areas, there is often a shortage of health care providers, which means that midwives being able to offer more well woman care may be the difference for many women between getting routine gynecological care and foregoing it. The possibilities of expanding the scope of practice for northern and rural practitioners through dual registration with registered nursing has also yet to be explored.

Based on the benefits of the employment funding model for integration with both other health professionals and health care administration, it is recommended that this added flexibility be sought within the current employment funding structure. In the current climate of political and bureaucratic management of the health care system, the close association with the health care administration which comes from employment may be important to remain a political priority and retain funding. The employment funding model has also created accessibility initiatives, including targeting midwifery positions in rural and northern locations, placing the midwives' practices in community clinics in lower income neighbourhoods in Winnipeg, and creating requirements about prioritizing disadvantaged women for care. These appear to have created tangible results which might not otherwise have been possible, and thus have successfully laid down a foundation of accessibility such that as the program grows, it will continue to expand serving a diverse client population.

Many participants discussed how if the midwifery practices were given more flexibility, there were other models they were interested in exploring to make the practices more accessible to clients (Participants 12 and 18):

> **Participant 1:** ...We don't have enough midwives from various cultural groups. We have like one of this and one of this and one of that. You really need a couple and they need to be working together (because often what happens is they have been working in separate call groups) to be able to actually offer service, say in a women's language. I think too, now that there has been some experience, there needs to be a look at what are some of the other things we can do, a look at different models of delivering care. Some of [the midwives] have been looking at trying different things. Like at [Clinic 1] midwives have started coming to Teen Clinic and see teens who drop in who are pregnant. Not necessarily consistently or taking them on but just when they're there, trying to catch them. With teenagers that's what you often have to do. They're not great at keeping appointments. But I think we've been looking at things like group appointments, some of the other more creative models of care. I think it would be an interesting time to have a look at that from a midwifery point of view. What can we do that would attract these people and would build in more support groups for them. Because for women, if you are socially isolated, to have prenatal group appointments is a really good way to build support groups, for instance.

It is essential though, that as the profession expands and becomes more flexible, it retains and supports these access initiatives to protect the service from being characterized as an extravagant add on used only by elites. The high costs of implementing a new profession become more worthwhile and politically beneficial when these costs are going towards addressing some of the challenges faced by the maternity care system, as well as incorporating skills and values which are beneficial to the pregnancy, birthing and early parenting experiences of all women.

Added flexibility in the midwives' practices would be best combined with the standardizing influence of a baccalaureate midwifery education program which would ensure a certain level of similarity in the midwives' model of practice and philosophy. A baccalaureate program would also take integration with other health professionals to the next level by fostering cross training between midwifery, nursing, and medicine to familiarize students with the facets of all three professions before they begin practicing. It would give the profession added legitimacy in the eyes of other health professionals

who see baccalaureate training as the standard for health care providers. A baccalaureate education program would also enhance professional unity within midwifery, and break down some of the current biases and resentments which exist between midwives because of their different training backgrounds. The need for a baccalaureate midwifery education program was unanimously identified by all participants. It is absolutely necessary to produce enough midwives to grow the program so that it is accessible to all Manitoba women throughout the province and in all Winnipeg neighbourhoods.

The current lack of such a program frustrates any plans of expanding the number of midwifery positions, especially because there are currently unfilled midwifery positions available. At present, support for education programs developed through the Midwifery Education Programs Approval (MEPA) process, and the Aboriginal Midwifery Education Program is essential to produce more midwives. It is unlikely that either MEPA or AMEP will produce a large number of midwives in the near future though. However, a gradual increase at the moment is still important to produce the midwives needed to sustain current numbers in the profession, fill all of the available positions, and gradually create a pool of midwifery applicants in the province who could make expansion of the program a possibility. The other way to produce this necessary pool of applicants would be for the province to buy seats in midwifery education programs in other provinces, while registering the practicing midwives in Manitoba as preceptors so that students could do their hands on training in this province. Having more midwives available in the province to practice would appear to be the only way to break the current circular argument that a baccalaureate education program is not

warranted if more midwifery positions are not going to be created, but more positions are not warranted if there are not enough midwives to fill the current available positions:

> **Meta:** So looking forward from this stall, what do you see as the future -- ?
> **Participant 2:** An education program. A series of education programs.
> **Meta:** As the most essential part of moving forward?
> **Participant 2:** I would think so. I think that would answer a lot of our difficulties and public education would come from that. Then there would be a desire by Regional Health Authorities to hire midwives because there would be a pool of applicants from which to draw. So I think it's just the sheer shortages which are our greatest stumbling block right now.
>
> **Participant 10:** We have to look at sustainability right now. To help and support our midwives so that they can continue to practice over the long term and so that we don't just burn them out.
> **Meta:** Yes.
> **Participant 10:** So I think that midwifery will continue and will be very successful in Manitoba, but it needs to grow. It depends a lot on a midwifery education program and also on our ability to recruit midwives.
> **Meta:** Yes.
> **Participant 10:** If I could say to Manitoba Health, 'There are this many midwives who are willing to and want to come and work with us and there is this much demand for services', then we would have a better case for getting more midwife positions in the region. But I can't really request more money to fund more positions because there are no midwives to hire.

Programs developed through MEPA and AMEP alone though can only support midwifery as an add on program on the periphery of the health care system. They do not replace the need for a baccalaureate midwifery education program:

> **Participant 6:** OK. The whole dilemma is we don't have a source of midwifery education in Manitoba.
> **Meta:** Right.
> **Participant 6:** We need to hire midwives, and the midwives that are working now are slowly burning out…If we're going to have midwifery, lets have midwifery. And don't just have these 28 midwives. We need to be educating more midwives. The College has done what it can to draw midwives from other places and put them through our PLEA process, but we need the education program that has been approved in Manitoba to be offered!...To have ongoing newcomers to the midwifery profession, we can take the high-spirited souls who are willing to do their own sort of self directed learning, then go away to get their clinical experience (the required number of pre and post natal visits, and

births and newborn exams) and come back and put them through the MEPA or the PLEA.
Meta: Right.
Participant 6: But we need more midwives than just the women who are willing to do that in order for midwifery to survive and even thrive in Manitoba.

On the other hand, AMEP and MEPA combined with a baccalaureate program could create a profession which primarily produces more mainstream midwives integrated with other health care providers, but is also inclusive of midwives and women who want something more alternative. At present both MEPA and AMEP are at such early stages that it is impossible to predict what impact they will have on the developing profession. They do however, offer strategies for addressing the accessibility issues inherent to baccalaureate programs such as higher tuition costs and a centralized urban location. They also represent continued support for multiple routes of entry to the profession. AMEP offers good possibilities to tangibly include Aboriginal women and Aboriginal communities into regulated midwifery in Manitoba. MEPA offers an excellent strategy for reducing geographic barriers for students in rural and northern areas who can work directly with local midwives in self study programs. MEPA also offers the possibility of creating a refresher program for immigrant midwives who are already educated, but need a chance to work alongside practicing midwives to refresh their skills and become more familiar with both the Canadian health care system and the Canadian model of midwifery care. These options combined with a baccalaureate education program create exciting options for the future of midwifery in Manitoba. This inclusiveness of multiple training routes may have costs though for professional cohesion. Unless a concerted effort is put towards retaining the focus on competency rather than credentials, a hierarchy between degree and non degree trained midwives could develop.

Leaving the midwifery program in Manitoba as it is though, is not an option. The current number of professionals mean that many of the rural and northern practice groups are not at a sustainable size, and half of the RHAs in the province still do not have a midwifery service. While their numbers are small, midwives in Manitoba must also maintain a complete professional structure in the form of the College of Midwives of Manitoba. The College plays an essential role in protecting the safety of the public. The close scrutiny and continuing education support that regulating an obstetric provider involves means that the CMM must continue to be well funded, and this is not possible out of the dues and volunteer time of such a small number of midwives without substantial provincial support. A strategy for increasing the number of midwives in the province to fortify current midwifery practices, expand the service to all RHAs, and make the College more self sustainable is needed:

> **Participant 13:** What I would like to see is Health sitting down with Advanced Education and, and discussing information about the obstetrical situation in Manitoba, what it's going to look like now, in a year, in three years, in 10 years, 15 years, whatever.
> **Meta:** Yes.
> **Participant 13:** And committing to midwifery as a viable program in which to invest… a statement that says by 2008 the goal is to have 20 practicing midwives in each Regional Health Authority in the province of Manitoba.
> **Meta:** Right.
> **Participant 13:** And the rationale for that might be because we know that family physicians are leaving obstetrical care. We know that obstetricians are leaving obstetrical care. We know that many rural and northern women and families aren't accessing obstetrical care…

Such a long term strategy should focus on supporting the development of AMEP, and using MEPA to consolidate rural and northern practices already in place so that they have the necessary four midwives in each practice group to divide the on call time appropriately. Inter-regional cooperation should also be fostered to work out a method

for midwives to become available to women in more RHAs while the number of midwives is still growing. RHAs which wish to offer midwifery services but do not currently have them should put in midwifery program proposals to Manitoba Health to put more pressure on the province to increase the number of positions and fund an education program. A growing pool of registered midwives from MEPA programs wanting to be hired would also make introducing a midwifery service more feasible to RHAs, which might then put in a proposal to Manitoba Health. Further, the AMEP and MEPA education programs must follow the same education and training requirements of a baccalaureate education program to prepare midwives for registration in Manitoba. As one participant mentioned, it is possible that a baccalaureate midwifery education program could grow out of AMEP (or a MEPA program) in time because of the curricular overlap that would have to occur:

> **Participant 19:** We need to have an education program. I do see that happening. I'm really happy about the midwifery program for Aboriginal midwives. I think that it will lead to a broader education program.
> **Meta:** Do you?
> **Participant 19:** Yes. I think it will. I think once a postsecondary institution makes the jump to owning that program it's not as big a jump to the next step, you know…there will be certain particular things, curricular components that will be geared for Aboriginal students and working with Aboriginal women but I think that since our legislation is inclusive those midwives have to be able to be registered, you know, with the College.
> **Meta:** So they have to know the same things.
> **Participant 19:** Yes, so there will be a lot of overlap.

The introduction of a baccalaureate midwifery education program is essential for the future of the profession. Whether it is implemented on its own, grows out of another education program in Manitoba, or evolves from a distance education program with another province, a formal midwifery education program is the next step in the development of the midwifery profession in Manitoba. As this thesis has tried to make

clear, a foundation for successful integration and equitable access to midwifery has been put in place in Manitoba. Once this is combined with a provincial strategy for gradually increasing the number of funded midwifery positions until there are sustainable practices in each RHA, Manitoba will then have fully integrated midwifery as a new and innovative facet of primary health care in the province.

9.7.1 Recommendations

The following recommendations offer potential strategies for Manitoba as it continues in the development of midwifery in this province:

11. As the service matures, the midwives' practices should be allowed more flexibility and autonomy.
12. This added flexibility should include allowing midwives to work with non midwife second attendants in the community, especially in rural and remote communities. Extending the scope of practice in well woman care beyond the reproductive year for providers in rural and remote communities would also be beneficial.
13. The added flexibility for the midwifery practices should be sought within the employment funding model and should retain the current access policies to maintain gains made in the diversity of the midwifery clients and retain provincial support.
14. The baccalaureate midwifery training program approved for the University of Manitoba should be implemented as soon as possible.
15. Until a provincial baccalaureate program is started, it is recommended that support be given to the development of the MEPA and AMEP education programs. Buying seats in midwifery education programs in other provinces should also be considered as a way to maintain and gradually increase the number of midwives in the province.

16. MEPA programs and AMEP in combination with a baccalaureate education program could facilitate a continued commitment to both multiple routes of entry and further integration of midwifery services.
17. A long term strategy combining midwifery education programs and a gradual increase in the number of funded midwifery positions in the province is essential for the sustainability of the midwifery profession.

9.8 Theoretical Implications

While the majority of this chapter has focused on pragmatic strategies for the future of midwifery in Canada, this section will revisit some of the theoretical and conceptual constructs which guided this project, and discuss how this study can contribute to our understanding of these theories. It will be argued that the introduction of midwifery in Manitoba supports the theories of declining medical dominance and biomedicalization, but that the trends in the health care system which are reducing medical dominance are also affecting the autonomy of the midwifery profession. Further, it appears that midwives in Manitoba have achieved relatively less autonomy compared to midwives in other provinces, and it will be suggested that this is one less positive result of the efforts in this province to downplay elitism in the creation of the new profession. It will be concluded that what becomes clear from studying the case of midwifery implementation in Manitoba is the support it offers for giving the state a central role in conceptual frameworks that attempt to explain recent changes in the Canadian health care system and the status of the health professions.

In chapter 3, the concept of declining medical dominance was outlined, and the trends which were identified as detrimental to medical dominance were seen to lend

support for regulating midwifery. According to Coburn (1993), once the state became involved in offering public health insurance in Canada, the government began to increasingly interfere with physician's control of the health care system to rationalize health care costs. One strategy used by the government to reduce health care costs has been the introduction of non physician health care practitioners who are believed to be cheaper providers to pay. In Manitoba, the implementation of the midwifery profession can be seen as a state led process which challenges medical dominance. Despite medical opposition, the midwifery model of practice which was legislated does not require medical supervision and the midwifery standards of practice do not match medical practice guidelines.

The philosophical tenets of biomedicalization as defined by Clarke *et al* (2003) in Chapter 3 also appears to explain some of the support for the introduction of autonomous midwifery in Manitoba. Midwifery in Manitoba indicates a shift in the specialization of the professions in this province from specific tasks and body systems to risk populations. It includes a model which places greater focus on preventative education and involves greater monitoring of social as well as physical characteristics. It also places more responsibility on the consumer for self care and informed choice, and involves offering more care in the community.

The fact that the Manitoba government has introduced autonomous midwifery indicates that it has priorities for the content and structure of the health care system which are at odds with the medical profession's interests. However, the same encroachment on medical autonomy by the state which has been identified by researchers appears to be affecting midwifery autonomy in Manitoba as well. The biomedical aspects of the

midwifery model of care have also been reduced because of state interference to reduce health care costs. A certain level of decision making power about the midwives' practices has been shifted into the hands of non midwife health care administrators, and issues of micromanaging by these supervisors based on economic priorities and non midwifery practice guidelines was identified. This has limited the ability of the midwives to customize care to the needs of individual clients. Bourgeault (1996: 298) noted this balance of costs and benefits of state interference in Ontario, stating that: "The midwifery incorporation process was not only promoted by the state, it was also bounded and constrained by it. That is, although midwifery gained legitimacy and autonomy through the state, this autonomy is ultimately limited and constrained by the state." However, the level of control and constraint of the midwives' autonomy appears to be even stronger in this province than in Ontario because midwives are government employees in Manitoba.

Part of the reason state control of midwifery is greater in Manitoba than in other Canadian provinces may be because there was less effort in this province towards demarcating an elite professional structure for midwifery, and greater effort put towards reaching goals around inclusiveness and equity. In chapter 2, Nestel's (1997 and 2000) concept of interlocking discourses of oppression was outlined to illustrate how it can be used to view the midwifery profession in Canada as both elite and marginalized. Nestel argues that at the same time that midwifery is marginalized by the medically dominated and sexist health care system, it has also become an elite locus of power through the creation of a professional structure which can be used to exclude certain practitioners from the benefits of registration. In Manitoba, it appears that one consequence of trying to downplay elitism as a part of achieving greater equity goals within midwifery is that

this made it easier for the state to consider it appropriate to interfere more with the profession. The province has placed requirements on the midwives' practices in terms of who they are to prioritize for the service which are not placed on other maternity care providers, or midwives in other provinces. Midwives in Manitoba are also paid at a rate which does not reflect their level of professional responsibility and commitment. As employees they are closely supervised and directed, while midwives in other provinces generally own their own practices.

Thus, whether this process is looked at through the lens of declining medical dominance, biomedicalization or interlocking discourses of oppressions, this study makes clear that the state has become a central player in determining the context and content of the health care system in Canada. The study offers another perspective on the state's role in creating declining medical dominance and biomedicalization, noting that the outcomes of greater state interference are far more complex than a competitive scenario where trends to the detriment of medicine are wholly beneficial for the other health professions. The study also indicates that the state can play an equally complex role in efforts towards greater equity and access for consumers and practitioners by both supporting and penalizing the profession for initiatives in this regard. While sometimes viewed as a neutral arbiter which can balance out the interests of consumers, midwives and other health professionals, this project makes clear that the state has its own priorities which must be carefully taken into consideration when attempting to explain and understand recent trends in the Canadian health care system.

9.9 Final Considerations of the Study

This final section of the thesis will outline the contributions this project attempted to make while taking into consideration its limitations. It will also suggest research topics which might be productively explored in future. The primary contribution of this project is that it is the first to extensively explore and document the implementation of midwifery in Manitoba. The case study research design which was used allowed this project to look in depth into a topic which had not been explored before, but this research design also has inherent limitations. These include the effects on the interview data of recall bias, and the point in time during midwifery integration when the interviews took place. Because of their flexibility though, case studies are good for identifying fruitful directions for future research, and three possible research topics will be offered.

9.9.1 Contributions of the Study

This project is one of the first to extensively study regulated midwifery in Manitoba, which was only four years old when the interviews were conducted. By documenting aspects of the midwifery implementation process in Manitoba, this study contributed to both the knowledge of this process in this province, and added new insights to the understanding of the broader development of the midwifery profession across Canada. This project also documented and discussed a midwifery regulation movement which was committed to making midwifery an equitable profession, and tried to create a service which did not just benefit middle class, white women as midwives and consumers, but also addressed inequities based on race, class and geography. Further, this movement problematized the assumption that midwifery was most valuable as a single ideal model challenging the existing health care system from the periphery.

Instead, the focus in Manitoba was on impacting the existing health care system in other ways, including giving midwifery added legitimacy through close integration, drawing on the strengths of multiple midwifery models, and illustrating the benefits of midwifery care for the widest distribution of clients possible.

This project also attempted to do more than document the events that unfolded in Manitoba. I have tried to evaluate the unique aspects of midwifery services in this province and explore whether participants perceived that these innovations created solutions to the issues which they were initially designed to address, or whether they had unintended consequences. By exploring the outcomes of these initiatives and suggesting recommendations based on the results of this research, it is hoped that this study will be used to assist the further integration of this profession in Manitoba. It is also hoped that this project will be a useful tool for provinces without regulated midwifery when they consider how to implement and integrate the profession.

9.9.2 Study Limitations

Despite the attempt to make these large contributions, this research project was necessarily limited in scope. This includes both the limitations which were placed on this project initially by the identified research topics, and the material constraints on data collection and interpretation which are inherent to a master's thesis. As a case study which partly relied on interviews, this project was also limited in that some of the data collected was influenced by recall bias. This bias not only includes participants having difficulty remembering past events accurately and in detail, but also how present situations in midwifery integration may colour their memories of earlier aspects of this process. It also includes how participants' personal agendas for the future direction of

midwifery in Manitoba may have influenced their statements. Strategies to reduce the impact of this limitation included using documentary data (which is not influenced by recall bias) as a framework for the interview data, and by selecting participants from multiple stakeholder groups and subgroups to balance out different viewpoints. Another limitation which cannot be addressed is the fact that participants' viewpoints are also affected by the point in time in midwifery implementation at which the interviews occurred. If this case study of midwifery implementation in Manitoba had been carried out 1 year or 7 years after midwives began practicing rather than 4, participants may have been concerned about different issues, and had a different evaluation of the benefits and costs of different initiatives. This must be taken into consideration during any replication of this project or comparison of its findings with other midwifery implementation studies.

9.9.3 Suggestions for Future Research

While the above limitations are inherent to case studies, one of the strengths of this research design is that its in depth exploration of a topic can identify many future fruitful avenues of research. One area of future research which was identified as needed by participants was a combined quantitative and economic analysis detailing who the midwifery clients are, what extra supports are being offered to higher needs clients, and what the clinical, economic and social outcomes are of this extra support. Acknowledging that midwives in Manitoba appear to be successfully prioritizing for care socio-economically disadvantaged women, it was also pointed out that it would be useful at this point to explore whether these clients feel that the midwives are respectfully meeting their needs and giving them extra support. Consumers who come to the service with certain expectations based on researching their maternity care options and the

midwifery model of care might also have important insights about the program which should be explored.

Finally, one last area of research which could be very valuable would be an in depth exploration of the experience of midwives practicing out of community clinics in Winnipeg. This practice model is particularly distinct in the country and offers exceptional opportunities for both improving access to the service by a diverse clientele, and increasing integration with other health professionals. It also poses extensive challenges for midwives who must become accustomed to working more deeply embedded within the existing health care system than if they were in their own stand alone practices. While this case study saw many strengths in this practice model at the macro level, a more micro level study which explores the everyday experiences in the community clinics might shed more light on the nuances of this model, and its costs and benefits.

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Appendix A: College of Midwives of Manitoba Letter of Support

COLLEGE OF MIDWIVES OF MANITOBA (CMM)

235-500 Portage Avenue
Winnipeg, MB R3C 3X1

Telephone: (204) 783-4520
Facsimile: (204) 779-1490
e-mail: admin@midwives.mb.ca
website: http://www.midwives.mb.ca

September 16, 2003

Health Research Ethics Board
University of Manitoba
P126 Pathology Building
770 Bannatyne Avenue
Winnipeg, Manitoba
R3E 0W3

Dear Chairperson – Health Research Ethics Board:

Re: Letter of Support for Meta Kreiner, MSc Candidate
"Stakeholder Perceptions of Midwifery Integration in the Health Care System in Manitoba"

On behalf of the Council of the College of Midwives of Manitoba I write this letter of support for Meta Kreiner, MSc. Candidate. Council members have had the opportunity to read Ms Kreiner's draft proposal titled *"Stakeholder Perceptions of Midwifery Integration in the Health Care System in Manitoba"*. Council members also met with the researcher to ask questions, and discuss the proposal in greater detail.

Council members agreed unanimously that the project is relevant, and will be useful for the continuing development of midwifery in Manitoba.

Sincerely,

Kris Robinson, BScN, SCM, MSc, RM
Chairperson – Council of the College

KR/pe

Appendix B: College of Midwives of Manitoba Pledge of Privacy and Confidentiality

COLLEGE OF MIDWIVES OF MANITOBA

235-500 Portage Avenue
Winnipeg, MB R3C 3X1

Telephone: (204) 783-4520
Facsimile: (204) 779-1490

Pledge of Privacy and Confidentiality

As a staff person/contract worker/volunteer/student at the College of Midwives of Manitoba, I support the primary purpose of the College, which is to protect the safety of the public in the provision of midwifery services. I will be fair and impartial in carrying out my duties for the College.

I understand that as a staff person/contract worker/volunteer/student at the College of Midwives, I must respect and maintain the privacy and confidentiality of midwifery clients and midwives, and others associated with the College.

Within the College, I can expect other staff/contract workers/volunteers/students to treat as private and confidential information which I may discuss with them in my role at the College. In discussions with people outside the College, I may raise general issues but pledge to respect privacy by ensuring the anonymity of persons involved. I therefore agree not to use the names or any other information or description that could result in the identification of any Midwifery client, midwife or person associated with the College. I also agree to exercise discretion and good judgment when discussing College business, and especially of matters in process or under development.

I understand my failure to abide by the requirements for privacy and confidentiality could cause serious harm to individuals, the College and/or the practice of midwifery in Manitoba.

I acknowledge that if I should make an unauthorized disclosure of information, the College may initiate disciplinary action up to and including terminating my role at the College.

By my signature below, I agree to the terms of this pledge of privacy and confidentiality. I will sign two copies: one for the College's records and one for my own files.

Name _____

Signature _____

Date: December 19, 2003

Witness _____

Appendix C: Manitoba Health Letter of Permission to Access the Minutes of the Midwifery Implementation Council

Manitoba

Health **Primary Health Care** **300 Carlton Street**
Winnipeg MB R3B 3M9

Meta Kreiner

Dear Ms. Kreiner:

RE: Your request to have access to the Minutes of the Midwifery Implementation Council (MIC)

I understand that you wish to review the Minutes of the MIC as part of your research for your Master's thesis. I do not foresee any problems with your request and am therefore pleased to give my permission for you to review the Minutes. This permission is granted on the condition that your review of the Minutes is carried out solely for the purpose of your research for your Master's thesis.

Best wishes in conducting your research. If you have any questions regarding the use of the MIC Minutes, please do not hesitate to contact me.

Sincerely

Marie O'Neill
Director

Appendix D: Information Letter for Contacting Research Participants

UNIVERSITY OF MANITOBA | Faculty of Medicine

Department of
Community Health Sciences
750 Bannatyne Avenue
Winnipeg, Manitoba
Canada R3E 0W3
Fax (204) 789-3905

Date

Dear (name of potential participant),

I am a student in the Department of Community Health Sciences of the University of Manitoba currently working on my Master's thesis entitled "Stakeholder Perceptions of Midwifery Integration into the Health Care System in Manitoba." In my work, I am researching whether key stakeholders who participated in midwifery implementation and integration perceive that the structure of midwifery services in Manitoba have met their objectives for the service in the areas of: the midwifery model of care; access to midwifery care; and the integration of midwives into the existing health care system. I am also exploring how issues within these three topics were defined and negotiated, and how agreement on these issues was translated into the regulatory framework and structures of midwifery care.

Your name, role and contact information was available in public documents or provided to me by the College of Midwives of Manitoba. This letter is intended to invite your participation in an interview which will provide material for part of my thesis.

The study will initially involve a review of primary and secondary documents from midwifery implementation and integration. This will be combined with in-depth interviews with 32-34 participants. Participants will be selected to represent five identified stakeholder groups in midwifery: women as maternity services consumers (represented by women's organizations), midwives, other health professionals including the medical and nursing professions, the provincial government, and midwifery implementation and professional bodies.

Participation in this research will allow you to reflect on the process of midwifery integration in Manitoba, such as how you believe the structure of midwifery services developed, and whether or not you think your goals for midwifery services in Manitoba have been met. You will also be asked to identify any barriers you see for further integration of midwifery services and how you think those barriers could be addressed.

16/11/2003

If you agree to participate, you will be asked to sign a "Research Participant Information and Consent Form" in which you agree to have any remarks you make in the interview recorded and used in my thesis and in any presentations of my work. You will later be sent a transcript of your interview, or if not tape recorded, the notes from your interview, which you may add or excise material from if you feel your views have not been accurately represented. All identifying information will be kept locked up and may only be accessed by myself and Prof. Patricia Kaufert, my thesis advisor. Interview transcripts will be stripped of all identifying information. Quotes from your interview will only be used with your permission. If you agree to be quoted, your name and other identifying information will not be used or revealed. Your quote will only be identified by your interview number. You may withdraw from the study at any point.

Your decision whether or not to participate in this research project may be influenced by personal attributes of the researcher, which can play a role in qualitative research. While I will make every effort to set aside my views during this research project, I am active in the area of reproductive health and have volunteered with the Women's Health Clinic and the Manitoba Association of Childbirth and Family Education (MACFE), two organizations which were consulted as part of the midwifery implementation process in Manitoba. I did not join these organizations until 2001, after practising midwives were integrated into the health care system, and I volunteered in programs unconnected to midwifery. I do not have private information on midwifery implementation from these organizations, nor is my research in any way affiliated with these organizations.

Thank you for taking the time to consider participation in this research project. If you are interested in contributing to this research project, please contact me by phone, mail or e-mail within one month of receiving this letter. By choosing not to contact me, it will be understood that you are not interested in participating in this research project, and you will not be contacted further.

Sincerely,

Meta Kreiner

Department of Community Health Sciences, University of Manitoba
750 Bannatyne Avenue,
Winnipeg, Manitoba R3E 0W3
Phone:
email: [redacted]

16/11/2003

Appendix E: Interview Guide

Meta Kreiner Page 1 of 3 01/11/2003

The purpose of the interviews will be to collect information on: (a) participants goals for, experience of, and role in midwifery implementation and integration, (b) their perception of midwifery services in Manitoba, and (c) to explore whether stakeholders perceive that midwifery services are meeting their initial goals for the service in the areas of: the midwifery model of care, access to midwifery care; and the integration of midwives into the existing health care system. The following questions broadly outline the topics which will initially guide the interviews. Some questions will be differentially relevant to different participants based on their positions, and interviews will therefore vary in length and depth. All questions may not be asked of all informants.

I. Personal (biographical/educational/philosophical) Background:

1. a. (For Midwives Only) When did you become interested in midwifery? Can you tell me something about the training process that you underwent to become a midwife? What is your personal philosophy of midwifery? Can you tell me something about your background – where and when you grew up and your socio-economic and education background?

b. (For all Other Participants) When did you become involved with childbirth and midwifery issues? How would you describe your perspective on midwifery? How did you arrive at this perspective? Do you think your perspective is representative of the majority of other people in your position?

II. Individual Goals for and Role in Midwifery Implementation and/or Integration:

2. Describe the role you played in midwifery implementation and/or integration in Manitoba. What do you think were the key factors being discussed during these processes?

3. What were your initial goals for midwifery regulation and integration into the health care system? What structure did you or your organization initially want for midwifery services? How did your goals change during the implementation process?

III. Midwifery Model of Care:

4. (For Midwives Only) Did you practice midwifery before regulation? Where? How has practicing regulated midwifery in Manitoba been different?

5. What do you think were the key factors being discussed during the development of the midwifery model of care and scope of practice for Manitoba? What do you think of the present midwives' model of care and scope of practice in Manitoba?

6. What do you think were the key factors being discussed during the development of the employment structure for midwives in Manitoba? How do you think the present employment structure (i.e. being salaried employees of the RHAs, working out of community clinics in Winnipeg) affects the midwifery model of care and scope of practice?

7. Have you had to deal with any challenges or witnessed any challenges to midwives practicing midwifery according to the practice guidelines set by the College of Midwives of Manitoba?

IV. Access and Barriers to Midwifery Care:

8. Do you think the changes Manitoba made to the midwifery licensing assessment process made the profession more accessible to a more diverse group of midwives than in other provinces? Do you think the diversity of backgrounds among midwives affects the diversity of the women who choose midwifery services? Why?

9. What do you think about the relationship between regulated midwifery and traditional Aboriginal midwifery in Manitoba? How did this relationship come about? What factors do you think influence access to midwifery services for Aboriginal women?

10. Do you see any barriers for women trying to access midwifery services? How do you think these could be overcome? What do you think were the initial goals for midwives having target populations? What do you think has been the impact of the target populations? What do you think were the initial goals for having midwives practice out of community clinics? What do you think has been the impact of having midwives practice out of community clinics for access to the service?

V. Midwifery Integration into the Public Health Care System:

11. (For Midwives Only) How would you describe your working relationships with other midwives? What factors do you think have influenced those relationships? Do you feel any tension between your conception of midwifery and the one which was legislated?

12. How would you describe the working relationships developing between midwives and other health professionals? What do you think has influenced those relationships? Do you think midwives practicing out of community clinics rather than independent practices has impacted the working relationships developing between midwives and other health professionals?

13. How would you describe the working relationships developing between midwives and RHA administrators? Manitoba Health Administrators? What do you think has influenced those relationships?

14. What do you think has been the impact of funding midwifery services through the RHAs for the integration of midwifery into the existing health care system?

VI. Future Perspective on Midwifery:

15. What do you think has been the primary impact of regulating midwives in Manitoba? Is this what you expected?

16. What do you think about midwifery services in other provinces in Canada? What do you consider the greatest strength of midwifery services in Manitoba? The greatest weakness?

17. Do you see any barriers to further integration of midwifery in Manitoba? How do you think those barriers could be overcome? What do you think the future holds for midwifery in Manitoba? In Canada?

Appendix F: University of Manitoba Health Research Ethics Board Approval

UNIVERSITY OF MANITOBA

BANNATYNE CAMPUS
Research Ethics Boards

P126-770 Bannatyne Avenue
Winnipeg, Manitoba
Canada R3E 0W3
Tel: (204) 789-3255
Fax: (204) 789-3414

APPROVAL FORM

Principal Investigator: Ms. Meta Kreiner

Protocol Reference Number: H2003:145
Date: November 24, 2003
Date of Expiry: November 24, 2004

Protocol Title: **"Stakeholder Perceptions of Midwifery Integration into the Health Care System in Manitoba"**

The Health Research Ethics Board at the Bannatyne Campus, University of Manitoba, which is organized and operates according to Health Canada/ICH Good Clinical Practices, Tri-Council Policy Statement, and the applicable laws and regulations of Manitoba reviewed the above mentioned study at the REB meeting held on November 24, 2003. The membership of this Research Ethics Board complies with the membership requirements for Research Ethics Boards defined in Division 5 of the *Food and Drug Regulations.* The research was approved as submitted.

The following is/are approved for use:

- **Proposal (dated October 1, 2003)**
- **Information Letter (dated 16/11/2003)**
- **Research Participant Information and Consent Form (dated 13/11/03)**

This approval is valid for one year only. A study status report must be submitted annually and must accompany your request for re-approval. Any significant changes of the protocol and informed consent form should be reported to the Chair for consideration in advance of implementation of such changes. The REB must be notified regarding discontinuation or study closure.

This approval is for the ethics of human use only. For the logistics of performing the study, approval should be sought form the relevant institution, if required.

Sincerely yours,

Ken Brown, MD, MBA
Chair, Health Research Ethics Board
Bannatyne Campus

Please quote the above protocol reference number on all correspondence.
Inquiries should be directed to the REB Secretary
Telephone: (204) 789-3255/ **Fax:** (204) 789-3414

UNIVERSITY OF MANITOBA

BANNATYNE CAMPUS
Research Ethics Boards

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Tel: (204) 789-3255
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APPROVAL FORM

Principal Investigator: Ms. Meta Kreiner

Protocol Reference Number: H2003:145
Date of Approval: October 15, 2004
Date of Expiry: October 15, 2005

Protocol Title: "Stakeholder Perceptions of Midwifery Integration into the Health Care System in Manitoba"

The following is/are approved for use:

- **Annual Approval**

The above was approved by Dr. Ken Brown, Chair, Health Research Ethics Board, Bannatyne Campus, University of Manitoba on behalf of the committee per your letter dated October 12, 2004. The Research Ethics Board is organized and operates according to Health Canada/ICH Good Clinical Practices, Tri-Council Policy Statement, and the applicable laws and regulations of Manitoba. The membership of this Research Ethics Board complies with the membership requirements for Research Ethics Boards defined in Division 5 of the *Food and Drug Regulations*.

This approval is valid for one year only. A study status report must be submitted annually and must accompany your request for re-approval. Any significant changes of the protocol and informed consent form should be reported to the Chair for consideration in advance of implementation of such changes. The REB must be notified regarding discontinuation or study closure.

This approval is for the ethics of human use only. For the logistics of performing the study, approval should be sought from the relevant institution, if required.

Sincerely yours,

Ken Brown, MD, MBA
Chair, Health Research Ethics Board
Bannatyne Campus

Please quote the above protocol reference number on all correspondence.
Inquiries should be directed to the REB Secretary
Telephone: (204) 789-3255/ **Fax:** (204) 789-3414

Appendix G: Research Participant Information and Consent Form

UNIVERSITY OF MANITOBA | Faculty of Medicine

Department of
Community Health Sciences
750 Bannatyne Avenue
Winnipeg, Manitoba
Canada R3E 0W3
Fax (204) 789-3905

RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM

Title of Study: "Stakeholder Perceptions of Midwifery Integration into the Health Care System in Manitoba."

Principal Investigator: Meta Kreiner, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba, 750 Bannatyne Avenue, Winnipeg Manitoba, R3E 0W3 Phone: (204) 943-3017

Supervisor: Dr. Patricia Kaufert, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba, 750 Bannatyne Avenue, Winnipeg, Manitoba, R3E 0W3 Phone: (204) 789-3681

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the study staff. You may take your time to make your decision about participating in this study and you may discuss it with your friends and family before you make your decision. This consent form may contain words that you do not understand. Please ask the study staff to explain any words or information that you do not clearly understand.

Purpose of Study

This research study is being conducted to study the integration of midwifery services into the existing health care system in Manitoba as seen from the perspective of stakeholders involved. This project will look at how three topics central to the national discussions of midwifery implementation were dealt with in Manitoba: (1) Defining the midwifery model of care; (2) Issues in access to care; and (3) The integration of midwifery care into the health care system.

The objectives of this project are:
(1) To describe how issues within these three topics were defined and negotiated;
(2) To describe how agreement in these issues was translated into the regulatory framework and the structure of midwifery care;

(3) To describe how these issues are now seen by stakeholders in the midwifery implementation and/or integration processes including what they see as having worked well, as partly successful, or in need of major revision.

A total of 32-34 participants will participate in this study.

Your decision whether or not to participate in this research project may be influenced by personal attributes of the principal investigator, which can play a role in qualitative research. While the principal investigator will make every effort to set aside her views during this research project, she is active in the area of reproductive health and has volunteered with the Women's Health Clinic and the Manitoba Association of Childbirth and Family Education (MACFE), two organizations which were consulted as part of the midwifery implementation process in Manitoba. She did not join these organizations until 2001, after midwifery services were integrated, and she volunteered in programs unconnected to midwifery. She does not have personal information on midwifery implementation from these organizations, nor is this research project in any way affiliated with these organizations.

Study Procedures

The first stage of this study will involve a review of the documents from the midwifery implementation and integration processes. This review will then act as a framework for the in-depth interviews. Participants will be selected for interviews based on their involvement in midwifery implementation and integration.

If you take part in this study, you will participate in one or two interviews expected to last between one to two hours in a location mutually chosen by the researcher and yourself. Interviews will be scheduled for a date and time mutually chosen by the researcher and yourself, and are expected to take place between January 2004 and April 2004.

Interviews will be tape-recorded with your permission, or notes will be taken if you prefer. All tapes will be erased and notes shredded after they are transcribed to ensure confidentiality. We would like to assure you that all information you provide in this interview will be kept strictly confidential. To ensure that you will not be identified in any way, your name will be kept separate from the interview and transcript data, as well as the document data. Access to this personal information will be restricted to the principal investigator and her supervisor, and will be physically secured at the Department of Community Health Sciences.

You can stop participating at any time. However, if you decide to stop participating in the study, we encourage you to talk to Meta Kreiner or Dr. Patricia Kaufert first. After the interviews have taken place, you will be given a transcription of your

interview to look over to ensure it reflects your perspective on the issues discussed, and you will be given the opportunity to change, excise or add material. Upon completion of the thesis, the researcher will make a copy of the thesis available through the College of Midwives of Manitoba.

Risks and Discomforts

The interviews may bring up feelings about past events. Participants may have feelings of anxiety after the interview because of statements they did not expect to make. Because of the small number of individuals involved in midwifery implementation in Manitoba, there is always some risk that the events and decisions discussed and reported might be recognizable or linked to you. When interviewing other individuals involved in the study, other persons mentioned in those interviews may be identifiable. When given a copy of your interview transcript, you will have the opportunity to change or excise material which you think may identify you. The researcher will further review the transcripts to insure all information is anonymized. However, this does not guarantee absolute confidentiality.

Benefits

There may or may not be direct benefit to you from participating in this study. We hope the information learned from this study will benefit the delivery of midwifery services in Manitoba in the future.

Payment for Participation

You will receive no payment or reimbursement for any expenses related to taking part in this study.

Confidentiality

Information gathered in this research study may be published or presented in public forums, however the researcher will request permission to quote you. If you agree to be quoted, your name and other identifying information will not be used or revealed. Your quote(s) will only be identified by your interview number. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law.

The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes.

Voluntary Participation/Withdrawal from the Study

Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time. If the study staff feel that it is in your best interest to withdraw you from the study, they will remove you without your consent. We will tell you about any new information that may affect your willingness to stay in this study.

Questions

You are free to ask any questions that you may have about your rights as a research participant. If any questions come up during or after the study, contact the study staff: Meta Kreiner at (204) 943-3017 and Dr. Patricia Kaufert at (204) 789-3681.

For questions about your rights as a research participant, you may contact the University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389.

Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

Statement of Consent

I have read this consent form. I have had the opportunity to discuss this research study with Meta Kreiner. I have had my questions answered by her in language I understand. The risks and benefits have been explained to me. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board for quality assurance purposes.

I (check one only)
- ❍ consent
- ❍ do not consent

to being contacted at a later time for more information.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

Participant signature_____ Date _____

Participant printed name: _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

Printed Name: _____ Date _____

Signature: _____ Role in the study: _____

Appendix H: Chronology of the Implementation of Regulated Midwifery in Manitoba

1982
The Manitoba HomeBirth Network and Manitoba Association for Childbirth and Family Education are established.

The Manitoba Social Planning Council's Community Task Force on Maternal and Child Health recommends the introduction of trained midwives.

1985
The Manitoba Traditional Midwives Collective is formed.

1987
The Manitoba Advisory Council on the Status of Women publishes *Midwifery: A Discussion Paper.*

1988
The Manitoba Advisory Council on the Status of Women recommends the legalization of midwifery services in *Midwifery: Recommendations to the Manitoba Government.* The model of midwifery recommended is designed to include both nurse and community midwifery.

The Nurse Midwives Association of Manitoba is formed.

1990
There is a stillbirth of a second twin following a hospital transfer from a planned home birth attended by two community midwives. An inquest is called, carried out through 1991, and the report of the inquest judge is released in 1992.

The Manitoba government commissions the College of Physicians and Surgeons of Manitoba and the Manitoba Association of Registered Nurses to write a report on whether midwifery should be regulated in Manitoba. The joint report is released in 1991, and recommends the legalization of hospital based nurse midwifery.

1991
The Manitoba government establishes the Manitoba Working Group on Midwifery which is to recommend whether or not midwifery should be regulated, and if so, how this should be done.

1992
The Nurse Midwives Association of Manitoba changes its name to the Association of Manitoba Midwives to reflect support for multiple routes of entry to midwifery.

1993
Nurse midwifery pilot programs are started at two hospitals in Winnipeg.

The *Final Report of the Working Group on Midwifery* is released by the Manitoba government. The report recommends that midwifery should be regulated in Manitoba and implemented as a direct entry, self regulating profession.

1994
The Health Minister announces midwifery will be regulated as an autonomous profession in Manitoba, and will become an insured service.

The Manitoba government establishes the Midwifery Implementation Council to implement regulated midwifery services in the province.

1997
The *Midwifery Act* is passed unanimously by the Manitoba Legislative Assembly.

1998
The assessment and upgrading for midwives starts at the Health Sciences Centre.

The Midwifery Implementation Council completes its mandate and is disbanded.

The Transitional Council of the College of Midwives of Manitoba is formed from a subset of the members of the Midwifery Implementation Council.

The Midwives Association of Manitoba is formed.

1999
The Manitoba government announces funding has been allocated for the midwifery profession.

2000
The Midwifery Act is proclaimed and midwifery becomes a self regulated profession in Manitoba. The *Midwifery Regulation* comes into force.

A two year memorandum of understanding is signed by the Manitoba Association of Midwives and Manitoba Health, which states that midwives will be publicly funded as salaried employees of Regional Health Authorities (RHAs). The Manitoba government approves funding for 26 midwifery positions, with 16 of these positions assigned for Winnipeg, and 10 for rural and northern regions.

The first 11 midwives register with College of Midwives of Manitoba. By the end of the year there are 18 midwives registered.

The Burntwood RHA hires 1 midwife, the Winnipeg RHA hires 13 midwives, and the SouthEastman RHA hires 3 midwives.

A baccalaureate midwifery education program is approved to start at the University of Manitoba, but the program is put on hold until a long term plan for the growth of the profession is developed by Manitoba Health.

2001
The assessment and upgrading for midwives is completed. 49 candidates were accepted, and 39 women successfully complete the program and are eligible to register with the College of Midwives of Manitoba. 25 midwives register with the College.

The Transitional Council of the College of Midwives of Manitoba is disbanded and replaced by a Council of registered midwives and public representatives. Midwifery becomes officially self regulating in Manitoba.

The Winnipeg RHA hires 4 more midwives, the Brandon RHA hires 2 midwives, and the Central RHA hires 2 midwives.

A midwifery reciprocity agreement is signed by the midwifery regulatory bodies in Ontario, British Columbia, Alberta, Quebec and Manitoba so that registered midwives who meet the necessary criteria can move from one province to another without having to be assessed by each province separately.

2002
The NorMan RHA hires one midwife, and the Brandon and Central RHAs are allowed to each hire two more midwives.

The Prior Learning and Experience Assessment (PLEA) process is run for the first time to assess and register new midwives.

2004
There are 37 midwives registered with the College of Midwives of Manitoba, with 28 registered as practicing.

The College of Midwives of Manitoba starts the Aboriginal Core Competency Development project.

The Aboriginal Midwifery Education Program (AMEP) is approved for further development.

The College of Midwives of Manitoba approves the Midwifery Education Programs Approval (MEPA) process, and 2 candidates are being considered.

The plan for decentralization of management of midwifery practices from the Winnipeg RHA to the community clinics is initiated.

Appendix I: Regionalization, Centralization and Childbirth in Manitoba

This appendix will discuss some of the broader factors affecting childbirth in Manitoba which played a role in the decision to implement midwifery. These factors include a decline in general practitioners attending childbirth and a concomitant rise in obstetricians attending normal vaginal deliveries. Manitoba also has a regionalized health care system, and the province has seen a trend towards centralizing childbirth to a few centres which puts added stress on rural and northern women having to travel for care. This centralization of birth also appears to play a role in the closing of rural and northern health facilities, which then increases shortages of health care providers in these communities. During the midwifery implementation process, midwives were often touted as a possible solution to address shortages of general practitioners attending childbirth, and as a way to return towards having more births attended in rural and northern communities.

There were 13,936 live births in Manitoba in 2003-2004 (Statistics Canada 2005). This number has been steadily decreasing since 1989-1990 when there were 17,885 live births in the province (Manitoba Health Advisory Network 1992). As is true across most of Canada, normal vaginal deliveries are increasingly being attended by obstetricians in Manitoba even though their training specializes them for high risk women and childbirth complications. This increase in obstetricians doing normal obstetrics is because of a decline in general practitioners practicing obstetrics for a variety of reasons. In 1998, there were 13,723 births in Manitoba. 11,368 of these births were vaginal deliveries, and obstetricians attended 8,234 or 60% of the vaginal births. 9,717 of the Manitoba births in 1998 took place in Winnipeg (70.8% of the total births). In Winnipeg, 7,930 of these

births were vaginal deliveries, and obstetricians attended 6,185 or 78% of the vaginal births (Human Resource Strategy for Midwifery Implementation Committee 1998). The increasing number of obstetricians attending normal births also plays a role in centralization because obstetricians are more likely to be found practicing in urban tertiary hospitals (Manitoba Government 1993). This high rate of obstetricians attending normal vaginal deliveries was part of the impetus for midwives to be regulated in Manitoba to replace the declining numbers of general practitioners doing obstetrics (Human Resource Strategy for Midwifery Implementation Committee 1998).

The geographical distribution of births within Manitoba can be presented based on Regional Health Authority (RHA). The Manitoba health care system was regionalized in 1997 (Manitoba Health, Undated). See Figure I.1 for a map of the present 11 Regional Health Authorities in Manitoba. Originally, there were 12 Regional Health Authorities, but there have been eleven since 2002 when the Marquette and SouthWestman RHAs were amalgamated into the Assiniboine RHA (Manitoba Health 2002). For this review of childbirth in Manitoba, Burntwood, Churchill and NorMan have been defined as northern RHAs, while all other RHAs are considered rural except for Winnipeg.

The majority of births in Manitoba take place in Winnipeg, but this does not simply reflect the larger population and birth rate of the city compared to the rest of the province. In 1996-1997, there were 7,611 births in Winnipeg to residents of the Winnipeg Regional Health Authority, but there were also 2,657 births in Winnipeg which were to residents of the other ten RHAs who had been transferred into Winnipeg to give birth. These 2,657 births reflect 36.7% of all births to residents of rural RHAs being transferred into Winnipeg, and 29.7% of all births to residents of northern RHAs being

transferred into Winnipeg. This large number of births being transferred to Winnipeg reflects a general trend in Manitoba to centralize childbirth into four provincial centres, the largest being Winnipeg, but also including Brandon, Thompson (located in the Burntwood RHA) and The Pas (located in the NorMan RHA). In 1996-1997, 56.4% of all births for residents of rural RHAs took place in either Winnipeg or Brandon, and 91.1% of all births for residents of northern RHAs took place in Winnipeg, Thompson or The Pas. Only 17.8% of all births in the province in 1996-1997 occurred outside of these four centres (Human Resource Strategy for Midwifery Implementation Committee 1998). See Table I.1 for the transfer rates for childbirth of residents of the 11 RHAs into Winnipeg, Brandon, Thompson and The Pas in 1996-1997.

This pattern of centralizing birth in the province has continued, and can be inferred from the fact that while there were 41 facilities in the province offering obstetric services in 1996-1997, there are only 24 facilities offering obstetric services in 2005 (Human Resource Strategy for Midwifery Implementation Committee 1998; Assiniboine RHA, Undated; Interlake RHA, Undated; NorthEastman RHA, Undated; Central RHA 2005; South Eastman 2004). This includes a decrease from five to two hospitals offering obstetric services in Winnipeg (Human Resource Strategy for Midwifery Implementation Committee 1998; Manitoba Hansard, 16 March 2005; Health Sciences Centre 2005; St. Boniface General Hospital, Undated). Traveling for childbirth can be very stressful for rural and northern women because of financial costs, time away from work and family, the need to arrange alternate childcare, and the fact that they are cared for by strangers. According to the research of Kornelsen and Grybowski (2004) in communities where large numbers of women leave to give birth because there are no local obstetric facilities,

physicians and nurses usually stop offering obstetrical care, and then gradually stop offering prenatal and postpartum care as well, because physicians lose their skills in identifying and handling prenatal and newborn complications. Without obstetric services, many rural health facilities stop being used to their full capacity and are often closed. It then becomes harder to recruit physicians to work in rural communities without hospital facilities, and the health care services throughout rural regions become stressed because they are working short of the needed numbers of providers, and accepting more clients from other communities which have lost health care services (Kornelsen and Grybowski 2004). Returning childbirth to rural and northern communities, and addressing rural and northern provider shortages are two more reasons that midwifery was implemented in Manitoba (Manitoba Government 1993).

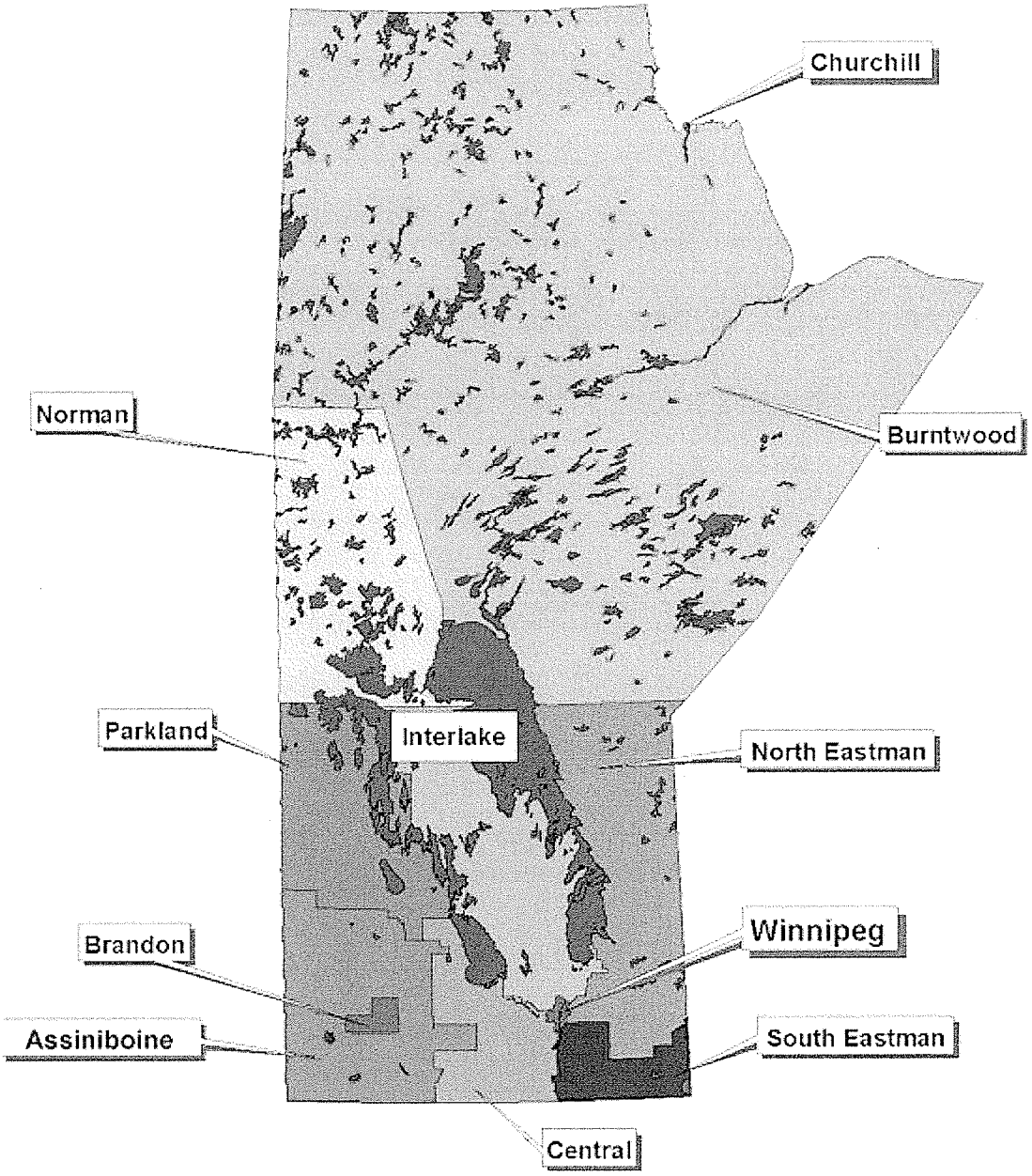

Figure I.1 Map of Manitoba Regional Health Authorities. Source: Manitoba Health. 2002. *Map of Manitoba's Regional Health Authorities*. Available online at www.Gov.mb..ca/health/rha/rhamap.html. Website accessed 18 February, 2005.

Table I.1 Number of Births in Winnipeg, Brandon, Thompson and The Pas to residents of the Eleven Manitoba Regional Health Authorities 1996-1997

Regional Health Authority	**No. of Births to Residents**	**No. of Births in Winnipeg**	**No. of Births in Brandon**	**No. of Births in Thompson**	**No. of Births in The Pas**
Northern RHAs	**1,574**	**467 (29.7%)**		**647 (41.1%)**	**320 (20.3%)**
Burntwood	1,158	401 (34.6%)		638 (55.1%)	30 (2.6%)
NorMan	395	54 (13.7%)		6 (1.5%)	290 (73.4%)
Churchill	21	12 (57.1%)		3 (14.3%)	
Rural RHAs	**5,417**	**2,190 (36.7%)**	**1,069 (19.7%)**		
Brandon	623	20 (3.2%)	569 (91.3%)		
Central	1344	447 (33.3%)	27 (2.0%)		
Interlake	909	640 (70.4%)			
Assiniboine	779	37 (4.7%)	462 (59.3%)		
NorthEastman	502	398 (79.3%)			
Parkland	526	56 (10.6%)	11 (2.0%)		
SouthEastman	734	392 (53.4%)			
Winnipeg	**7,739**	**7,611 (98.3%)**			
Total	**14,730**	**10,068 (68.3%)**	**1,069 (7.3%)**	**647 (4.4%)**	**320 (2.2%)**

Data for Table from: Human Resource Strategy for Midwifery Implementation Committee. 1998. *Human Resource Strategy: Midwifery Implementation: The Manitoba Scene: Work in Progress.* 21 December. Unpublished report. Winnipeg: Manitoba Health.

Appendix I: References

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