Midwifery Legislation in Manitoba

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Master of Science in Community Health

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By

Carol M. Scurfield M.D. CCFP

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BY

Carol M. Scurfield

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SCIENCE

Dedicated to my parents,
Bill and Cynthia Scurfield,
who taught me to love learning.

Abstract for Thesis entitled: Midwifery Legislation in Manitoba
Author: Carol M. Scurfield M.D. CCFP
Produced for Masters in Science (Community Health) Degree,
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Currently midwifery legislation has been newly developed or is being contemplated in every province in Canada. In 1997 Manitoba became the fourth province to pass an Act to create midwifery as an autonomous, self-regulated health profession. This act is called the Midwifery and Consequential Amendments Act.

In order to set the context for the development of the Manitoba midwifery legislation the history of midwifery is discussed with respect to the medicalization of maternity care, the relationship between midwives and nurses, the home birth movement, the history of midwifery in Manitoba and the procedures required to pass legislation in Manitoba.

The main body of the thesis discusses policy decisions that were made by the Midwifery Implementation Council and their impact on the development of the Act and Regulation. These policy decisions relate both to the process for development of the legislation and the specific clauses of the regulation. The types of decisions discussed include: the creation of the Midwifery Implementation Council, consensus decision making, the protection of the title of midwife and the substantial acts of a midwife, home birth, election to limit practice, entrance to practice requirements, aboriginal peoples, public representation and the complaints process.

Acknowledgements

This thesis would never have been written without the patience and wisdom of my thesis advisor, Dr. Patricia Kaufert. Her gift with words and humour were invaluable and inspired me to work through all the information that was before me even when it seemed impossible. Her gentle guidance provided me with the focus to finish this project.

Thank you to Dr. Tom Hassard and Dr. Lorna Grant, the other members of my thesis committee. Their gracious willingness to read yet another draft of this thesis and freely give thoughtful advice was greatly appreciated.

I am grateful to the College of Midwives of Manitoba for their encouragement to take on this project and their assistance with finding the information necessary for this thesis. They are an amazing group of women!

I have been extremely fortunate to have been involved with the development of regulated midwifery in Manitoba and am truly in awe of the dedication of midwives to their work and their clients. It is this dedication that encouraged me to continue to contribute what I can to the development of midwifery in the form of this document. The women of Manitoba are well served by their midwives.

I am grateful to my employer, the Women's Health Clinic, for understanding my need to focus on this work and for being a place that encourages women to challenge the status quo in health care.

As any woman will know, work like this cannot happen without someone helping to keep the home fires burning. Thank you to Niamh Acton and April McGregor who took on the load so that I could finish this task.

My family is my true inspiration. Paddy, Ailish, Senan, Keelin and Max, you complete me. Thank you for understanding.

Midwifery Legislation in Manitoba

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Summary of Policy Decisions

Chapter One

Midwifery Legislation in Manitoba

A. Introduction

The Midwifery and Consequential Amendments Act, which now regulates the practice of midwifery in the province of Manitoba, received Royal Assent on June 28, 1997 and came into force by Order in Council on June 12, 2000 in accordance with the legal process required by the Province of Manitoba. The process for the creation and passage of legislation in Manitoba is outlined in Appendix A. Four documents form the basis for the regulation of midwifery, the Act, the Regulation, which are passed through legislative procedures and the By-law and Standards, which are created by the College of Midwives. This thesis discusses the historical background to this legislation and the various factors that shaped its final form. While there is a small but diverse literature on midwifery in Canada, relatively little has been written on the legislative aspects. Some information can be gleaned from the final content of the legislation related to midwifery in Ontario (Ontario Government, 1991), Alberta (Alberta Government, 1994), British Columbia (British Columbia Government, 1995) and Quebec (Quebec Government, 1999), but there is very little material available on the processes, negotiations and policy decisions that preceded the passing of this legislation. The negotiations around the content of legislation can be quite complex. Even if there is broad agreement on the importance of midwifery,

there can be deep divisions over who should become a midwife and the scope of her practice. This thesis will describe the critical role played in the negotiations that took place in Manitoba by the adoption of a process of consultation and consensus building based loosely on feminist principles. As well it will examine policy decisions made by the Midwifery Implementation Council (MIC) and their effects on the content of the legislation.

The legislation, which forms the basis of the practice of midwifery in Manitoba, is an amalgam of many different influences. These influences include the legislation of other provinces that went before it and the legislation of other health professions. The imagination and advice of women who had looked seriously at this issue, including doctors, nurses, lawyers, consumers from many walks of life and of course midwives of various backgrounds left their mark on the legislation and were critical to the success of this work. The development of the legislation was time consuming and required many drafts of both the Act and the Regulation before the final document was completed to everyone's satisfaction. Controversial clauses took hours of soul searching and creative problem solving to try and come to consensus. The persons involved in the decision-making tried to hold the basic foundation of what midwifery promised the women of Manitoba at the forefront of their minds when making decisions. It was believed that midwifery in Manitoba must be responsive to the needs of Manitoba women. It must be woman-centred, respect the woman's right to make decisions

about her care based on good information, and be cognizant of the needs of all women in Manitoba including immigrant women, Aboriginal women, poor women, women with disabilities, young women .... all women. Not only must midwifery meet the needs of the birthing women of the province it must also be accessible to these same women if they chose to pursue midwifery education.

The challenge of putting together a new regulated profession was to try and do it differently. To learn from the mistakes of other professions and to produce something that was different, that protected the public but was more responsive to the needs of the women it served. The desire was to produce a profession that strives to empower its clients, not to disempower them. A profession that leaves its clients, stronger, better informed and better able to cope with parenting and perhaps life in general.

The Manitoba legislation would not have taken the shape it did were it not for the unique history of midwifery, not only in Manitoba, but in the rest of Canada and in other developed regions such as the United States and the European Union. Chapter two will discuss recent and past historical issues that helped to shape the development of midwifery in Manitoba. The tension between nursing and midwifery, the rise of the medical profession, the move to birth as a medical event requiring hospitalization and the important political support given to midwifery by the home birth movement in Manitoba and elsewhere in Canada will be highlighted in this chapter.

Chapter three will discuss the changing midwifery regulatory situation in Canada and abroad during the time that the Midwifery Implementation Council was developing a system of regulation for midwifery in Manitoba. The situation with respect to the regulation in Ontario, Alberta and British Columbia and Quebec will be discussed. This chapter will focus on the history of midwifery in Manitoba, why regulation was being considered at this time and what circumstances existed at the point when the Council was beginning its work.

Several critical policy decisions had to be made in order to develop the content of the legislation. The first and most critical policy decision was that midwifery should be a self-governing profession. This decision was based on the criteria set out in the Law Reform Review Commission report of 1994. Chapter four discusses this report and how midwifery meets the criteria for a self governing profession including the difference between midwifery and other professions that achieved legally recognized self government in the past.

Chapter five speaks about the process put in place to facilitate the development of the legislation. It includes a brief description of the Midwifery Implementation Council, a summary of the various tasks involved in setting up the legislation and what processes the MIC used to approach these tasks. This chapter discusses the importance of the membership of the MIC and the consensus process used by the Council to make the critical policy decisions

necessary in the legislation. Early on the MIC recognized that much of their task could be either facilitated or blocked by the nature of the relationships it could build with stakeholders, particularly the nurses, the physicians, the lay midwives, the nurse midwives and the consumers. For this reason the MIC placed a strong emphasis on communication with stakeholders. This is discussed in this chapter.

To govern a profession requires decisions with respect to what the person is able to do (scope of practice) what they may call themselves (protected title) and what they must do in order to be eligible to register with that profession (entrance to practice requirements). The decisions made with respect to the protection of the title "midwife", the definition of the substantial acts of a midwife and the entrance to practice requirements of women seeking registration with the College of Midwives of Manitoba are discussed in Chapter six.

Home or out of hospital birth is an issue that haunts the regulation of midwifery in Canada. The way the issue of home birth is handled in the Act and Regulation including the made in Manitoba exemption clause for midwives who wished to limit their practices to births in only one setting are the subjects of Chapter seven.

Chapter eight addresses the issue of how Aboriginal midwifery would be considered under the Act. Manitoba developed a unique process for the

inclusion of Aboriginal people in the governing of midwifery that allows for significant input at all levels of the regulatory process.

Chapter nine discusses the constitution of the governing body of the College of Midwives and discusses the important issues of how public representatives are included in the process of governing midwives. This issue is new and controversial when it comes to the governing of a self-regulated health profession. As well Manitoba's decision to legislate an arms length committee to select public representatives represents a unique method to ensure effective public representatives on the Council and committees of the governing body of midwifery.

The final policy decision that was pivotal to the development of the act and regulation was to decide on the format for receiving, processing and deciding the outcome of complaints against members of the College. Chapter ten outlines this procedure including the possibility of the use of mediation for dispute resolution and multiple remedies to be applied if a complaint is found to be valid.

The material presented in this thesis should be of value to other Canadian provinces engaged in the development or redevelopment of their own midwifery legislation. It may also be useful to other occupational groups who are seeking similar legislation. Women's organizations, facing similar challenges in terms of maintaining internal consensus while also negotiating

with external stakeholders, may also learn something from the Manitoba experience. Finally, this thesis adds to the literature on health professions.

B. About the Author

My training is as a physician with specialty training in family practice. During my family practice residency I undertook an extended 6 month period of training in obstetrics at a tertiary care hospital in the city of Winnipeg, Manitoba. This training provided me with the technical skills to be able to apply obstetrical forceps, induce labours, apply scalp clips, insert intrauterine pressure monitors, manually remove placentas, repair fourth degree tears and in an emergency perform a cesarean section. This training meant that I approached childbirth well trained in the science of the medical management of labour and birth.

During my training I was also provided with the opportunity to travel to several isolated Aboriginal communities to learn from the itinerate physicians who periodically serviced those living in these settlements. Following my post graduate family practice training I worked in the isolated northern communities of Churchill and the Inuit settlements along the west coast of Hudson's Bay. These experiences provided me with the opportunity to see how health care was delivered by nurses in these outposts with far less in the way of technological supports. As well I began to understand the

impact of the determinants of health, including social and economic factors, on the health of women.

Churchill had a small hospital staffed by family practitioners that served the town of approximately 1000 people but also served a much larger population for the purposes of providing hospital and birthing services to the Inuit and non Inuit women living the contiguous area of the North West Territories. While I was working in this area I witnessed the birth of an Inuit child in a nursing station under the care of a midwife. Within two years of this experience policies had changed and no planned births were occurring in the nursing stations. All pregnant women were being transferred to Churchill Health Centre or Winnipeg for their births. My experiences with respect to providing care to women birthing in Churchill made me realize that a woman could give birth without an obstetrician and the resources of a tertiary care hospital.

Following my return to Winnipeg in 1986 and the birth of the first of my four children I became an employee of the Women's Health Clinic, which is a feminist community health service directed by an elected community board. This clinic grew out of the feminist women's health movement and was committed to not only providing women-centred health care but also advocating for changes within the health care system with respect to women's health issues. The legalization of midwifery was one of the concerns the clinic took on as an advocacy issue.

In 1994 the Manitoba Minister of Health appointed me as the Chairperson of the Midwifery Implementation Council. My role was to chair the committee who was charged with overseeing the development of the legislation to regulated midwifery and creation of the framework for the functioning of these newly regulated health professionals. This included developing practice standards, recommending practice sites, financial considerations, assessment and upgrading of existing midwives, development of the regulatory structure and the education of midwives in the future.

As the chairperson of the Council I was the primary liaison with the Manitoba government whether it be with the bureaucrats or the elected representatives. It was also my role to attend all Council and committee meetings in order to ensure that the process was running smoothly. Ensuring that the consensus process was being used and that the Council members were kept informed as to what issues were upcoming and what our constraints were whether they be time, financial or political was an important aspect of my job. There was no part of the deliberations with respect to the Council's task that I was not a part of. When the legislation was proclaimed I became the first acting registrar of the College of Midwives until we were able to hire a registered midwife as the registrar. It was also my job to be the primary person presenting our work to the other health professionals which included receiving their feedback and communicating it to other members of the Midwifery Implementation Council.

My training as a physician meant that I understood the technical and research issues related to childbirth. My experiences in the north and at Women's Health Clinic allowed me to appreciate that there are alternate ways to approach health care delivery. My experiences as a consumer of obstetrical care made me recognize that options with respect to birthing and birth attendant were not only valuable but also necessary.

My intimate knowledge of the decision making and negotiations that had to take place during the process of regulating midwifery in Manitoba poses some challenges to the writing of this thesis. Due to confidentiality concerns only those documents and information that are in the public domain have been used in the creation of this document. The College of Midwives is aware of my thesis topic and has provided me with permission to use the documents and information as described above.

As a feminist, woman, physician, mother and ex chairperson of the Midwifery Implementation Council I have many perspectives on the issue of midwifery and maternity care in general. I have tried to set these prejudices aside and provide the reader with a thesis that will be informative and perhaps useful.

Chapter Two

History of Midwifery

A. Introduction

In 1990 Canada was one of only eight members of the World Health Organization that did not allow for the provision of midwifery services (Burtch, 1994). The explanation for this situation lies in the history not only of midwives, but of the medical and nursing professions as well. This history can be roughly divided into: the early history of midwifery in Canada, the rise of the medical profession coincident with the exclusion of the midwife, the struggle between nursing and midwifery, the medicalization and hospitalization of birth, the rise of the women's health movement with its demands for a more women-centred approach to childbirth, birth in northern Canada and the emergence in North America of the home birth/community midwifery movement. The boundaries between these periods are relatively flexible and vary from province to province and community to community.

B. The Early History of Midwifery in Canada

Aboriginal midwives were present and providing care to women long before European settlement and information about childbirth would have been widely disseminated within the whole community. This diffusion of knowledge was particularly important among the Inuit and other groups who spent large portions of their year hunting and living in relatively isolated

camps. Family members and experienced community women would be called when a woman was in labour, but some women were recognized as having special skills and were called upon more often to attend births. These were the midwives, often trained by their mothers or aunts.

This form of traditional midwifery survived for many years particularly in the Canadian Arctic and the more isolated communities of northern Manitoba and Saskatchewan. The Inuit Women's Association set up a study in the early 1990's to interview elders who had helped other women in childbirth and/or had themselves given birth "on the land" (Archibald etal, 1996). Although many of the women of this earlier generation had died, the project was able to complete interviews with 77 elders, a good indication of how long traditional ways of childbirth had survived, despite the social disruption caused by hunger, disease, epidemics and then the resettlement policies of the 1950's. The disappearance of the midwives was initially triggered by the Christian missionaries and accelerated by the Canadian Federal Government as it started to play a larger role in the North. Traditional midwifery was displaced much earlier in the southern Aboriginal communities of Saskatchewan and Manitoba, but even then the speed of this transition would have depended on the degree of isolation, the availability of alternate care providers and commitment to traditional ways (Archibald etal, 1996).

Some of the women who came to Canada with different waves of settlers were midwives either formally trained or trained by a type of apprenticeship model similar to the training an Inuit midwife would have had. These midwives brought their own midwifery traditions to Canada and usually cared for women within their own communities of origin. Since not all communities would have had the benefit of a local midwife, many births in the early days of European settlement were handled by local women, neighbours, who would be called to assist in whatever way they could once a woman's labour became established. These women were not formally trained and did the best they could under difficult circumstances. Langford (1995) describes the plight of childbearing women on the Canadian prairies in the late 1800's and early 1900's. She speaks of the incredible hardships these women endured due to the lack of trained help available to the women during their pregnancies, births and in the postpartum period. She blames the primitive living conditions, the vast distances from care providers and the hard physical labour required of women for the appalling rates of maternal and infant deaths. She also goes on to describe the negative effects of the protectionism of the urban based medical professional elite and their prejudice against the services of local midwives.

A few of the physicians and nurses who moved into the small towns and rural communities worked with local midwives, but many saw them as competition and refused (Langford, 1995). They also criticized the midwives,

describing them as untrained and unclean and contrasting the dangers of midwifery care in childbirth with the new and presumed safer methods of the physicians. As midwives were forced out of practice, many rural women were unable to find any care in childbirth. When efforts were made to develop a service that would provide a combination of nursing and midwifery care for rural women it was unsuccessful due to resistance by the medical profession (Langford, 1995).

C. The Rise of the Medical Profession

The development of an influential medical profession had a large part to play in the disappearance of the midwife in Canada and most of North America. With the rise in power and influence of the medical profession the midwife who was often poorly educated and unconnected stood little chance of surviving the physicians' intentions to monopolize birth services.

In 1795 the first Act to Regulate the Practice of Medicine was passed in Upper Canada making it illegal to practice physic, surgery or midwifery without a license. This Act did not appear to result in any conviction for practising midwifery without a license and in fact at the time was heralded as being rather foolish since the majority of the population did not have access to a licensed medical practitioner who could provide them services anyway (Gourlay, 1966).

In 1815 a new law was passed exempting midwives and stating that they did not require a license to practise midwifery. This exemption remained intact through two amendments to the act until 1865. In 1865 a law was passed which made it illegal for someone to pretend to be a licensed midwife. The ambiguity in the law was that it would seem that someone could still practice as long as they made it clear that they were not licensed. Physicians of the day were very concerned about this possibility. Some expressed their concern based on clearly misogynist principles. A physician in the Dominion Medical Journal in 1869 wrote in an editorial with respect to the ability of women to continue to practise midwifery despite the law:

> "They (the legislators) leave midwifery open to public competition, as if it was something any ignoramus, mule, or female could dabble in with impunity" (Ontario Government, 1987)

Other physicians objected to this situation based on the financial implications of midwives providing service to women who were giving birth. Many physicians felt that the Act should have outlawed midwifery and one stated his objection in the Canada Lancet in 1873 when he wrote that the Medical Act:

> "takes money out of our pockets, by placing it within the power of others who have never spent a farthing, nor lost an hour for the sake of becoming properly educated, to attend cases of confinement" (Ontario Government, 1987).

In 1899 and in 1915 attempts were made to convict women of practising midwifery without a license. In one case the midwife was found

not guilty because her client had not paid her and in the other case she was found guilty but the judge refused to apply any penalty. After this doctors abandoned the route of criminal prosecution and resorted to threatening letters from their governing bodies and intimidation of local midwives to put them out of business (Ontario Government, 1987).

The medical profession was not singling out midwives in their attempt to control the provision of health care to the public. By the early part of the 20th century medical practitioners were not only ruling their own profession but also had managed to either exclude, limit or control the practices of midwifery, nursing, pharmacy, chiropractic and dentistry (Coburn, 1998). Coburn (1998) also describes the struggle within medicine where the medical elite, who were the urban based academic physicians tried to either 'raise up' or if that was not possible to exclude the physicians who were not university trained and in the process began to exclude all types of other health care providers from legitimate practice.

Meanwhile in the United States a similar struggle was unfolding pitting a developing male dominated medical profession against the community midwife. Birth in colonial times in the United States was a social event where women were assisted by female friends and relatives who offered aid and comfort. Physicians were only called upon to assist if the birth was a particularly difficult one where instrumentation might be required (Suarez, 1993). By 1765 the first medical school was functioning in the United States

and by the early 1800's medical schools were teaching midwifery to their predominantly male medical students and the word obstetrics was born (Wertz and Wertz, 1989).

Initially some American physicians were willing to work with midwives. The midwives would care for women having uncomplicated births and the physicians would step in to only provide care in complicated cases. Gradually this situation changed. The reasons for this change are unclear but speculation is that it was related to the financial benefits physicians saw that they could reap from birthing women coupled with their belief that physicians using their scientific approach could provide better care to birthing women. Reynolds (1996) noted the intense rivalry between physicians and midwives for control of childbirth services in the late 1880's in New York. By this time upper and middle class women had been convinced of the actual or potential danger of birth and were calling on physicians more and more for every labour (Wertz & Wertz, 1989). Due to intense pressure from the organized and powerful medical profession state after state began to pass laws banning midwifery practice and limiting the practice of obstetrics to physicians (Ehrenreich & English, 1973). Years of lobbying by the professions including door to door visits by the Victorian Order of Nurses, articles in popular magazines like Chatelaine and edits from the medical profession, all touted the necessity of having medical care throughout a woman's pregnancy and birth (Gourlay, 1966). Thus began the move from birth being centred on the

woman to birth being controlled by physicians and hospitals, with the majority of women not questioning why or how this came about (Suarez, 1993).

While midwives in North America were trying to survive the threat of a medical profession who had decided that they were the only qualified persons to attend women during birth, midwifery in European countries, managed to survive the development of the male dominated medical profession and through training to become an established occupation (Ehrenreich & English, 1973). However midwives in the United Kingdom suffering from a lack of government support became subservient to the powerful physician and nursing lobbies and by the 1970's were delegated to providing care under the direction of the family physicians and the obstetricians (Benoit, 1998).

D. The Medicalization and Hospitalization of Birth

To truly control birth and who might attend a woman in birth it was important that women give birth in hospital where physicians controlled what services were delivered and who delivered them. Writing about childbirth on the prairies during the early 20th century, Langford (1995) describes the efforts made to move childbirth into community district hospitals. The cost, the difficulties of travel and the imperatives of being a farming wife and mother meant that most women could not avail themselves of the services of these facilities which were distant from their homes (Langford, 1995). As late

as 1924 approximately 50% of births in Saskatchewan were at home and medically unattended (Benoit, 1998).

The controversy over the role of midwifery simmered throughout the years until the advent of antibiotics in 1937. This discovery was hailed by physicians as the reason for improved maternal mortality rates and the public was informed that medicalized birth was finally beginning to demonstrate that it was the best and safest way to give birth (Ontario Government, 1987). It was in hospitals that the latest technology could and would be employed. The use of anesthetics and the prospect of a break from their normal routine enticed women into the hospital for their births. Throughout the 1940's, 50's and 60's the modern hospital birth package became more complex as more procedures were added. Shaving the perineum, routine enemas, episiotomies, inductions, augmentations of labour and increased rates of cesarean sections were the results of the move to the hospital environment and the attempts to medically manage labour and birth (Romalis, 1985). By the 1970's electronic fetal monitoring kept most women confined to their hospital beds during their labours. Ironically the very power women were seeking with accessibility to pain control measures resulted in more control by the medical profession over birth and an increasing definition of birth as a medical event (Romalis, 1985).

Once women were socialized to giving birth in hospitals attended by physicians the next move was to begin to limit the number of hospitals which

could provide birthing services. As birth became more technological, the costs in equipment and specialist physicians to use this technology significantly reduced the number of hospitals who were able to support what was deemed the necessary level of service required to provide 'safe' births for women. Initially these hospitals were not allowed to provide care for women who were designated high risk. Eventually as the medical community began espousing the idea that a birth is only low risk in hindsight, that is if nothing happened requiring intervention during the birth, the ability of the smaller community hospitals to provide care for any birthing women was further impacted. The result was that within Canada women were required to travel further and further to give birth in specialist staffed, high technology centres. As this happened the rates of interventions during birth increased and the satisfaction levels of the consumers decreased (Romalis, 1985).

E. Women's Health Movement

At the same time as the management of birth became more and more medical, a parallel movement of protest started up. In the late 1950's and early 1960's the lay press, began to investigate the "tortures that go on in modern delivery rooms". Scultz (1957) itemizes these "tortures" including strapping women to the delivery table, isolating women in labour and slowing down birth to wait for the doctor to come. Women began to question the volume of the interventions, including shaving the perineum, enemas and

routine intravenous usage, that were imposed on women giving birth in hospitals (Wertz & Wertz, 1989). The move to "natural childbirth" which had begun in England in the early 1940's met with great resistance from the physicians and the hospital staff (Wertz & Wertz, 1989). As this movement spread to the United States it became the basis for the childbirth education movement and the questioning of the obstetrical system in America and somewhat later in Canada (Romalis, 1985). Change was slow to come.

By 1990 many cosmetic changes had happened within the practice of obstetrics including birthing rooms with nice wallpaper and rocking chairs, but women continued to call for more substantial changes. In this year four American consumer groups including the Women's Institute for Childbearing Policy, the National Women's Health Network, the National Black Women's Health Project and the Boston Women's Health Book Collective developed a policy paper calling for the recognition of midwives as the most appropriate primary care giver for most childbearing women. They stated that midwifery is safe, enhances access, meets the needs of virtually all childbearing women, involves judicious use of technology, is associated with a highly favourable liability record, is well-received by childbearing women and is highly cost-effective. The pressure was mounting to respond in significant ways to women's concerns (Women's Institute for Child-bearing Policy, 1990).

F. Nurses, Midwives and Nurse-Midwifery

While the midwife's relationship with medical practitioners has been one of struggles and compromises the relationship with nursing has been equally marked with challenges related to what the relationship should be. Nursing and midwifery have long struggled with the tie that has developed between these two professions. On the one side there are those who see midwifery as a natural specialty of nursing. On the other side there are those who recognize the divergent roots these professions have and who feel that the association with nursing has been problematic for the full development of the potential of midwifery. The loss of autonomy under nursing has been stated to be a problem as it has meant that midwives could not provide a unique model of care to women but are limited to the nursing/medical model of service. The European experience is a good example of the struggle that is being played out in most developed nations.

In countries where midwifery has survived such as the United Kingdom, the move to increased hospital births and increased use of technology has turned midwives into specialized hospital nurses. Strict practice protocols dictate to the nursing/midwifery staff what procedures should be employed and when. The physician staff developed the protocols with very little input from nursing or midwives. These protocols serve to further stifle any professional independence that the midwives might have demonstrated on the labour floors of the hospital. In the United Kingdom there has been very little community midwifery and most women would not

have any contact with the midwife who attended their birth before or after the birth (Benoit, 1998).

On the other hand Denmark and the Netherlands are examples of where independent midwifery practised in the home setting has successfully passed the test of time (Benoit, 1998). In these countries where midwifery has been particularly successful there are two commonalties as noted by Benoit (1998). These countries have first of all extensive state support for birthing families and secondly midwives who are relatively autonomous from medicine and part of a health team that puts the needs of the birthing families first.

Over the past 20 years political changes, more specifically the formation of the European Economic Community now called the European Union, provided the impetus to look at the regulation of midwifery in all of the member nations. In 1980 an advisory committee to review the training of midwives was ordered by the Council of the European Communities. This Council existed to implement areas of agreement that were included in the Treaty establishing the European Economic Community. One of the mandates of the Council was to develop a process to recognize professional qualifications among citizens of member countries of the Community ensuring however that an equally high standard of training was maintained (Council of the European Communities, 1980).

This committee began meeting in 1984 and included members from: Belgium, Denmark, Germany, Greece, France, Ireland, Italy, Luxembourg, Netherlands and the United Kingdom. It's initial tasks were to address the length of training a person would need to become a midwife and to recommend the number of births that a midwife should be required to attend in order to qualify for registration (Commission of the European Communities, 1986). In 1991 the Committee reported to the Commission that it was very difficult to come to an agreement on entrance to practice requirements as the practice of midwifery was so different in various countries that they could not be sure they were comparing like to like (Commission of the European Communities, 1991). It reported that, depending on the country, the type of training program that was most attended by midwifery students varied. Several countries such as France, Germany and Greece reported that the majority of their midwives graduated from direct entry educational programs and did not have nursing qualifications. Other countries such as Ireland, United Kingdom and Italy reported that the virtually all of their midwives were trained as nurses before they went on to receive their midwifery training. In response to the concerns about entrance to practice requirements in their third report they recommended two options for midwifery training (Commission of the European Communities, 1991). A basic three-year direct entry program or an 18 month post nursing certificate

program were the suggested minimum requirements for registration as a midwife in the European Union.

Their fourth report encouraged the development of national bodies that regularly reviewed midwifery training in member states and reported their findings to the other member states of the European Union (Commission of the European Communities, 1996). The support of the direct entry midwifery program was clear throughout their documents and directly influenced the move to create a direct entry midwifery program in Ireland where previously only the post nursing program of midwifery studies was available (Byrne, 1999).

The United Kingdom, which has a long history of legalized midwifery care, had moved to a system where midwives trained initially as nurses and then went on to further training in midwifery in order to be registered as a midwife. By the 1990's most women were giving birth in hospitals and most were attended by midwives who were employees of the hospital and worked as shift workers on the maternity units. Midwives had become specialized hospital based nurses. Some worked in out patient clinics providing pre and postnatal care while others worked on labour floors providing intrapartum care only. In 1994 the UK government adopted a policy of "women-centred care" (Allison, 1996) based on a report entitled "Changing Childbirth" (House of Commons, 1992). This groundbreaking report clearly was an opportunity to expand the role and power of the midwife in the United Kingdom

(Anderson, 1993). The report offers a view of midwifery as an independent community based service as well as supporting the option of midwives attending home births. As a result of this policy direction, one of the newer trends in midwifery in the United Kingdom is the move from nursing based midwifery education to direct entry midwifery schools as a prerequisite for midwifery registration in the European Union.

Currently midwives in both Ireland and the United Kingdom are governed by nursing bodies according to legislation. In the United Kingdom this group is called the United Kingdom Central Council for Nursing, Midwifery and Health Visiting and in Ireland it is called the An Bord Altranais (Council of the European Communities, 1980). However changes have occurred in the past few years to begin separating midwifery regulation from nursing regulation. In 2000, Ursula Byrne, was named the first Registrar for midwifery in Ireland. This marked the first time that midwives were actually placed on a separate registry from nurses and began the development of a unique governance structure for midwives in Ireland (Byrne, 2000). However O'Connor (2002) writing in the Midwifery Digest still decries the "iron grip of nursing over midwifery" and claims that the only way for midwifery to survive is to gain full autonomy from nursing. She is concerned that in 2002 there are still only 3% of midwives working in the community in Ireland while a full 97% continue to be hospital employees.

There were and continue to be two types of midwives in the United States, those whose primary training is as a nurse and those whose primary training has taken place in a direct entry program of studies or through informal training in the community (termed lay or direct entry midwives). Various states legally recognize one or both or neither of these types of training (Butler & Kay, 1988). The lay midwives view the nurse midwives as too "medical", too dependent on the medical technologies available to them and the specialist physicians who are readily available for them in the hospital setting. The nurse midwives view the lay midwives as under trained and irresponsible (Davis-Floyd, 1997).

The American College of Nurse Midwives (ACNM) was created in 1935 to further the interests of midwives who were also nurses. Despite years of trying to develop the credibility of nurse midwives as autonomous professionals they still find themselves defending the value of midwifery within the system of maternity care in the United States (Mariso, 1995) Currently most nurse midwives work in hospitals (Declercq, 1992) or are salaried employees of health maintenance organizations in their state and their work is generally directed by obstetricians. Most lay midwives work in the community, often with less advantaged groups of women, providing care to those who do not have heath insurance or who cannot afford the services of an obstetrician. The other group of women who use the services of a lay midwife in the United States are those women who due to their belief

systems do not wish to avail themselves of the services of the established medical profession. These are women who wish to birth at home or whose philosophy of birth more closely matches those of the lay midwives. This group of women is often highly educated and middle class.

The lay or direct entry midwives as they may be called formed an organization called the North American Registry of Midwives (NARM) as a way of gaining credibility for this group of women who entered midwifery practice through multiple routes of study. This organization developed the NARM examination process that, if a midwife successfully passes, gives her the right to call herself a Certified Professional Midwife (CPM). They developed a process for the accreditation of direct entry midwifery programs overseen by the Midwifery Education and Accreditation Council (MEAC) as a way of giving non university based programs an opportunity to gain credentials (Davis-Floyd, 1997).

The rivalry between the nurse midwives and the lay midwives in the United States was seen to have weakened the political power of the midwife. In the mid 1990's the American College of Nurse Midwifery voted to begin recognizing direct entry midwifery programs and to open up their accreditation process to direct entry midwifery (International Confederation of Midwives, 1996). However Davis-Floyd (1997) points out that they are only willing to acknowledge those midwives who graduate from a ACNM accredited school that produces midwives who have a University level midwifery degree

or equivalent. This position means that all other midwives who come from non accredited schools, direct entry schools or who trained by apprenticeship or in a foreign country would still not be eligible for accreditation with the ACNM. At this point in time the NARM and the ACNM continue working at odds with each other developing parallel processes for the accreditation of midwives.

In 1999 the Pew Commission released a report "Charting a Course for the 21st Century: The Future of Midwifery" (Dower, 1999) which addresses the future of midwifery in the United States. Their report strongly stresses the need for an autonomous midwifery profession with entry to practice based on successful completion of an accredited education program or the equivalent and a national certification procedure. They clearly state that midwives should not be directly supervised by other health care professionals and should have hospital admitting privileges consistent with the profession's standards. Health care systems, according to the Pew Report, should recognize that midwifery is distinct from other health care professions. This being said there are still states that do not recognize midwives right to practice in any form.

Midwifery in New Zealand underwent a huge shift in 1990 with the passage of the Nurses Amendment Act, which changed maternity services in New Zealand by legalizing midwifery as an autonomous profession. The nursing governance body subsumed midwifery previous to this. A new

governing body called the New Zealand College of Midwives was formed. Their first priority was to develop models of care for childbearing women that promote a partnership between the midwife and the woman based on the principles of individual negotiation, equality, shared responsibility and empowerment (Young, 1996). The New Zealand model of midwifery governance and provision of midwifery care is held up as a model for best practices by many midwives around the world.

Canada's experience of the effects of nursing regulation of midwifery are illustrated in the experience of Newfoundland and Labrador which are the only areas of Canada where midwifery has always been legal. However there have not been midwifery services available to women for many years. The Midwives Act was passed in 1920 and up until 1934 direct entry programs trained midwives to provide services to the birthing women of Newfoundland and Labrador. Their services were especially valuable for the women living in more remote communities along the coasts of this province. In 1953 nursing was given the responsibility for taking over the regulation of midwives and the opportunity for direct entry midwifery became lost. Currently no midwives are providing midwifery services in Newfoundland or Labrador.

British Columbia, Alberta, Saskatchewan, Manitoba, Ontario and Quebec all have regulated midwifery at the time of the writing of this thesis. All of them have chosen to regulate midwifery through the creation of

independent regulatory bodies for midwifery. None of the provinces require a nursing education in order to enter practice as a midwife.

G. Home Birth Movement and Midwifery in Canada

Between 1960 and 1990 birthing women in the United States and Canada were becoming more vocal about the need for reform within the obstetrical system. A lack of continuity of caregiver, increased intervention rates and a shortage of physicians providing obstetrical services meant that the system was being seen as less and less responsive to the needs of the women and their families who were requiring these services. While hospitals were trying to improve the physical space where women laboured and gave birth it was still not seen as satisfactory by some vocal groups of women. These women wanted more substantial reforms. A small group of men and women chose to take things into their own hands and gave birth to their children at home. Some did this without any attendant while others secured the services of community midwives in their area. Government was feeling pressure from women and men who were supportive of home birth. These women were frustrated with the monopoly held by the medical system with respect to birthing and called for midwifery and home birth as a viable alternative.

By the time serious steps were taken to legalize midwifery in Canada there were vast areas of the country without any midwives practising. Those that were practising were hampered by the necessity of practising either in a

hospital setting under the direction of a physician or in the community without support of the law or backup from the obstetricians. Prior to legalization midwives working in the community were only able to function due to a network of citizens who strongly supported women's right to birth at home and were willing to support the midwives providing this service financially and politically if the situation required. Despite the lack of support by physicians for home births approximately 60 births out of the roughly 14,000 per year in Manitoba were occurring at home. Prior to this no data is available. The support of the home birth families cannot be underestimated in the success of the movement to legalize midwifery.

Each province had grass root groups of supportive citizens who were working along side of midwifery organizations to support the legalization of midwives and their ability to provide care to women who were choosing to birth at home. In British Columbia this group was called the Midwifery Task Force. This organization was predominantly comprised of consumers of midwifery care and its purpose was to educate the women of British Columbia about midwifery and to lobby government for the legalization of midwifery. In Manitoba the similar group was called the Home Birth Network which was comprised of families who had birthed their children at home and midwives who were providing home birth services. This Network lobbied government for the legalization of midwifery services with the primary goal of enabling midwives to provide care at home without fear of reprisal.

Midwifery in Canada has been strongly supported by the clients of the community midwives who provided home birth services. The tie between midwifery and home birth in Canada is quite probably much stronger than in other developed countries with long histories of regulated midwifery where midwifery is more strongly associated with hospital based services. Politicians were influenced by the home birth lobbies to ensure that the issue of home birth was addressed in whatever legislative process was developed. For better or for worse midwifery in Canada is entwined with the home birth issue. This tie has had an influence over the pervasive presence of home birth issues in the development of the regulatory processes for midwifery in Canada.

H. Birth in Northern Canada

The history of birth in northern Canada is an excellent illustration of the move from home based birth to hospital birth and mirrors the development of the control of the health professionals over the birthing process as well as what is possible when a community wants to take back control over this important aspect of life and health. Aboriginals are among the small group of Canadian women who have had life experience with both local traditional midwives and nurse midwives in the Federal nursing stations.

Midwifery in the far north of Canada was alive and well until the 1960's when the move toward hospital births began to really expand in the north.

Previous to Caucasian movement into the Arctic, neighbours, family members and experienced community women were called when a woman was in labour. Western medicine came to the north in the form of federally funded nursing stations staffed by registered nurses who often also held midwifery qualifications from the United Kingdom or another Commonwealth country. Low risk births gradually moved into the nursing stations and complicated cases were sent south to centres with doctor's care available. By the early 1980's most births were occurring in the hospitals of the provinces to the south. The pregnant women were flown out of their communities two weeks before their due date and were required to remain in the south until their baby was born. This was seen as very disruptive to the family and the community (Archibald etal, 1996). Nevertheless despite concerns expressed by the communities women continue to be removed from the communities for birth to this day.

In Rankin Inlet, NWT, community pressure led to the opening of a birth centre. This centre opened in 1994 and was created in order to allow women to stay in the community to birth rather than be evacuated to the south to have their children. At that time the community had a population of 1967 people the overwhelming majority of which were Inuit. Rankin Inlet is 250 kilometres by air from the closest hospital in Yellowknife to the west and almost 500 kilometres from the hospital at Churchill, Manitoba to the south. A birth centre was established to demonstrate that safe birthing with

midwives providing care was possible in the north. This project has been favourably received by the community (Morewood-Northrop, 1997) and there have been moves to increase the number of women giving birth there by reducing the restriction on whom is eligible for birth at the centre. The strong community support for the midwifery staffed birth centre was the impetus for the creation of the centre.

The birthing centre project in the Inuit community of Povungnituk is an example of creative birthing service delivery motivated and supported by the local citizenry. Birthing in northern Quebec pre 1986 required that the women be transported to a southern community several weeks before birth to remain until she and her newborn were able to travel home. The regional Native Women's Association took the initiative to bring their concerns with this practice to the attention of the regional health authorities. They explained the negative impact on the health of the women, their families and the community when the women are required to leave their children and partners at home for extended periods of time. Women were reluctant to seek prenatal care or were misrepresenting the date they were due to deliver in order to avoid evacuation. The community had lost the traditions and supports associated with birth and this was felt to be contributing to problems such as poor breast feeding rates and a lack of postnatal education and support for the new mothers. With strong community input a birthing centre was opened under the guidance of a group of European trained

midwives. While this project was developed to provide services through the perinatal period to women of the region the training of Inuit women elected by their communities to become midwives was equally as important. The project set out to provide an opportunity for the community to become involved in the birth process and to become more self reliant when it came to issues related to childbirth and pregnancy. This project has been very successful with improved perinatal outcomes, trained Inuit midwives and communities that are much more involved in birth and birthing issues (Stonier, 1990).

I. Summary

Midwifery has been practised in Canada since the beginning of human habitation. The aboriginal people had women who functioned as midwives long before European immigration brought with it their version of midwives. However, as the medical profession became stronger and hungrier for patronage the midwife was put out of business through legislation and intimidation. Only in very isolated northern Inuit communities were midwives able to continue to function into the 1960's. In order to succeed at putting the midwives out of business the physicians needed to provide something that looked superior to the care the midwives provided. Technology proved to be the key. By initially attracting women to their services by offering pain relieving medications and the magic of forceps birth in difficult situations the

physicians soon found that they had a captive audience. Once women were asking physicians to attend their births it was only a matter of time before women were being brought to the physicians in their hospitals in order to benefit even more from the technologies the physicians had to offer. For some women these benefits seemed more like liabilities and the women's health movement was born.

By the 1950's most births were occurring in hospital accompanied by many interventions including tying the woman down, shaving the perineum, enemas, IV's, inductions, etc.. A backlash which was spreading across the Atlantic Ocean meant that women were starting to question the need for all of this intervention and were requesting more control over their births and more comfortable surroundings in hospital in which to give birth to their children. Some more radical families were taking matters into their own hands and giving birth to their children at home. Most of these families used the services of a community midwife who was working outside of the law. Their calls to the government to legalize the service of these home birth midwives accompanied by pressure from the public to humanize the care provided to women in the hospital provided a strong impetus for the government to decide to move on legalizing midwifery and to ensure that home birth was a part of the package.

The issue of whether Canadian midwives should be nurses or not comes from the long tension that had existed in Europe and the United States

over whether midwives are specialized nurses or a profession unto itself. The recent (albeit slow) movement in the European Union to non nurse or direct entry midwifery and the movement to recognize direct entry midwifery in the United States were also noted by the government when decisions were made with respect to what background a registered midwife in Manitoba would be required to have.

The development of the Povungnituk birthing centre where local Inuit women are being trained by apprenticing with the midwives hired to provide birthing services is an interesting example of how community pressure can begin the process of returning birth to their communities.

It was against this long and complex history that the Manitoba government began to consider why and how to legitimize the practice of midwifery in Manitoba.

Chapter Three

The Manitoba Situation

A. Why Regulate Midwifery Now?

Why was the decision made to regulate midwifery in Manitoba at this point? There had been several reports previously that had recommended legalizing midwifery. What was different now?

The debate over whether or not to regulate midwifery in Canada has been complex and divisive. Midwives have managed to practice despite lack of legal sanction and public financial support throughout the decades. So why the move to bring midwifery into the realm of government regulation? Was there a demonstrated need for this service to be regulated?

The province of Ontario was the first to decide that midwifery needed to become a part of the regulated, funded health services provided by the provincial government (Bougeault, 1996). The commitment to the profession was further underlined by the funding of a direct entry midwifery Baccalaureate program at McMaster University in Hamilton, Ontario. Benoit (1997) notes that prior to regulation midwives tended to present a very positive picture of midwifery as an emerging profession. They focused on the efforts their organizations had made to set standards and ensure the midwives in practice were well educated. The uniqueness of midwifery knowledge and the commitment that midwives had to their clients were presented as evidence of the professional nature of midwifery practice. In

Ontario Van Wagner(1994) claimed that the regulation of midwifery was necessary in order to be able to meet the needs of a wider group of women. When midwifery was neither government funded nor recognized, only those women with financial resources and the self-confidence to choose to use a service which was not condoned by the dominant culture were using the services of a midwife. This meant the midwifery clients before regulation were generally white upper or middle class women. Van Wagner states that it began to look like avoiding regulation was a form of "elitism".

Does midwifery offer an attractive alternative to the existing system? Arguments exist that the only way to improve perinatal outcomes in North America is to move to a system that supports the normal process of labour and birth. Suzanne Armes (1975) talks about the doctor's attempts to turn birth with all of its unpredictable events into "clean, safe science". Korte (1992) notes that obstetricians worldwide use basically the same technology and drugs in childbirth. In countries other than the United States (and one could argue Canada) doctors use them in a different way. In Japan, for example, where they have the lowest infant mortality rate in the world, doctors use few or no drugs and are much slower to interfere with the natural process of birth. The interference with natural childbirth by the necessity of birthing in hospital, the overuse of drugs and the adoption of procedures done for dubious indications, all increase the risk of pathologic births and poorer perinatal outcomes (Suarez, 1993). Midwifery is seen as a

possible solution to the developing "problem" of iatrogenic birth complications (Wagner, 1994). Midwifery services that emphasize the normal and discourage the use of technology appear to be a true alternative to the existing system and may offer an improvement in services to birthing women and their babies.

Could this problem have been dealt with by having more women physicians providing birthing services to women? The suggestion has been made that the answer is to bring the woman's touch into birthing by having more women physicians available to provide care to women during pregnancy and the birthing process. Unfortunately this has not proven to be useful. The hope that women physicians would innately know how to deal with birth in a way that was less invasive and supportive of the natural process, in other words behaves more like a midwife, has not born out. Medical school selection processes, the minority status of women in medical schools, the reality that the same approach to birth is taught to both genders of medical students and the underlying message to students that intervention and technology are always advantageous has dispelled any hopes that women physicians as a group would make a difference (Suarez, 1993).

Another problem lay in the reduction in the number of physicians providing care to women during labour and birth. Both family physicians and obstetricians were opting out of the practice of obstetrics due to financial issues related to the fee paid for this service, the escalating cost

of malpractice insurance and life style issues related to the long and unpredictable hours an obstetrical practice demands.

Regulation in Manitoba was also sparked by several legal proceedings which highlighted to the courts and to government that midwifery and home birth were in demand by a sector of the public. Without midwifery being a recognized profession it was very difficult to protect the public from practitioners who were perhaps not as skilled as they should be (Conner, 1992). In fact it was very difficult to decide if a midwife was practising up to acceptable standards because no one was setting those standards in Manitoba. There was no way that a woman who was contemplating whether or not to use the service of a particular midwife, could be assured that this woman had received midwifery training and would be able to provide an acceptable level of midwifery skills to the woman and her family. In the unregulated system a woman would have to make these decisions herself. In a regulated system a woman would be able to assume that a person had basic midwifery skills. She could then base her choice of midwife on other factors such as personality or special skills that a midwife might have to offer such as advanced skills in water births or expert knowledge in the use of herbs.

Some supporters of midwifery, however, argue that regulation runs the risk of loosing the heart of midwifery. They fear that regulated midwifery might result in the medicalization of midwifery with the resultant loss of

midwifery knowledge and skills (Devries, 1993). Devries (1993) expressed the concerns that professionalization may lead to the distancing of the relationship between midwives and their clients with an erosion of the services such as continuity of caregiver as currently provided by the unregulated midwives. Reid (1989) mused as to whether midwives could:

> set up and achieve an alternative women-centred occupation that lies outside the traditional sphere of professional groups but is accepted by them and has access to professional resources and rewards: Or, in order to achieve those rewards, do midwives have to conform to the demands of (and be dominated by) professional authorities? (p. 10)

The debate in simplistic terms is whether midwifery could retain its heart and soul if it had to answer to two masters: the client and the professional body.

Concern also existed as to whether or not regulated midwifery could enfold all of the diversity that existed within the midwifery population. Would the few lay midwives who remained in practice be able to continue to provide services to birthing women? Could midwives who trained in other countries find a place within the regulated midwifery community to begin to provide much needed services to the women in those communities? Skeptics felt that the system would not be flexible enough to be able to welcome all midwives into a regulated system (Schroff, 1997)

Benoit (1998) expressed the concern that the midwives' need to protect themselves from increasing exposure to malpractice claims would lead to a loss of the close relationship with the client that is so often spoken of as

a cardinal feature of midwifery care. She suggests that the midwife would be so busy charting and making sure that nothing goes wrong that she would be driven to develop a style of practice that more closely resembles the practice of a physician. This would not meet the needs of the population that has been calling for regulated, funded midwifery services.

On balance the political pressures on government from the public as well as several reports to government that had strongly recommended the regulation of midwifery in company with suggestions from the courts that this occur pushed the government of the day to opt for the recognition of midwifery as a regulated profession.

B. History of Midwifery in Manitoba

As discussed in Chapter two the movement to implement regulated midwifery in Manitoba was part of a wider process of reforming care for women in childbirth, which had started in the 1980s and gathered power in the 1990s. It took slightly different forms from country to country, but its focus was always on providing more control to women giving birth and on establishing a different relationship between the woman and her caregiver. Manitoba's history of regulated midwifery mirrors the struggles that have occurred elsewhere in Canada and the developed world and yet displays characteristics that make its history unlike any other region of the country.

The modern history of midwifery in Manitoba is peppered by reports to government on the issue of whether or not to regulate the practice of midwifery and if so who should be eligible to practice. In April of 1982 the Community Task Force on Maternal and Child Health, which was sponsored by the Social Planning Council of Winnipeg in cooperation with the Manitoba Department of Health and Community Services, produced a report that identified high risk groups of women with respect to adverse outcomes during the perinatal period. They identified a lack of responsiveness to consumer participation in the birth process as a part of the problem creating these poor outcomes.

In 1987 the Manitoba Advisory Council on the Status of Women undertook an extensive consultation with health professionals and consumers with respect to the introduction of regulated midwifery. They noted the demand from the public for midwifery services. As well they discussed the reality that midwives were practising in Manitoba both in the northern regions of the province as well as in urban areas despite the legislation that made this illegal. Nurse midwives were practising in northern nursing stations under federal legislation.

In 1990 the Minister of Health asked the College of Physicians and Surgeons of Manitoba and the Manitoba Association of Registered Nurses to prepare a ministerial consultation paper defining a proposed role for midwives in the Province of Manitoba. This committee consisted of four physicians and

three nurses, one of whom had midwifery qualifications. In February of 1991 they released a report proposing the introduction of nurse midwifery in Manitoba. They specified that "there is no role for the lay midwife" except perhaps as a "companion". In preparing their report they consulted many organizations but notably absent are the community midwives and their clients.

The Alternative Health Care Services Task Force Sub-Committee on Midwifery (1990) was established by the Manitoba Health Advisory Network Steering Committee to "review alternative health care systems appropriate to reduce expensive health care services without compromising quality of care." This committee was comprised of a physician and four nurses. Midwifery was one of the suggested possible alternate services. After consulting with several organizations and individuals including the Traditional Midwives Collective who represented community midwives and a family who had chosen to have their baby at home with the services of a midwife they endorsed the idea of regulated midwifery. They saw the need for midwifery services to fill the void being created by physicians ceasing to provide this service to their clients.

The Manitoba Government in 1991 commissioned the definitive report on midwifery in Manitoba. It was produced by a group called the Working Group on Midwifery and proved to be the last report presented to government before they decided to regulate midwifery and set about the

process to do so. The Manitoba Minister of Health established the Manitoba Working Group on Midwifery, in June of 1991. The primary role of this working group was to recommend whether midwifery should be implemented in Manitoba and if so suggest a framework for how this should happen including an estimate of the financial implications. The committee included representatives from stakeholder groups such as the College of Physicians and Surgeons, the Association of Registered Nurses, nurse- midwives, traditional (or community midwives), community women's health activists, consumers and government. It was chaired by an academic, who was neither physician, nurse nor midwife from the University of Manitoba. In February of 1993 this group produced their report. Forty-four recommendations were made. These recommendations formed the beginnings of the policies that shaped midwifery in Manitoba. A complete list of their recommendations is included in Appendix B.

Their most critical recommendation was that midwifery should be recognized as a legal autonomous health profession available for Manitoba women and that it should be a service funded by the Manitoba government as an insured health service. The basis of this decision was that women wanted a system of care that viewed pregnancy and childbirth as "normal life events". Women were looking for a system that offered "less intervention and more continuity of care". Midwifery was seen to be the best option to fill this need.

The Working Group report laid out a clear path to follow for the development of regulated midwifery. The next step was the appointment of the Chairperson and the members of the Midwifery Implementation Council whose task it would be to bring about regulated midwifery in Manitoba.

On International Midwives Day, May 5th, 1994, the Minister of Health for Manitoba announced the formation of the Midwifery Implementation Council and my appointment as the Chairperson of the Council. The MIC was charged with the responsibility for making recommendations to the Minister of Health for the implementation of the new regulated profession as it relates to legislation, education, practice and equity/access issues. The terms of reference for the MIC are included in Appendix C. The mandate of the committee was to implement regulated midwifery in Manitoba, not to produce another report.

Shortly after the announcement of the intention to set up the Midwifery Implementation Council reaction began to be heard both by the Minister of Health and the newly appointed chair of the Council. Both individuals and groups reacted to the announcement. Some were writing to offer their services as potential members of the MIC. Others were concerned about the form the regulation would take. Some were concerned that it would be too restrictive while some were concerned that it would not be restrictive enough. Either way it was clear that this was a topic that provoked

diverse reactions and these viewpoints would need to be considered when the Council began meeting.

C. Setting the Stage for Midwifery in Manitoba

This section will attempt to clarify the situation that existed as the MIC began meeting in January of 1995 to initiate its task of developing the midwifery legislation. Two groups of midwives existed, the Traditional Midwives Collective and the Nurse Midwives Association. The traditional midwives are those who trained in various ways including self-study, correspondence courses, formal and informal apprenticeship. These midwives have been called lay midwives, traditional midwives and/or community midwives. For the purpose of this thesis these terms are equivalent. The nurse midwives are those who had training in both nursing and midwifery. While these two organizations had a few members who were able to communicate across group boundaries most members of each group had a strong distrust of the other group. The community midwives felt that the nurse midwives had been co-opted by the medical model of midwifery care and did not understand the art of midwifery. The nurse midwives saw the community midwives as little more than dangerous lay women who risked women's' and babies' lives everyday irresponsibly attending home births. Many of these nurses were supportive of the idea of nurses becoming

registered midwives but were very suspicious of the process and were sure that like in Ontario they would be excluded from the registration process.

As the MIC began their work there were approximately 7 community midwives working in Manitoba and another group of about the same size who called themselves aspiring midwives and provided various levels of care. All but one of them was based in Winnipeg, but Winnipeg midwives would travel long distances to attend births if it was possible to do so. Community midwives were attending home births and were acting as birth attendants or doulas when their clients gave birth in the hospital. There had been an inquest into the death of a second twin after the first twin was born at home that had created a large stir in the birthing community in Manitoba and had created more questions than it had answered. The outcome was that the judge felt it was time for midwifery to come into the light of day, be recognized and regulated (Conner, 1992). Unfortunately this inquest only served to reinforce the idea of community midwives being dangerous. Although the College of Physicians and Surgeons had decided to turn a blind eye to what midwives were doing in the community the threat of being charged with practising medicine without a license was still a concern.

Individual physicians' positions with respect to the regulation of midwifery were variable. A small handful of physicians supported midwifery care but generally assumed midwives would be nurses working under the direction of a physician. The rest of the physicians saw midwives as a threat

to their income and/or their power and were particularly horrified by the prospect of community midwives becoming registered to practise since they saw them as dangerous and under trained. Much of this impression came from stories of physicians being called to hospital to take over from a home birth gone awry. They did not have any knowledge of the home births that were happening successfully in Manitoba at about the rate of 60 home births per year (Vital Statistics, 1995).

A small number of nurse-midwives were working in a transfer of function situation with physicians at one of the tertiary care hospitals. In this case the physicians gave the midwives the permission to provide pre, post and intrapartum care as long as they were following the protocols as set out by the physicians. They were bound to working in a medical model of care under the direction of a physician.

A shortage of physicians and nurses and financial pressures on the health care system were at the forefront of the government's agenda. Midwifery was a small agenda item for the government and had to compete with much larger issues for the government's attention and resources.

Midwifery Regulation Elsewhere in Canada

The regulation of midwifery in Manitoba began at a time when both Ontario and Alberta had relatively new legislation on this issue and British Columbia and Quebec were at various stages of setting up regulatory structures through the development of legislation. None of these provinces

required nursing as a prerequisite to registration. Ontario had proclaimed Bill 56, The Midwifery Act on January 1, 1994 and the 71 midwives who had successfully completed the assessment process began practising on that day. Only midwives who had been actively practising midwifery in Ontario prior to legalization qualified for the assessment program. Midwives in Ontario were providing care in community sites providing pre, post and intrapartum care in an autonomous model of care that focused on continuity of care for the clients. These midwives provided services at home and in hospital and in fact in order to maintain their registration had to attend ten home and ten hospital births each year. They had the authority to prescribe a defined list of medications and order tests relevant to the practice of midwifery.

Alberta passed its midwifery regulation in November of 1994 and by the fall of 1996 held its first assessment process for midwives who wished to work legally as a midwife in Alberta. Alberta midwives are required to practice in a model that is virtually identical to the model espoused in Ontario. Both in and out of hospital births and continuity of care are requirements for continued registration. At this time very few midwives are practising in Alberta due to a lack of government funding for payment of the midwives.

In December of 1997 the Minister of Health for British Columbia announced the intent of the government to pass legislation with respect to the regulation of midwives. This legislation came into effect on January 1,

1998 making British Columbia the third province to have a system of regulated midwifery. The B.C. regulation, much like that of Ontario and Alberta, was based on a model of midwifery that was community based, autonomous, had access to laboratory services and had the right to prescribe medications as outlined in the regulation. Midwifery care is funded under the provincial health care plan. Home births were required under the regulation but all home births had to be monitored under the Home Birth Demonstration project. The purpose of this project was not to demonstrate the safety of home birth but to monitor issues arising out of the implementation of home birth in British Columbia.

In 1990 the Committee on Accreditation to practice as a midwife was set up under the Quebec Act. This committee included midwives, a nurse, a physician, a representative each from Colleges and Universities and a consumer. A process for the assessment of midwives' skills included a written exam, a review of their clinical experience, and an oral/clinical exam. It was developed for the purpose of deciding which midwives would be qualified to provide midwifery care. The successful midwives would be employed for a limited period of time within demonstration projects set up by the government. Forty midwives were able to complete the assessment process. These midwives provided services to the women of Quebec from eight designated sites, which included clinic facilities and attached birthing centres. Hospital births were not an option as the physicians blocked hospital

privileges for midwives. The demonstration projects were evaluated in 1997 and felt to be a success in general. This success convinced the Quebec government to go ahead with the development of a legislative framework for midwifery in Quebec. Bill 28, which sets up the regulation of midwives, was passed by the Quebec National Assembly on June 17, 1999 and came into effect on September 24, 1999.

Midwifery within the developed countries where it had been a part of the health care systems since their inception was looking for newer regulatory models and an increased definition of midwifery's uniqueness to enable greater separation from existing professions such as nursing.

The regulation of professions was a topic that was on the agenda of governments across Canada. Several provinces had reviewed this issue and had made recent changes to the ways they were regulating health professions in particular. The provinces of Alberta, Ontario and British Columbia had moved from the system of individual acts governing each profession to an overarching health disciplines committee that oversaw all regulated health professions. In this case the Colleges of Midwives answered to their provincial Health Disciplines Committees. Manitoba had recently released a pivotal report by the Law Reform Commission (1994) on the regulation of professionals but was still using the system of separate regulatory bodies with no overarching regulation.

D. Summary

The recent history of midwifery in Manitoba was one of several reports all recommending some form of regulated midwifery that might fill the void created by physicians departing the field of obstetrics. As well midwifery offered the hope that it could provide the kind of care that segments of the population were calling for. The situation was ripe in Manitoba for the introduction of midwifery as a regulated profession. Other provinces were in the process of regulation and a version of Canadian midwifery was becoming clearer. That version included midwifes as autonomous practitioners, registered by an independent body, who were not nurses first. Canadian midwives would provide care to women in a continuity of care model and would attend births both in and out of hospital including homebirths and birthing centre births.

With the production of the final report of the Working Group on Midwifery, Manitoba was being challenged to also adopt this new Canadian midwifery model. The Working Group report called for midwifery to be regulated as an autonomous health profession with multiple routes to entry to practice. As well this report clearly laid out the process for implementation and the issues that needed to be addressed during this process.

Chapter Four

Self Governance for Midwifery

A. Law Reform Commission

In order to follow the development of the Midwifery and Consequential Amendments Act, it is first important to understand the basis of the regulation of professions in Canadian provinces. Several provincial governments reviewed their legislation and published reports on this topic in the 1980's and early 1990's. By 1992 Ontario, Alberta, British Columbia, Quebec and Saskatchewan had all produced reports looking critically at this issue. In Manitoba the Law Reform Commission had been charged by the Minister of Justice and the Attorney General with reviewing the regulation of occupations and professions. The issues they were asked to cover in their report included:

- the effectiveness of the present system within Manitoba for the governing of professional and occupational associations with reference to the policy and practices of the other Canadian provinces;
- the extent to which the provincial government should delegate governing authority to the professional and occupational associations, including the criteria by which self-governing status should be conferred on professions and occupations;
- the necessity of a structure within government to deal with issues pertaining to the governing of professional and occupational associations and the nature of that structure;
- the advisability of enacting general legislation regarding the governing of all occupational and professional associations and the proposed provisions of any legislation recommended;
- the advisability of permitting incorporation of professionals;

- any other matter which would assist the government in determining an effective policy for the governing of professional and occupational associations.

(Law Reform Commission, 1994, p.1)

The report discusses the differentiation made in Manitoba between 'occupations' and 'professions'. It notes the decision as to whether a particular occupational group constituted a profession had often been made in the past based on how convincingly that particular group had been able to argue the case for their professional status. The arguments put forward were usually framed around the advanced level of training required to perform their occupation and the commitment to public service of the practitioners of this occupation.

Greenwood (1957) states that:

> At the heart of the career concept is a certain attitude toward work which is peculiarly professional. A career is essentially a calling, a life devoted to good works. Professional work is never viewed solely as a means to an end; it is the end itself. Curing the ill, education the young, advancing science are values in themselves. The professional performs his services primarily for the psychic satisfactions and secondarily for the monetary compensations. Self-seeking motives feature minimally in the choice of a profession; of maximal importance is affinity for the work (p.53)

Early in the twentieth century, professions started to develop their own code of ethics (Pue, 1991). These codes sought to enforce the idea of public service before profit and warned against the "undertaking of any enterprise inimical to the public welfare" (Wagner, 1955). Each professional was and is

to this day expected to serve the public by committing themselves to putting the best interest of the client or patient first, even if this infringes on their own interests. They are expected and in many cases legislated to maintain strict rules with respect to confidentiality of client/patient information (Personal Health Information Act, 1999) or the use of this information for personal gain (Canadian Medical Association, 1990).

Professions are usually self-regulating in the sense that members of the profession develop and monitor the standards required to enter and remain a member of the profession. The Law Commission noted that self-regulation is based on the belief that only those in professional practice have the education and experience necessary to set out and enforce the standards relevant to their profession. Furthermore, it implies that only other members of the same profession are able to judge what is, or is not, improper conduct. These arguments have led to the successful bid for self-regulatory status for professions such as medicine, law, architecture and engineering thus granting them the legislative ability to set and enforce standards, not only with respect to initial membership in their profession, but also for the maintenance of membership.

The Law Reform Commission (1994) outlines two self-regulatory regimes that have historically been given to professions. The first is called a 'licensing' regime. This type of regulatory authority gives the members of the profession the exclusive right to provide a particular service or services to the

public. The second regime is called a 'certification' regime. This regime only gives the professional exclusive right to use a name or title. It does not exclude others from providing the same or similar service.

These self-regulatory systems, particularly the licensing system, have given professions a great deal of power. Not only can a self regulating profession control who enters a profession and how they behave once a member, it also gives the regulatory body the ability to define what practices constitute the profession. Most legislation defining the scope of practice of a profession is quite vague, leaving it to the profession itself to make any necessary adjustments to new conditions or developments. Some professions have used this power to prosecute anyone providing services that they claim should be exclusively delivered by members of their profession.

The Law Reform Commission (1994) concluded that the current model of a professional for legislative purpose included someone with a high level of education (usually a university degree) and a commitment to the public interest expressed in a code of ethics as well as by putting the interests of individual clients or patients above their own. Professions are usually self-regulating, acting through their own specially appointed regulatory body.

The Law Reform Commission Report describes the usual process followed in order to achieve professional status in Manitoba as follows:

> A voluntary group of practitioners is formed which is dedicated to creating a profession from a group of practitioners who may have no common educational background and little or no previous contact with one another (Nepveu 1970, Gullet 1971). The primary object of the

> group is usually to raise the standards of service of the occupation. If no university program exists for the study of the group's occupational service, efforts are made to establish one; if such a program exists, links to the university are developed. (Bohnen, 1977) Continuing education programs are begun and members are encouraged to attend. A code of conduct is designed and members are expected to commit themselves to it. If a group is successful, membership in the group often becomes prestigious and may be necessary in order to obtain a job, despite the fact that membership is not legally required in order to practice (p. 5).

The Law Reform Commission explains that after the occupational group is well established they begin to lobby legislators for a form of regulation and self-government. Their aim is to convince the government that they are similar to all ready legislated professions. So long as the group is well-organized, financially stable and able to make a good case, they usually have little difficulty in getting the legislation passed, although it may take some time to do so. A group may face opposition if another occupation feels threatened, or if more than one organization feels that they represent the same practitioners. In such cases the Government must either reach a consensus between the groups or chose which group to satisfy.

Some researchers have questioned the wisdom of giving professional status and the rights of self-regulation to occupational groups based on their claims to having a university based education program and a code of ethics. These critics point out that a licensing system can lead to greater inefficiencies in the system with fewer practitioners and higher prices to the public or the government, depending on who is paying the fees of the

professionals (Slayton & Trebilcock, 1978). There has also been considerable criticism of older established professions, particularly in relation to their ability to police standards, handle public complaints and monitor the quality of professional practice (Sinclair, 2000). An increasingly skeptical public sees many professionals as being more concerned about their financial situation than the well being of the public (Cherniak, 1979).

The Law Reform Commission (1994) concluded that the best approach to deciding whether a group should be self-regulatory was to consider whether or not self-regulation would benefit the public.

> Regulation should not be used to reward a university education, a code of ethics or the admirable traits of individual practitioners. Nor should regulation be used to bestow social status or financial benefits on a particular occupational group. Instead it should be implemented only to the extent that it provides a net benefit to the public; its impact on practitioners should be disregarded (p.8).

One of the concerns of the Commission was the tendency of many professions, once granted self government, to raise the requirement for education and training necessary to register in their profession, based on the grounds that a more educated professional will provide a higher quality of service. However, studies done by Scheffman and Appelbaum (1982) found that practitioners with lower levels of education and training performed as well or better than those with higher education levels. Another effect of raising training levels is that it may inadvertently reduce service to the public. Excluding all but the most highly educated members reduces the number of

practitioners available to the public as well as increasing the cost for their services. Some members of the public may actually lose access to the practitioners and either have to use the services of an unqualified practitioner or perform the service themselves.

The Law Reform Commission also criticized the widespread belief that only a professional can govern another professional. The Commission argued that so long as they had access to expert advice, non-professionals could understand the issues relevant to regulation and the governing of a profession. They cite the situation where government currently successfully regulates all kinds of activities and that the departmental employees or the independent boards or agencies that provide this service are not usually educated in the same manner or to the same degree as the individuals they regulate.

In conclusion the Law Reform Commission recommends that there are still situations where self government is appropriate and may be the most cost effective and efficient method of regulating a particular profession. However they also suggest that some functions that have previously been delegated to professions should not have been, that delegated powers need to be supervised by government, and that public representatives should assist practitioners in administering a regulatory regime to ensure that public interest is always paramount. To assist with this they recommended the setting up of an arms length organization consisting of persons with a range

of skills that will advise the government on whether or not an occupation should become a self regulated profession and if so what type of regulation would be most appropriate. This body would set the standards for entrance into the profession and the scope of practice of the members. They note that not all acts of a practitioner may need to be regulated, only the ones that pose significant potential to harm the public if wrongly performed. This body would regularly review self-governing professional organizations and have an important role in public complaint's management by the organization. Their final area of responsibility would be to oversee the public representation on self-governing bodies and to ensure the public is kept informed about issues related to the activities carried out by the governing bodies. This governance style if what currently exists in British Columbia, Alberta and Ontario.

B. Should Midwifery be Self-Governed?

Interestingly midwives had been following the path to regulation that the Law Reform Commission (1994) outlined in its report. Two organizations had evolved in Manitoba, the Traditional Midwives Collective and the Nurse-Midwives Association. As mentioned previously the Traditional Midwives Collective was an organization of those persons who were working in the community providing home birth services and labour support services in hospitals since they could not attend births as primary attendant in hospital. They also allowed women who wished to become midwives to join their

organisation. They joined together to provide support for each other, to lobby for legalization of midwifery (although there was dissention with respect to regulation or no regulation) and to provide continuing education opportunities for the practising midwives and aspiring midwives as they were called. The Traditional midwives had applied to the Apprenticeship branch of the Manitoba government to see if midwifery could be recognized as an apprenticeship based certified occupation.

The Nurse-Midwives Association was an organization of nurses who were trained as midwives in countries where midwifery was a recognized occupation. Many of these nurses had trained in the United Kingdom. Some were Canadian born and others immigrant midwives who due to their dual training as nurses were able to register and practice as a registered nurse in Manitoba. Similarly they met to support each other, to provide continuing educational opportunities for each other and to lobby for the legalization of midwifery. Initially they were clear that midwifery should be regulated as a subspecialty of nursing although this position changed as midwifery legislation became closer. The Nurse Midwifery Association was involved with lobbying to get a midwifery course appended to the basic Bachelor of Nursing degree program as a masters level specialization of nursing.

Both groups had joined the Canadian Confederation of Midwives, which was a fledgling national organization that supported the development of midwifery in Canada. As well both organizations had adopted the

International Confederation of Midwives' definition of a midwife. The community midwives had a very strong commitment to serving the community of women who requested their services even at the peril of being prosecuted by the College of Physician's and Surgeons.

Based on the way a profession had been defined prior to the Manitoba Law Reform Commission's report, midwifery did meet some of the criteria for acknowledgement as a profession but also had some significant differences. Midwives had formed groups to try and legitimize their cause, however there were two distinct groups with differing visions of regulated midwifery. Midwives lacked the financial resources to demonstrate an ability to govern a self-regulated profession. Midwives power to influence government did not come from the status of the members of the profession but from the lobbying efforts of some very committed consumers of midwifery care. If the original criteria as outlined in the Manitoba Law Commission Report (1994) were to apply to midwifery it is unlikely it would have been able to achieve the status of a self-regulated profession.

If one looks at the regulation of midwifery from the point of view of the Manitoba Law Reform Commission's recommendations for a new vision of professional regulation the first question that should be asked is if there is a need for the regulation of midwifery. In doing this the benefits and the risks of regulation need to be weighed. If the risks of regulation outweigh the benefits than there is no public benefit and regulation should not proceed.

The result of this process of identifying and weighing the risks and benefits of regulation depends on who is carrying it out. The following is one analysis of risks and benefits.

Midwifery as an occupation requires that midwives identify situations where a mother, a fetus or a newborn's life and/or health is at risk and once identified to act in a way to obviate these risks as much as possible. The risk of an untrained or poorly trained midwife, who is not required to meet any occupational standards, is high. Death and/or permanent disability are the potential repercussions of a situation where anyone, including those without the necessary skills and knowledge, could call themselves a midwife or perform the substantial acts of a midwife.

At the time that legislation was being contemplated anyone could call themselves a midwife and there was huge variability between women who were practising the profession of midwifery. The community midwives were women who had struggled to pull together midwifery knowledge and skills through informal apprenticeship programs, self study, correspondence courses and travelling to other countries to spend periods of time working with a mentor and gaining actual birth experience. The lack of a standardized training program with identified core competencies meant that the group of midwives varied from those that had minimal knowledge and experience to those that had years of experience providing pre and post natal care and had provided care at many births. Families that employed a midwife

took on the responsibility of assessing the midwife's knowledge and skills and deciding if they felt she was competent. Needless to say this process of each client having to assess a midwife's competency was cumbersome and inefficient. A regulated system of midwifery would provide families who were looking to access the services of a midwife with the knowledge that she had a basic level of skills based on the competencies assessed by the regulating body to be necessary for the safe practice of midwifery in Manitoba.

For midwives to move into the health care system as a regulated health care provider seemed to require that they have some kind of credentialing. With the problem of reduced numbers of physicians choosing to provide services to birthing women, midwives were proposed as a possible alternative to physician care. The fact that providing birth services was currently a regulated act also meant that to give midwives the ability to provide this service meant that they had to be regulated. Alternatively the act of providing assistance to birthing women would have to be considered so inconsequential and without potential for harm that it could be deemed not necessary to regulate and unregulated midwives could take over this service. To expect that government would allow an unregulated health professional to provide care previously deemed risky enough that only a physician could provide this service seemed unlikely.

To obtain the services of a midwife prior to regulation required that the women contracting the services pay for the services from her own

resources. Midwives were open to negotiating fee reductions and would also barter for services. When the issue of the financial implications of regulated midwifery were considered, the financial impact depended very much on whether the services were paid for by government as an insured health service, or whether women would have to continue to pay for the services out of their own pocket.

Regulation was likely to increase the costs of midwifery services. Midwives would be required to pay fees to the regulating body and malpractice insurance fees. Malpractice insurance fees had been increasing exponentially for physicians who were providing birthing services and could also pose a large financial outlay for the midwives. Overhead would increase, as midwives would be expected to carry more equipment and medication with them to out of hospital births. If the services of a midwife were to be covered under the provincial health care plan then the cost to the consumer would decrease and the cost to the government would increase. If, as in Alberta, the Manitoba government did not agree to fund this service the cost to the consumer could rise quite precipitously to cover all the extra costs of midwifery practice in a regulated system.

Would regulation adversely affect the number of midwives available to provide care to Manitoba women? The College of Physicians and Surgeons had chosen to turn a blind eye to the midwives' practices leading to the term 'alegal', meaning that its position with respect to the legal system was

uncertain. It was often viewed as neither illegal nor legal (Burtch, 1994). Nevertheless the threat of being prosecuted by the College of Physicians and Surgeons meant that very few midwives were practising in close to a full scope of practice in Manitoba at the time regulation was beginning to be developed. There were approximately seven midwives openly providing community midwifery services including home birth. A few nurse midwives were providing midwifery care in the context of a transfer of care function from local obstetricians in a hospital setting and many more women with midwifery training were providing intrapartum care on labour floors as nurses. These nurse midwives would be able to continue functioning in these roles once legislation was passed as they would be classified as providing nursing care and protected by the Registered Nurses Act. The community based midwives were the ones who would be at risk of having their ability to practice eroded should regulation proceed. Thus regulation risked reducing the number of midwives who would be able to provide home birth services. It was critical that when the criteria for registration eligibility were decided that an attempt be made to mitigate this concern. A system of regulation that denied registration to all midwives who provided home birth services would not be in the best interests of the public. The Midwifery Implementation Council clearly understood this issue and lobbied for a regulatory system based on assessing the midwives competency not their educational qualifications (Frost, 2001). In this way the number of midwives

providing service to Manitoba women should increase not decrease after regulation.

The Manitoba Law Reform Commission (1994) expressed the concern that regulation may create inefficiencies in the system. The regulation of midwifery would certainly add to the paper work that a midwife would be required to complete. Registration and continuing education documents need to be filled out yearly to renew registration with the professional body. Charting and recording keeping would need to become much more elaborate when midwives entered the world of hospitals as primary care providers. Publicly funded health services where issues of productivity and risk reduction relative to malpractice situations are of grave concern require precise and copious documentation. These systems would no doubt add hours of work to midwives' jobs that would take away from their ability to provide hands on care to birthing women.

On balance it would appear that the practice of midwifery might indeed meet the new criteria for regulation in Manitoba as a profession. The risks of regulation were that the cost of services to government would go up and documentation requirements would increase for midwives. The benefits of regulated midwifery would include more consistency in the quality of care provided, more public accountability, more midwives available to the public and a new care provider to step into the service void being created by physicians abandoning the practice of obstetrics. In other words it would

appear that the best interests of the public would be met by regulating midwifery services.

The next consideration was whether midwifery could be regulated under an existing regulatory body such as nursing or medicine. This at first seemed possible, as certainly there are overlaps in the scope of practice of all three professions. One statement made by the Manitoba Law Reform Commission (1994) made it possible to argue that this was not a satisfactory situation. The Commission states that where there are significant differences in philosophy with respect to provision of the service, there is an argument for a separate regulatory body. This was indeed the situation with midwifery. In order to bring in both sides of the midwifery community, the community midwives and the nurse midwives, a unique profession needed to be articulated which was an amalgam of the medical model of birth and the community model of birth. The regulatory body of midwives needed to be able to develop midwifery as a unique service option for Manitoba women. The only way this could happen would be if the regulatory body was separate and did not have to answer to any existing regulatory bodies.

C. Summary

The Law Reform Review Commission report to government in 1994 offered a new vision for the regulation of health professions. This new vision was that self-regulation should be granted to professionals only if the benefits

of self-regulation outweighed the risk to the public. Based on the potential harm of an unskilled practitioner providing services to the public, the benefit of public accountability for the practice of midwifery and the need for more birthing services in the community it was decided that midwifery did meet the criteria for self-regulation. On reviewing the available types of self-regulation a licensing regime seemed to offer the most protection for the public. Under this system not only the title of midwife but also the acts of a midwife that could pose a danger to the public would be regulated. The creation of a new regulatory body for midwives seemed the best alternative due to the philosophical differences that existed and needed to continue to exist between, medicine, nursing and midwifery in order for midwifery to offer a true alternative to the status quo.

Chapter Five

Process for the Development of the Legislation

A. Creation of the Midwifery Implementation Council

Once the Manitoba government had decided that it was time for the regulation of midwifery to occur several key decisions were made to initiate the process. The first decision was the appointment of the Chairperson of the Council as described previously and the second decision was with respect to the appointment of the members of the Midwifery Implementation Council (MIC). The process and rationale behind the constitution of the MIC is the focus of the first part of this chapter. Once the MIC was appointed the members had to make decisions as to how they would approach the work they had been charged with completing. The next step was for the Council to identify the work that was required of them and then create the committee structure necessary to attack this work. Once this was done, the Council could turn its attention to how they would go about making decisions as a group of diverse individuals. After discussion the Council members agreed to use a consensus decision making process to make all future decisions. Finally the Council agreed that it would be critical to the successful outcome of this project to develop positive relationships with other stakeholders if at all possible. The discussion of this issue forms the final portion of this chapter.

Policy Decision One: To create an arms length, multidisciplinary body, the Midwifery Implementation Council, to oversee the implementation of regulated midwifery.

The Working Group on the Implementation of Midwifery (Appendix B) recommended the creation of a multi-disciplinary implementation council to act as an interim governing body of midwifery until such time as enough registered midwives were available to serve on a self-governing regulatory body. This body would be called the Midwifery Implementation Council (MIC). They recommended that as registered midwives became available the Council should be gradually replaced with midwives registered by the College. The Working Group had advised that the Council should be representative of a broad cross-section of consumers and health care providers with an interest in the introduction of midwifery. The Council's responsibilities should include making recommendations to the provincial government with respect to the implementation of midwifery and to work with an educational institution to develop the assessment and upgrading process. Their advice was that the Council should have four committees with particular expertise sought for them. The committees would be Legislation, Education, Practice and Equity/Access.

The chair of the MIC worked with Manitoba Health personnel to develop a list of names that they recommended to the Minister as persons who could serve as members of the Midwifery Implementation Council. The

persons selected reflected the skills needed by the MIC to be able to fulfil its mandate. These persons were not representing their stakeholder group on the Council but were there to provide the expertise necessary to complete the task at hand.

The medical community was not particularly supportive of midwifery at the time the council was being formed. There were only a few obstetricians who were known to be supportive of midwives who were currently practising in the community and that support was tentative. More physicians were supportive of a hospital based nursing model of midwifery such as was practised in the United Kingdom. The options for representation on the Council were limited unless the decision was to bring on a hostile member and try and work with them to resolve their issues and get on with the process of regulation. Discussions ensued as to whether this might be useful in that if the Council was able to work out the issues with this individual it might give insight into how to work with the other hostile physicians in the community. However it was decided given the work load and the short length of time available to proceed with this work that it made more sense to recommend a supportive physician and look to them for guidance as to how to approach other physicians when this became necessary.

The need for the diverse group of voices around the table was felt to be critical. Obstetricians, nurses, community midwives and nurse-midwives all had had serious philosophical differences related to the regulation of

midwifery. Bringing all of these persons to the table to make the tough decisions about the regulation was a calculated risk. Each of these groups would have been quite happy to regulate midwifery on their own terms without having to deal with the other groups. As well all of these groups felt that they were the most appropriate group to regulate midwifery to a greater or lesser extent. Fortunately, throughout the process of the Working Group meetings there was movement towards a greater tolerance between the nurse-midwives and the community or traditional midwives. For example the Nurse-Midwives Association came to accept that midwifery should have multiple routes of entry to education meaning that you did not need to be a nurse before you could become a midwife. This was a huge step and one that contradicted the policy line of their mother organization the Manitoba Association of Registered Nurses. They went so far as to change the name of their organization from the Nurse Midwives Association to the Associations of Manitoba Midwives.

The actual council membership was not decided upon until the end of 1994. The process for deciding on the twelve members of the council was not a formal process. A list of potential candidates for the MIC was developed by Manitoba Health based on those who were known to be supportive of midwifery and/or brought the requisite skills to the table. The skills that were sought were:

1. A person with educational experience that could advise the council on matters related to the development of an education program as well as bring contacts in the educational community.

2. A lawyer who could bring an understanding of legal issues to advise on issues related to the development of the legislation and the regulation as well as other legal issues that may arise.

3. An Obstetrician who could provide feedback related to practice issues as well as assist with the interprofessional relationships within the medical community.

4. Two traditional or community trained midwives who could bring experience providing home birth services in the community and assist with the development of a educational model that would reflect the variety of training methods midwives use.

5. Two nurse midwives who could bring hospital experience and an understanding of the issues related to hospital practice and nurse midwifery training models.

6. Two consumers of midwifery services to bring the perspective of the community to the table and ensure that the consumer voice was able to help guide the process.

7. An Aboriginal representative to speak to issues related to Aboriginal midwives and to aboriginal women who may want to use the services of a midwife.

8. Rural representation to speak to the unique issues of rural women consumers and midwives.

9. An immigrant women who could bring the perspective of the immigrant midwife and consumer to the council's attention.

10. A community activist who could bring political knowledge and understanding of the community resources to the Council.

11. A nurse to assist with issues that will arise with nursing.

12. A woman with understanding of the disability community to allow the Council to have this perspective represented.

Nursing was very concerned about the road that midwifery regulation and education would take in the province. In light of this and in light of the fact that if a university based program was sought nursing would be a likely ally, the Faculty of Nursing was asked to name a person to the council. The final selection of members of the Midwifery Implementation Council is included in Appendix C.

The Government of Manitoba funded a midwifery co-ordinator position to assist the MIC with its work and to act as liaison with government. The Council was very concerned that the co-ordinator be supportive of the model of midwifery outlined in the working group report. They successfully lobbied to have the Chair of the Council on the hiring committee to represent their issues during the hiring process.

Reasons behind the decision to create the MIC as it was:

The makeup of Midwifery Implementation Council's across Canada has been varied in their membership. For example Ontario's implementation body was created based on recommendations from the Report of the Task Force on the Implementation of Midwifery in Ontario (Ontario Government 1987). The Ontario Lieutenant Governor in Council appointed a 13 member Interim Regulatory Body called the Interim Regulatory Council (IRC) to oversee the implementation of regulated midwifery. The membership of this body did not include any midwives. The chairperson of the Interim Regulatory Council (IRC) was a lawyer. A group of midwives was appointed to advise the IRC with respect to practice issues. This advisory body of midwives was chosen from midwives who had been accepted into the midwifery integration program or who were eligible for the program. Personal communication with midwives who were on this advisory committee stated that they were required to do large amounts of work without the ability to make decisions that the IRC had. They strongly recommended midwives on the implementing body.

In Alberta the Midwifery Regulation Advisory Committee (MRAC) was appointed by government to develop the Midwifery Regulation and policies under which midwifery would be governed in Alberta. Midwives, consumers, nursing, government representatives, physicians and potential employers were all represented on the MRAC.

British Columbia had a large implementation committee. The Implementation Advisory Committee was appointed by the Minister of Health and was comprised of twenty members drawn from professional associations (midwifery, medicine and nursing), health boards, educational institutions, professional regulatory bodies and government Ministries.

Manitoba reviewed these potential models and decided that what was needed for our purposes was a group that was small enough to function well but included all stakeholders including professionals, midwives and consumers. The government representation would be from the co-ordinator who was a paid employee of Manitoba Health.

Impact of the decision:

The Midwifery Implementation Council proved to be a very positive and productive committee. Attendance was in general very good which meant that input into decisions was received from those most effected by the issue at hand.

The Midwifery Implementation Council was small enough that it could work efficiently. It had membership from the various stakeholder groups so that it was very rare that the Council was surprised by a reaction from one group or another. Usually someone on the Council could predict the kind of response that would be expected from the groups that would feel affected by something the Council was about to do or a decision that was being taken. However, as everyone on the MIC was committed to the implementation of

an autonomous inclusive midwifery model, the Council was sometimes surprised by the vehemence of the opposition that was expressed by other stakeholders in the community.

Generally the members around the table were senior members of their own groups and although they were not representing a stakeholder organization, they were able to speak to issues within their respective professional communities with some authority. This was very helpful when questions arose from their peers. Their ability to diffuse a lot of the contention because of the respect that they commanded was often very important.

It was particularly difficult to ensure that the voices of immigrant women were heard at the Council table. With only one immigrant woman, as a member of the Midwifery Implementation Council, it was difficult to ensure the issues of a variety of immigrant women's experience were heard. The area of immigrant women's needs with respect to midwifery service and access to practice proved to be one that challenged the processes of the MIC.

Processes of the Midwifery Implementation Council

The Midwifery Implementation Council created four subcommittees called the Legislation Committee, the Education Committee, the Practice Committee and the Equity/Access Committee to advise them about issues relevant to the terms of reference of the MIC. The Chairperson of the Council attended all subcommittee meetings in order to ensure that communication

was flowing smoothly between committees and to minimize the risk of two committees working at cross purposes on an issue that affected both.

At their first meeting, the Midwifery Implementation Council developed a group agreement that was to lay the foundation of their work together. It was felt to be critical that this group gets to know and trust each other so that the important and contentious decisions could be made. The group agreements were:

1. The underlying philosophy of the Council encompasses:
   - respect for the diversity of opinion and variety of experience which is brought to the Council by stakeholders;
   - process which is built upon trust, communication, and an openness to all ideas and new learning;
   - a willingness to acknowledge and examine personal biases;
   - a process that acknowledges the concerns of consumers, health care providers and government, but that is centred on women and their families;
   - a recognition that choices may be different for each woman;
   - a sensitivity to cultural issues;
   - no physician/nurse/traditional midwife "bashing"

2. In developing a midwifery model for Manitoba, Council will consider the effect of their recommendations for the next seven generations of childbearing women and their families.

3. Council is the decision-making body and will consider recommendations put forward by its Committees. The Council will make decisions on a consensus basis. Conflicts will be handled in an open and timely manner using a process agreed to by Council members.

4. To facilitate the work of the Council, members will:
   - develop work plans and adhere to time lines;
   - assume responsibility for completing specific tasks;
   - respect meeting dates/times and come to meetings prepared;
   - share information on pertinent issues so that all members will be kept current;
   - consult with appropriate organizations/individuals;

- contribute their experience/expertise to the Council's work but leave their formal affiliations outside of the Council.

4. Council meetings are restricted to Council members only. From time to time, and as required to facilitate the work of the Council, guests may be invited with the permission of the members of the Council (MIC minutes Jan.9,1995)

The last two points were very important for a smoothly functioning Council. Formal affiliations were not why persons were at the table and it was important for them to realize this and commit to leaving them aside. The council members were at the table to develop a system of midwifery for Manitoba women that would give them the best midwifery possible not to further their organization's cause. If a Council member was unable to attend then no one came in their place. If the member was going to be away for an extended period of time the Council had the option of bringing in a replacement but generally that was not done.

The written group agreements were critical to the smooth functioning of the group. It allowed all members to be aware of their rights and responsibilities with respect to the functioning of the MIC and gave the Chairperson the permission to call a member on behaviour that violated the group agreement.

At their first meeting the new Council began to discuss challenges and strategies that the Council was going to need to address in the future. These challenges were broken into categories, those that will affect the Council as a

whole and those that will effect the various committees of the Council. These were:

1. Challenges for the Council as a Whole:

(a) Ensure excellent process for consultation, communication and education between and among stakeholders and the Midwifery Implementation Council.
Strategies Identified: Newsletter/bulletins. Public events/speaking. Regular consultation with clearly identified stakeholders. Allow time for education and discussion for an issue by MIC prior to draft recommendations. Innovative outreach (bulletin boards and Free Net). Utilize other health focused groups.

(b) Lack of Budget/Resources for MIC and Midwifery.
Strategies Identified: New budget submission. New government grants.

(c) Education of the public and health care providers re: the MIC. For example the midwifery model(s), home birth issue, place of birth does not define the caregiver.
Strategies Identified: Be watchful of media misrepresentation. Make ourselves available to groups etc.. Ensure there is written press release along with interviews and utilize chair as spokeswoman for consistency. Need consensus with MIC in what midwifery model is.

(d) Actually practicing the consensus approach.
Strategies Identified: Inform ourselves about process. Utilize outside sources to help us understand consensus decision making.

(e) How to keep it simple and in keeping with the fundamental principles and spirit of midwifery.
Strategies Identified: Use the basic, fundamental, ethical principles of midwifery to evaluate decisions and directions taken by the Council. Keep the principles at the forefront- birth as a normal process, be woman-centred.

2. Challenges for all Committees

(a) Ensure midwifery is examined and strategise within broader social changes including:

A. Health reform and deform. Including cutbacks, overprofessionalization, preventive healthcare, obstetrical reform, consumer centred healthcare, community health clinics.

B. Education. Federal reforms. Adult education (apprenticeship). Community education.

C. Legal Professions review report.

Strategies Identified: Look at the big picture and build in links. Be aware of these changes as discussed.

Other challenges were identified but have not been included as they are not relevant to the discussion in this thesis.

This process allowed the members to identify and record the issues that most concerned them with respect to the work at hand. The early identification of these issues allowed for the inclusion of these important issues and ideas into the plan for the council's work. Spending the time up front to lay out the expectations of members of the MIC and to map out some of the challenges was critical to the success of the working of the council. These processes served two purposes. Firstly they allowed everyone to put their worst fears on the table and to have some resolution of them through the development of our group processes and the development of some plans for how to address challenges. The process used for development of these lists required the midwives to work in a variety of small groups that meant they got the opportunity to get to know and interact with the members of the council early on in the process. Many midwives were not convinced of the value of having other health professionals on the Council and it was critical for them to develop a working relationship with these members in order to allow the work of the Council to move forward.

B. Consensus Decision Making Model

Policy Decision Two: To work by consensus.

Consensus decision making is a process that gives all members of the group the opportunity to discuss the issue before them until a decision that is acceptable to everyone is reached. Generally consensus decision making is a process that is part of a non-hierarchical organizational structure which can also be called a consensual organization. Consensus decision making has been adapted to meet the needs of many feminist organizations that are particularly sensitive to the hierarchical organizational models that are seen to reinforce the suppression of women. The roots of this come from the writings of Emma Goldman, an anarchist feminist in the late nineteenth century. Goldstein and anarchist feminists that have followed focus on the effects of hierarchy and organizational structure on the fostering of patriarchy and advocate for alternative forms of organization that stress rotated leadership, shared responsibility and diffused power within the group and its processes (Iannello, 1992). Consensus decision making was a process that fit the anarchist feminist ideal of shared power.

Iannello (1992) in her book *Decisions without Hierarchy* describes an adaptation of consensus decision making that had evolved to allow the spirit of consensus decision making to continue but at the same time better meet the efficiency needs of the organization. This modified decision making process allowed the organization to move on with its day to day functioning

while preserving the contribution that consensus decision making can make to the overall path and goals of the organization. In this process decisions that are clearly routine are delegated to those persons within the organization that have the skills and knowledge to make the routine decision. When critical decisions arise they are referred to the whole group to consider and decide using consensus as the model.

From the onset the Midwifery Implementation Council committed to a structured consensus method for decision making (Appendix E). The decision-making framework required that all members of the Council at a bare minimum could "live with" whatever decision was being put before them. If they truly felt that the decision was not one that they could support, even at that level, they could block the decision and it would not go forward in that form. If a block occurred the concerns of the person or persons who blocked the decision would be clarified and the issues discussed one at a time. If no consensus could be reached at that time then the issue would be referred to the appropriate committee for further discussion and a new recommendation. The Chairperson of the MIC working with the Chairs of the Committees of the MIC and the co-ordinator made most of the routine decisions with respect to the business of the MIC. Any decisions that were seen to be substantive, that is would shape the direction of the development of midwifery, or controversial were discussed at the appropriate committee and then brought to the MIC for a decision using the consensus decision

making model a described in Appendix E. This strategy for organizational structure for the MIC would fit with Iannello's modified consensus decision making model.

Reasons behind the decision:

Decision-making in a diverse group can be very challenging. Most committees work with a decision-making process that allows for discussion and then a vote that confirms the decision presented in the form of a resolution. This process often leaves those people who hold a minority view out of the decision as there is no pressure to try and accommodate their opinion in the decision-making.

The strength of consensus decision-making is seen to be in its inclusiveness not only to individuals but also to a multitude of ideas and solutions (Brown, 1992). Consensus decision-making purports to reduce inequities by requiring that all concerns are addressed and that everyone involved in the decision-making must feel that their issues have been addressed within the context of the decision-making. The diversity of the membership of the Midwifery Implementation Council meant there were serious concerns about whether various view points could be accommodated. Indeed previous to the appointment of the MIC numerous letters and phone calls were received expressing concern about the balance of membership on the MIC.

The traditional midwives and the nurse-midwives who had a long history of antagonism and disparate viewpoints on the practice of midwifery were both worried as to whether there would be more or less members from one group or the other. If the decision-making was to be done by a majority vote, the balance of power on the MIC was critical. The Midwifery Implementation Council needed a variety of skills. It could not function simply as a group of 6 nurse-midwives and 6 traditional midwives. For example consumer input was seen as crucial to the development of a service which would meet the needs of the women of Manitoba. The MIC wanted to actually use women's experiences and knowledge to make decisions more appropriate to the Manitoba childbirth services consumer needs. Without the consensus decision making consumer input could be quickly diluted and even discounted. Gastil (1993) supports consensus decision making as "the surest safeguard against an unequal distribution of power".

Critics state that there are many difficulties with the use of consensus decisions making models. These difficulties are identified as difficulty resolving conflict, the length of time it takes to make decisions, the demands participation in the process puts on a person and the fostering of homogeneity (Reinelt, 1995).

The Council considered these difficulties but decided that the time was well spent on the important issues that would come before the MIC. The belief was that the quality of the decisions made through the use of the

consensus model would more than made up for the extra time and effort it may take to come to the decision. It was believed that the decisions hammered out in this way should be stronger decisions that would meet the needs of the stakeholders both those around the table and those in the community. With the diversity of view points represented around the table one could hope that if the decisions sat well with the women around the table there was hope that the needs of the larger community were better represented in the decision.

All of the members of the Council were chosen because they were felt to have critical skills, experiences or knowledge that were needed to achieve the tasks the MIC was being asked to undertake. In order for decisions to be made all members of the Council would have to be given the opportunity to understand the issues, to understand other members concerns and to have developed the trust within the group that people were taking everything into consideration when they are deciding whether to support the decision or not. In a consensus decision making model the minority viewpoint is critical and once they members are comfortable using the system the members will improve their listening skills and go out of their way to draw out quieter members of the organization (Gastil, 1993)

Many of the members of the Council had had quite extensive experience using consensus decision making in their workplace or in community organizations they had been involved in. This experience was

important as they were able to speak about what it was like to work in a consensus model and support the value of the process. In particular the chairperson of the council (the author) came from a work background at the Women's Health Clinic where she had been working by consensus in a participatory management model for the past 8 years. This gave her the ability to function comfortably in this type of structure as well bringing significant experience with participating in consensus decision making to the table. Those who had not worked with this model became adept at using consensus to make decisions and could look to the members who had more experience for advice if questions of procedure came up.

Impact of the decision:

All decisions made by the Midwifery Implementation Council were made by consensus. This meant that finding a middle ground and creative decision-making were employed to address the concerns of all the members of the Council. Consensus decision making put the onus on individuals to stand firm for issues that they really believed in. If they were able and willing to do this they had to be heard and their concerns addressed by the rest of the group. Fortunately the MIC consisted of a group of women who were genuinely committed to the consensus model and the goals of the MIC. Brown (1992) points to the value of a shared vision or values to the functioning of a consensus decision making model. The MIC for the most part shared a vision of a midwifery profession that focused on the needs of

the consumers. The details of how this would happen were areas of contention but these were resolved through discussion and negotiation at the times that decisions had to be made. Occasionally when very tough decisions were being made some members expressed the concern that they felt pressure to compromise on points that they did not want to compromise on. When this issue came up it was a reminder to the rest of the Council that this was not congruent with the consensus decision-making model and members made a concerted effort to listen and work towards a solution everyone could live with.

The decision to allow a window of opportunity for midwives who did not wish to provide birth services in the home to choose to permanently limit their practice to one birth setting was an example of a difficult decision that needed to take in the concerns of all the women around the table. This was a tough decision because there were members of the MIC who felt very strongly that home birth was an integral part of the practice of midwifery. In their view all midwives should offer this service to their clients. Other MIC members felt that it was not in the public's best interest to have midwives providing this service if they were not comfortable with attending a birth at home. They also felt that these midwives had a lot to offer the women of Manitoba and should not be barred from practice. Reaching agreement on this issue was very difficult but once a standard had been developed to safe

guard home birth and accommodate the wishes of these midwives a consensus was reached.

The value of the consensus decision making model was that every person who sat at that table had to understand the decision and to support it. Brown (1992) speaks to the value of consensus decision making in increasing an individual's commitment to the decisions made for the following reason:

> the overt and explicit synthesis of views involves the participant in an understanding of the problem - the reasons why a decision is taken - in a way which is not possible when decisions are simply received. (p.15)

This meant that the members were able to speak to the issues raised by the community because the Council had all ready considered these issues and resolved or reconciled them during the decision making process.

The MIC agreed that the College of Midwives should use the consensus decision making model. The College of Midwives of Manitoba is the only College of Midwives in Canada that uses this process to make decisions. In fact as far as the MIC could determine it is the only governing body of a profession in Canada that uses consensus to arrive at decisions. The understanding that the future College of Midwives would work by consensus is the underpinning of the decisions around the makeup of the Council of the College and its committees. With the knowledge that persons could not be voted down, the MIC could proceed with looking at the makeup of the council and committees without concern for balance of representation in case of a vote.

C. Stakeholder Relationships

Policy Decision Three: To focus on relationships with stakeholders.

The MIC recognized that it would be important to prioritize the development of harmonious relationships with stakeholders. This goal was approached through maintaining open lines of communication, frequent consultations and attempting to integrate stakeholder concerns into the decisions made by the MIC. The main stakeholder groups were: physicians, nurses, government (including civil servants and elected representatives) traditional midwives, nurse midwives, immigrant midwives, Aboriginal people and consumers including the home birth and rural consumers. The techniques used to develop these relationships were dependent on the group that was under consideration.

Consultation with community members included sending letters to women's groups throughout the province formally asking for their written comments on the Act, Regulation and Standards. Open meetings were also held in communities all over the southern and central part of the province, in Thompson and in several other

northern communities. These meetings included a brief presentation by a member of the MIC, followed by a general discussion.

Similar letters asking for written comment were sent to health professional organizations. All of the physicians in the province were also invited to attend various meetings at various times to discuss the Act and Regulation. There were many other formal and informal opportunities to discuss midwifery issues. For example several meetings were held with the Registrars of the College of Physicians and Surgeons of Manitoba. The chairperson of the MIC spoke to the Registrar of the College of Physicians and Surgeons on numerous occasions about issues that arose during the course of the development of the College of Midwives. The chair of the practice committee of the MIC was a member of the College of Physicians and Surgeon's Perinatal Mortality and Morbidity Committee and was able to discuss issues with respect to the safety of midwifery practice in this venue. Various members of the MIC were invited to attend rounds at the hospitals and to make presentations to the physicians who would actually be working with the midwives. When the government established the Regional Health Authorities the MIC prioritized presentations to them as the potential employers of midwives.

On several occasions meetings were held with the Manitoba Association of Registered Nurses, including special meetings with nursing subcommittees to discuss issues, as well as meetings with the executive

director of the organization to discuss specific issues such as dual registration. At every meeting the desire of the MIC to receive feedback from the organization or from individual members was stressed and the chairperson of the MIC and the co-ordinator made themselves available to any person if questions arose at any time.

Several meetings with prospective midwives were held to discuss issues such as the contents of the upgrading program, the issue of whether or not midwives should be required to attend home births and how immigrant midwives should be included in the assessment process. If the issue was thought to be particularly contentious, such as the home birth discussion with the nurse midwives, an outside professional facilitator was hired.

Regular meetings were held with provincial civil servants who were charged with the development of the legislation. The relationship between the MIC and the government was facilitated by the appointment of a provincial civil servant as the co-ordinator. She attended all MIC meetings and many of the committee meetings providing input on issues of relevance to the government. The chair of the Council met with any new deputy ministers and ministers of health to discuss the current issues before the MIC and answer their questions on potentially contentious issues such as midwifery's relationship to nursing and the home birth issue. This direct communication from the Council to the politicians was critical to the support the MIC received from government. The Chair and the co-ordinator also

presented to other groups within government who might have a role in the development of regulated midwifery, for example the deputy ministers of education. The MIC was always careful to consider the political issues that might arise from the decisions they were making and made every effort to ensure that the government was aware of these and was prepared to answer any questions that might arise from the press or from the public.

Reason behind the Decision:

The introduction of a new regulated health profession is a rare occurrence. Most regulated professions are created through a relatively orderly progression from an organized occupation to regulated profession as outlined in the Law Reform Commission report (1994). Generally these occupations are already a relatively common and accepted part of the health care system that then seeks legal standing through regulation.

The difference with midwifery is that with regulation a new Canadian profession would be created. Most Canadian trained health professionals had no prior experience of working with midwives. Unfortunately Canadian physicians' and nurses' contact with community midwives was often the result of a transfer to hospital from an unsuccessful home birth. If a health professional had trained or worked overseas, they were familiar with midwives as fully integrated members of the health care system. However midwives were rarely independent practitioners but were more likely employees of the hospital system and worked under the direction of

physicians and nursing administrators. The implementation of regulated midwifery was based on a very different model in which the midwife would be an autonomous practitioner allowed to prescribe medications, order tests and admit women to the hospital. (Previously only physicians had these privileges). She would also provide services previously not a part of the medical mainstream, including the use of alternative therapies and attending home births, which created the potential for more concern on the part of other health professionals.

As has been mentioned previously there were two distinct camps of midwives in Manitoba at the beginning of the regulation process. Truly hearing their concerns and working towards creative solutions was a priority of the Midwifery Implementation Council. The solution reached with respect to the place of birth exemption clause in the legislation was an example of listening to the concerns of the nurse midwives and working towards a solution that could meet the needs of the public and still protect the basic tenants of the midwifery model of care.

The demand for midwifery care and the small size of the existing midwifery community put pressure on the Council to register as many midwives as possible. The MIC was also very aware of the problems encountered in Ontario and British Columbia once their Acts came into force. In Ontario, a number of lay midwives were banned from practising. The opposition expressed by the midwives and their clients to being excluded

from registration created a great deal of negative publicity for the new profession (Schroff, 1997). In British Columbia a midwife chose not to register and continued to practice illegally after the law was passed (Hogben, 1999). The College immediately became embroiled in a lawsuit to stop her from practising. While the suit was successful it was a major drain on the new College financially and created a number of political problems. The public visibility of an unregulated midwife providing care that did not meet the standards of the College of Midwives in British Columbia was fodder for those physicians who were anti-midwife. This lawsuit impacted the attention the College in British Columbia was able to apply to other important issues. The College in Manitoba was committed to working hard to bring all midwives to the table and to develop a practice and a process that would meet the needs of most of the midwives contemplating going into practice.

The unique needs of Aboriginal women and immigrant women were also a concern of the MIC. Other provinces had not dealt with this issue very successfully. The MIC was committed to reaching out to these women to try to bring their views and needs into the process being developed in Manitoba

Government support was very important to the smooth movement of the Act and Regulation through the legislative process. The MIC recognized that a realistic understanding of the political process and the adoption of a respectful attitude towards the government were very necessary to retaining government support. For example the MIC endeavoured to ensure that the

government was informed in advance before any foreseeable politically sensitive issue became public.

Impact of the decision

Professional consultations were challenging as often it was difficult to get the professionals to attend meetings. At one point 900 physicians were invited to an information meeting and three showed up. The MIC discovered that it was better to request time on their agendas.

Public consultation was also a challenge. When public meetings were held often the persons who attended were those who were all ready familiar with midwifery and were interested in finding out more about what was happening. While often useful, these meetings did not allow the Council to get input from women unfamiliar with midwifery and more representative of the general population of women. In retrospect, it may have been more useful to go to women where they gather already such as women's clubs or groups. Consultation with women from immigrant communities was also challenging partly due to language barriers but also due to cultural barriers. Unfortunately the lack of financial resources made it impossible to conduct in depth consultations and to explore their views of the role of the midwife in Canada.

Consultation with midwives was somewhat facilitated by the small number of midwives that were considering registration in Manitoba. One to

one consultation was frequently the most used form of information sharing with midwives.

D. Summary

The constitution of the Midwifery Implementation Council as a diverse group of women each coming from one of the stakeholder groups within midwifery but representing themselves not their organization was the first important step to developing a process for regulation of midwifery. Once the MIC had clearly identified that these women were at the table due to the particular skills, knowledge and life experience that they brought to the table they were able to look at the task at hand and develop the processes that they would follow to achieve their goal of regulated midwifery. The decision to use consensus decision making was critical to the successful completion of the Council's work. While recognizing the potential drawbacks to using this model for decision making, its strength was that all members of the MIC felt able to influence decisions. As a result, their commitment to decisions made by the MIC was much stronger. The final process decision made by the MIC was to focus on relationships with stakeholders. The importance of this was underlined by bad experiences in other midwifery jurisdictions and the tone of communications to members of the MIC in the past. The MIC wished to avoid these problems as much as possible by remaining open to dialoguing with stakeholders and by communicating effectively with them.

Once the process decisions were made and a framework was established for the work necessary to achieve the MIC's goals the MIC could move forward to consider the policy decisions that needed to be made to begin development of the legislation.

Chapter Six

Defining midwifery

In order to govern a profession it is critical to be able to define several parameters. The first is to define what the professional may call themselves, also termed the protected title. The second is to describe what exactly that professional is allowed to do, referred to as the scope of practice of that profession. The third is what the requirements are to be admitted to the profession, otherwise called entrance to practice. Since midwifery was to be a self-regulating profession following a licensing system as discussed in the preceding chapter, both the title and the scope of practice would need to be included in the protection afforded by the legislation. The following policy decisions were made with respect to defining midwifery in the act and regulation.

A. Protection of Title

Policy Decision Four: To protect the title "Midwife" vs. "regulated midwife" .

The protection of the title "midwife" is in the Act and is worded as follows:

> 4(1) No person except a midwife shall:
>
> (a) represent or hold our, expressly or by implication, that he or she is a midwife or is entitled to engage in the practice of midwifery; or
>
> (b) use any sign, display, title or advertisement implying that the person is a midwife.

> 4(2) No person except a midwife shall use the title "midwife", a variation or abbreviation of that title, or an equivalent in another language (Part 2).

The Act in Section 58(1) also specifies that a person who contravenes the Midwifery Act by calling herself a midwife when she is not registered as one, will be fined up to $5,000 for the first offence and up to $15,000 for a subsequent offence.

Reason for the Decision

One of the principle reasons for the regulation of midwifery was to bring midwifery into the mainstream where it could be monitored. While midwifery was being practised outside the law, no one had any jurisdiction over its practitioners. This meant that the public had no assurance that the person calling herself a midwife possessed midwifery skills.

After the proclamation of the Midwifery and Consequential Amendments Act anyone in Manitoba calling themselves a midwife had to have been assessed by the College of Midwives of Manitoba and had earned the right to use this title under the Act.

Whether to protect the title 'midwife' or 'registered midwife' was debated. Some felt that the title, midwife, was such a part of women's traditions that it should not be made exclusive to one professional group. This group included many women who were still ambivalent towards the need to regulate midwifery and were reluctant to allow the title 'midwife' to be

appropriated by the College. They would have been happier if anyone who practised some form of midwifery was still allowed to call themselves a midwife with only those midwives who agreed with and met the standards set by the governing body of midwifery eligible for registration. Others were concerned that if only 'registered midwife' was protected perhaps women could continue to practice as a 'midwife' and not be in contempt of the legislation. Their primary concern was that consumers might not understand that 'registered midwife' meant that that the midwife had met a legislated standard and was monitored by a governing body. In this circumstance the woman calling herself a 'midwife' may or may not have the necessary skills to give her the service she was seeking. The direction given to the MIC by government and the Working Group was that the protection of the public must take priority and therefore only registered, regulated midwives should be practising midwifery in Manitoba once the Act was passed. Although a difficult decision for the MIC, the final consensus was that 'midwife' should become the 'protected title'. The MIC was influenced by the concern that unregulated midwives might pose a real risk to the public due to a lack of skills, knowledge and/or judgement. Their second reason would be the difficulty of explaining that there were two types of midwives to a public that knew very little about midwifery. 'Regulated midwives' who have been assessed by the College of Midwives and unregulated midwives who may or may not have the necessary midwifery skills.

B. Scope of Practice of a Midwife

The scope of practice of midwives in Manitoba is protected legislatively by three key areas of the legislation. The first is in the Act where the important services a midwife provides are delineated under the 'substantial acts' of a midwife clause. The second is also in the Act and defines a midwife as an autonomous practitioner, who has the right to consult with other health practitioners, but is not directly supervised by them. The third area of the legislation that defines the scope of practice of a midwife is the Regulation, which includes the lists of tests a midwife can order, medications she can prescribe and procedures she can perform. The following will discuss the decisions that led to the inclusion of these clauses in the legislation.

Policy Decision Five: To protect the substantial acts of a midwife.

The Act protects both the title "Midwife" and the substantial acts that a midwife performs. The accepted international definition of a midwife states:

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

> She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service.
>
> (Council of International Confederation of Midwives, 1972)

This definition was used by the MIC when developing its own definition of the scope of practice of a midwife. The Midwifery Act defines what a midwife does:

> 2(1) The practice of midwifery means the assessment and monitoring of women during pregnancy, labour and the post-partum period and of their newborn babies, the provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous vaginal deliveries.
>
> 2(2) In the course of engaging in the practice of midwifery, a midwife may
>
> (a) Order and receive reports of screening and diagnostic tests designated in the regulation;
>
> (b) Prescribe and administer drugs designated in the regulation; and
>
> (c) Perform minor surgical and invasive procedures designated in the regulation (Part 2).

The protection of the practice of midwifery is included in the same section of the Act and states:

> 3(1) Subject to subsection (2) no person other than a midwife may engage in the practice of midwifery.
>
> 3(2) Nothing in the Act prevents a person from performing any action described in section 2
>
> (a) in an emergency; or
>
> (b) under the authority of another Act of the Legislature (Part 2).

Reason for the decision

There was some concern that if the Act only protected the title of midwife then anyone who wanted to practise without registering could simply

get around this issue by calling themselves something else while still performing the essential acts of a midwife. For example, the term monitrice has been used to describe a woman who provides care to pregnant and birthing women. The Council wanted to ensure that regardless of what title they used, someone providing the services of a midwife without being registered with the College of Midwives, would be deemed in contravention of the Midwifery Act and would be eligible for prosecution.

The primary purpose for inclusion of the listed actions in the legislation is that these require a level of skills, knowledge and judgement that only a trained professional such as a midwife or a member of another related health profession would have. The acts that were regulated were those that if performed improperly could jeopardize the safety of the public. The MIC did not want to regulate such areas as prenatal education, as many people can and do provide this service adequately without being a midwife or another health professional. It was not the intention of the MIC to set up a profession who would monopolize all issues dealing with birth. Likewise it is not the intention of an Act to list everything a midwife knows or does. The only acts the MIC was concerned with were those that clearly required the skills of a midwife.

The final clause exempts from prosecution anyone who performs the protected acts as long as they are a member of another health profession that has the ability to provide these services according to their legislation.

The Act also provides an exemption from prosecution for those that provide care in an emergency. This provides protection for persons in the situation where a woman gives birth precipitously and needs assistance from whomever is close at hand.

Impact of the decision

The Manitoba College of Midwives has not had to prosecute anyone for practising without registration. At the time that midwifery regulation was brought into force all the community midwives who wished to continue to provide services were involved in the registration process. The College granted student registration to anyone enrolled in the Midwifery Upgrading Program run jointly by the Transition Council of the College of Midwives and the Health Sciences Centre Educational Programs Department (See page 126-27). Student registration allowed a midwife to continue to provide care to any women she had agreed to help before legislation came into force as long as she had a fully registered midwife supervising her practice.

Policy Decision Six: Midwives will practice as autonomous primary care providers according to the Model of Care of the College of Midwives.

Certain health professionals, primarily physicians, but also some nurses, felt that midwives should work only under the direction of physicians. The Midwifery Implementation Council following the advice of the Working Group

decided to set midwifery up as an independent profession that could provide primary care in an autonomous fashion. The Act clearly speaks to this point by defining the practice of midwifery. It outlines three specific areas that define what autonomy means in the context of midwifery.

> 2(3) A midwife may, in accordance with this Act and the regulation, engage in the practice of midwifery as a primary health cares provider who
>
> (a) is directly accessible to clients without referral from a member of another health profession;
>
> (b) is authorized to provide health services within the practice of midwifery without being supervised by a member of another health profession; and
>
> (c) consults with other health professionals, including physicians, if medical conditions exist or arise during pregnancy that may require management outside the scope of the practice of midwifery (Part 2).

Reason for the decision

The practice of regulated midwifery was a new profession that was carving out a niche for itself with respect to the other health professions in Manitoba, such as nursing and medicine. A clear delineation of the rights and responsibilities of the midwife with respect to practice issues was felt to be in the best interests of the public. In order for midwives to work effectively in the health care system, other health professionals needed to understand what a midwife could do and the midwife needed to be able to point to the legislation as the authority that allowed her to do the work of a midwife. The legislation supports the right of the midwife to see women without

referral from another practitioner, but also her right as an autonomous health care provider to consult with another health care practitioner.

Midwifery legislation in British Columbia includes a clause in their Regulation requiring that midwives advise women to see a physician in the first trimester of the pregnancy. The intent of this clause is somewhat unclear, but the underlying assumption is that a physician should decide if a woman is a suitable candidate for midwifery care. The MIC decided that this was unnecessary, as the midwife should be able to decide whether the woman met the criteria for midwifery care according to the standards set out by the College of Midwifery. Requiring physician consultation on all women seeking midwifery care would be a burden, both financially and from a person-power perspective, on the medical system.

Clause 2(3)(b) was developed to delineate the relationship between physicians and midwives without getting into specific details. The details were addressed in the standards of the College of Midwives particularly the *Standard on Consultation and Transfer of Care.* This standard lists the various circumstances under which the midwife must consult and/or transfer care to a physician. It is very detailed and represents as best as possible an exhaustive list. The problem with lists is that new or unique situations will be missed. It was for this reason that the list was included under standards where the College could adjust it or add to it more easily. The Quebec Act (Quebec Government, 1999) includes a list of the reasons a midwife must

transfer care to a physician. For the reasons described above, Manitoba chose to do otherwise.

The section that states that midwives do not work under supervision was placed in the Act to ensure that it was crystal clear that midwives did not work under the guidance of physicians. The importance of this section is that it defines working relationships but also makes the physician-midwife relationship clear for medico-legal purposes. Many physicians were very concerned about their liability with respect to midwives and raised this issue frequently during consultations. Clearly defining midwives as autonomous practitioners working under their own auspices would perhaps make it more evident to the courts that a midwife is not another variety of nurse working under the direction of a physician.

Section 2(3) c that addresses consultation with other health professionals was added to try and address the concerns of physicians that autonomous midwives would be working completely outside of the existing medical services. It was never the intent of the MIC to set up midwifery as a service that functioned outside of the existing medical system. The MIC felt that collaboration between midwives and consultants was the model that would give the women of Manitoba the best possible care.

The ability of midwives to function autonomously was congruent with what was happening in other provinces and was important to protect. The Agreement on Internal Trade was pushing professions for consistency across

provincial boundaries. Although the midwifery discussions had not yet happened when the Manitoba Act was passed, information received by the MIC suggested that this Agreement should be considered when drafting the Act.

The final reason why the MIC was committed to a model of autonomous midwifery was that they did not want midwifery to become essentially another medical model of obstetrical care that would not provide women with a true option. The MIC felt that only an autonomous practitioner would have the opportunity to practise in a way that challenged the existing system without fear of reprisal from a supervisor within that traditional system.

Impact of the decision

Midwives are functioning as autonomous health professionals who consult with nurses and physicians when necessary for the benefit of their clients. They are not working under the direction of any other health professional but are employees of Regional Health Authorities and are working according to the standards of the College of Midwives. They all have admitting privileges to hospitals and are considered members of the medical staff with rights and responsibilities consistent with those of the physicians in their department.

Midwives in Manitoba are providing options in maternity care that have never been available in the funded health care system before, such as home

birth services and complementary/alternative health care services. If physicians had been the supervisors of the midwives this would never have happened. Physicians have questioned the practices of midwives, which is healthy, but they have also not pushed the issue because they are aware that it is the role of the College of Midwives to police the practice of midwifery and set standards, not the role of the physicians.

Following the passage of the legislation physicians seemed to be less concerned about the fact that midwives would not be working under physician's supervision. There was still some difficulty with community based physicians not understanding midwifery, but that is gradually improving as they are more exposed to midwifery practice in the community.

Clearly stating in the Act that midwives may access physician services as needed was helpful when negotiating a fee payment for physicians who consult for midwives. Ontario midwives had warned the MIC that one of the big hurdles for midwifery in Ontario was that there was no way of paying a consulting fee to a physician who provided consultation services to a client at the request of a midwife. Normally when a family physician asks a specialist physician to see a patient the Manitoba Health Services Commission pays the specialist a higher fee than if they had been accessed directly by the patient. In Ontario no funding had been made available to pay specialists the consultation rate if the referral was made by a midwife. Not only were

physicians reluctant to see midwives' clients because they were not supportive of midwifery, their fees were less if they actually did see them!

The clause in the Act stating that midwives needed to consult was another good reason for the Midwifery Implementation Council to strongly advocate for a consultation fee for physicians who provided services at the request of a midwife. This fact plus the realization that the amount of money that would be necessary for this payment to physicians was a small amount (estimated to be in the neighbourhood of fifteen thousand dollars per year for consultation fees to physicians consulting for all the midwives in the province for the first few years) facilitated the ministerial approval of new funds to the Manitoba Medical Association for payment of consultation fees for midwifery clients. This fee was equivalent to that paid for family physician's patients.

Policy Decision Seven: To include tests, medications and procedures in the regulation.

The regulation contains the detailed lists of what medications a midwife can prescribe, what tests she can order and what procedures she can perform. The three lists are Schedules A, B and C of the Midwifery Regulation. These lists further define the practice of midwifery. For example, giving midwives the legal ability to order a test to detect mastitis and prescribe the necessary antibiotics to treat this infection adds another level of definition to the scope of a midwife's practice. These lists are a

mixture of the names of specific medications and general classes of medications that midwives can prescribe. Specific medications are listed when there is only one medication in that class of medications that a midwife would possibly need to use. Classes of medications are listed when there are more than one medication in the list that conceivably may be used by the midwife or there are new medications in that class of medication coming on the market that a midwife may wish to use in the future.

Reasons behind the decision

These lists were developed by reviewing the similar lists that applied to the midwives in other provinces and by asking midwives what medications, tests and procedures that they needed access to for their work. The Chair of the MIC also discussed this issue with midwives who had practised in Ontario and British Columbia and discovered they had some concerns about medications that the midwives in these provinces were not able to prescribe. For example, midwives in Ontario and B.C. were not able to prescribe antibiotics under any circumstance. This was problematic because it meant that they had to consult a physician for a woman who had a breast infection that was not responding to other manoeuvres or for prophylaxis of vaginal streptococcus infections in labour. Both of which are not uncommon situations.

An important part of defining the role of the midwife is defining her clinical expertise. This definition is important because it helps to define the borders between the midwives and other health professionals whose scopes of practice overlap that of the midwife. It is also helps define the areas of practice in which the public can expect to receive competent, safe care from a midwife. A decision was made to provide a finite list of tests a midwife could order, medications she could prescribe and procedures she could perform. The alternative was to provide very general powers to order tests, prescribe and perform any procedures that would relate to their work. This was felt to be too general an approach and would not help define a midwife's responsibilities or offer the public the protection they should have.

These lists could have been in the Act or in the Regulation. By choosing to place these lists in the Regulation it means that it is easier to amend the lists in the future. To change the Act would require that it be opened and voted on in the legislature. This means that any or all of its provisions can be debated and amended. The MIC was very concerned that significant amendments might be made as a result of pressure exerted on the government by groups interested in changing the existing legislation. In consideration of the issues that the council was trying to protect in the Act it was felt that the fewer times the Act had to be opened the better.

The legislative counsel assigned to the development of the midwifery legislation strongly supported putting anything this detailed into the

Regulation, rather than the Act, as there would no doubt need to be amendments to the lists once midwives had practice experience in the regulated system. Cabinet can amend a regulation with less trouble and less threat to the major tenants of midwifery.

Impact of decision:

The legislation in Manitoba provides Manitoba midwives with the broadest scope of practice of midwives in Canada. For example only in Manitoba can midwives prescribe oral contraceptives or insert Intrauterine Contraceptive Devices (IUD). This gives Manitoba midwives the option of providing a broader level of care to the women they serve. Some midwives were concerned that a few of the items included in the regulation were not basic midwifery skills. The ability of midwives to insert IUD's, for example, is not necessarily a skill a midwife must have in order to practice her profession competently. However if a midwife is working in a remote community and is the only care provider available for postpartum women, then it might be necessary for her to be able to provide this service. If the ability to place an IUD were not in the regulation, then she would never be able to legally provide this service. Once it was explained that both basic and advance skills would need to be in the legislation if any midwife was ever going to provide that service, the midwives felt better about the inclusion of these skills in the regulation.

Based on feedback from consultation undertaken on the Regulation, changes were made to the Schedules outlining what midwives could prescribe, which tests they could order and what procedures they could perform. Several tests were deleted based on the argument that they were only necessary to assess women with complications and should not be done by any one other a physician. However, within 6 months of midwives starting to practise in the regulated system, it became apparent that changes were needed in these lists. A new proposed Regulation has included the tests that were deleted in the past as well as other tests requested by individual physicians in the time since midwives began working in the system. The reason is that the physicians who midwives had referred clients to started asking the midwives to order tests to speed up the referral process.

Unfortunately, although amending the Regulation is theoretically easier, it is difficult in practice. Consultation and trying to come to a consensus on exactly what needs to be included in the revised Regulation has been time consuming. Two years after midwives began practising there has not been any changes to the Regulation despite knowing within the first few weeks of practice that changes needed to happen.

C. Entrance to Practice Requirements

The decision with respect to who is able to practise midwifery is critical to the profession. The standards set in order to allow a woman to become

registered as a midwife, to call herself a midwife and to perform the acts of a midwife are the foundation for the protection of the public. These requirements are set out in general terms in the Act and then are expanded in the Regulation. The reasoning for the placement of the requirements in these two places is once again related to balancing the need to protect something, in which case it goes into the Act, and the flexibility to amend a clause, in which case it goes into the Regulation.

Setting requirements for entrance into the practice of midwifery is one of the areas of midwifery legislation that is challenging. Prior to legislation there was no one widely accepted standard for becoming a practising midwife. Two decisions were influential to the direction of the legislation with respect to entrance to practice. The first decision was that it should be up to the College of Midwives to decide the entrance requirements and the second was that the College would provide an opportunity for midwives to practice under supervision until they demonstrate competence in the area they required supervision for. These two decisions provided an opportunity for midwives to enter practice who otherwise might not have qualified to register. These decisions are discussed below.

Policy Decision Eight: The entrance requirements to practice should be defined by the College not defined in the legislation.

The Act says very little about the requirements to enter practice in Manitoba. The Act states in Part 4 Section 12(1) (a):

> The board of assessors shall approve an application for registration as a midwife if the applicant
>
> (a) meets the competency requirements approved by the council;

The Regulation in Section 4(1) expands on this somewhat by stating that:

> The applicant must have satisfactorily completed one of the following:
>
> a) The applicant must complete a program of studies leading to a degree, diploma or certificate in midwifery. The program must be acceptable to the college and must be based on the core competencies of midwifery established by the college.
>
> b) The applicant must complete an assessment process approved by the college of the applicant's ability to perform the core competencies of midwifery.

The Act and Regulation sets up a situation whereby the College is able to decide what qualifications will be recognized and what assessment process will be adopted as long as it is based on the core competencies of midwifery as defined by the College.

Reason for the decision

The MIC was presented with two options with respect to legislating the entrance to practice requirements for midwifery. Some professions require a degree from an approved University or even a very specific program of studies which is named in the Act. The other option is to leave it up to the professional body to decide what appropriate registration requirements would be.

The first option sets up a limited range of educational routes for entrance into the profession. For example, if a Baccalaureate program of

studies is required as a minimum for entrance to practice then there is no room for registering someone who has had a different type of training. Such an individual may have all of the required skills, knowledge and judgement that would be required to perform the tasks of the profession, but would still not qualify for registration. The benefit to this style of legislation, however, is that the public and other health professionals can be assured that the person registered in that profession has a minimum of a baccalaureate level education. Many health professionals and many of the members of the public are comfortable with and expect members of a profession to have a University level education. They are also more likely to accept another profession if a University degree is required as preparation for practice. As far as midwifery legislation goes, the nursing profession would have preferred that the entrance to practice be defined in the legislation as having a degree in nursing with a specialty in midwifery. This was neither the direction the Working Group recommended nor the wishes of the MIC.

The second option, that of leaving it up to the profession to set the requirements for entrance to the profession has its own set of benefits and challenges. The benefit to this approach is that it provides some flexibility and an opportunity to look at a wide range of options for entrance to practice. The College would be able to accept any combination of training and/or experience as the minimum requirement for practice. If practitioners come from a variety of educational backgrounds, then the regulatory body

can define the requirements for practice in such as way as to be inclusive of all skilled practitioners. The recognition of foreign credentials and innovative educational approaches are facilitated by this method of legislation. Some critics of this approach felt that it would give the College too much leeway and the freedom to require a level of preparation to practice that is unreasonably high, or so low as to insufficiently protect the public. A tendency to overestimate required qualifications was identified as a common problem by the Law Reform Review Commission (1994) which noted that professions have a tendency to increase educational requirements once they receive regulatory authority.

The MIC was committed to an inclusive approach to registration and wanted the College to be able to develop criteria that could accommodate midwives from all types of educational backgrounds. The requirement that the midwife must have completed a course of studies based on the core competencies was to ensure that the legislation at a minimum addressed the idea that practitioners registered had the knowledge, skills and judgement necessary to practise safely. The MIC was also very aware a program of studies leading to a degree, diploma or certificate would provide some reassurance to other health professionals that all midwives had some form of recognized training. All of the lay midwives had completed some kind of a course at a university, college or other institution. These courses had included anatomy and physiology courses, women's studies courses or short

apprenticeship courses in sites such as El Paso or Jamaica. None of these courses in and of themselves would give the midwife all of the knowledge, skills and judgement that she would need to become a registered midwife, nevertheless, they did satisfy section 4(1) (a) of the regulation (See page 121).

Part (b) of Section 4(1) permits the College to decide on what assessment process they wished to use to assess the midwives' ability to perform the core competencies required for registration. This was important as it gives the College the ability to change its assessment process to keep it current and in line with the best processes available at the time. After reviewing a consultant's recommendations on available exams, the MIC decided on the North American Registry of Midwives (NARM) exams. These exams were the only ones that had referenced answer keys and had been psychometrically tested, validated and were legally defensible. The consultant had also noted that these exams had been tested on a culturally diverse group of midwives and thus were probably better suited to the group of midwives in Manitoba. The NARM exam process was shorter and easier to administer. It was felt to be truly a certification exam whereas the others reviewed were seen to be more examinations that would be useful in an educational program. The only concern she expressed was that the NARM exam did not cover certain areas exclusive to Manitoba such as medications and local legislation and standards. The MIC was not particularly concerned

with these areas as all of the midwives who would be initially registered would be required to successfully complete an upgrading course designed by the College of Midwives in conjunction with the Health Sciences Centre in Winnipeg. This course was comprised of 17 modules, all of which had to be completed with a minimum grade of 75%. The contents of the upgrading course were decided upon by asking the midwives who were going to seek registration what they felt they needed to receive more training in before they registered. The community midwives identified medical and hospital issues as areas they had not had access to and therefore needed to upgrade. Many of the nurse midwives had not had experience in out of hospital births or the use of alternative therapies. The upgrading course covered these areas, as well as including modules in emergency skills, pharmacology and neonatal resuscitation. The combination of the upgrading course and the NARM examination were decided upon as the best choice for Manitoba at that time.

The upgrading course was offered five times over two and a half years. Once this time had passed the course ceased to exist and the College began looking at other assessment processes.

Impact of the Decision:

The choice of allowing for multiple routes of entry into practice versus requiring a university degree made an impact on the diversity of the midwives whom ultimately registered in Manitoba. None of the midwives who initially

registered to actively practise in Manitoba had a university degree in midwifery. Among the first 26 midwives who registered, 6 had certificates from direct entry schools of midwifery, 12 were community trained (two of these were nurses), two were foreign trained as a part of a related professional training scheme but had not practised as midwives and the rest were nurses who had midwifery certificates earned after their nurses training in European countries. Fifteen of the midwives were Canadian born. The remaining eleven midwives were from China, Bosnia, Czech Republic, Scotland, Spain and Germany. Two were of Aboriginal origin. The only registrants with the College with degrees are several nurse midwives who have chosen to remain on the inactive register. No midwives continued to practice outside of registration after the proclamation of the Act. The flexibility of the legislation allowed the College to register a diverse group of midwives who otherwise would not have been eligible for registration if university level education was required.

Policy Decision Nine: Midwives who do not meet currency of practice requirements will be under supervision until such time as their supervisor deems them ready to practice independently.

The *Standard for Currency of Practice required for Initial Registration as a Practising Midwife (*College of Midwives of Manitoba, 1997e) states that in the two years previous to registration the midwife must have been primary

midwife at ten births and three of these births must be within the context of continuity of care. Continuity of care is defined in this standard as:

> four (4) prenatal visits; labour care, the birth and care in the first two hours postpartum; the initial newborn examination; and three (3) postpartum visits, including the six week check-up, all with the same client and her newborn.

Midwives who had not practiced in the previous two years or who did not have current experience in one or the other birth setting, were allowed to register. However, they were required to practice under the supervision of a midwife who was not herself under supervision until such time as she was deemed able to practice independently by her supervisor. Supervision contracts were designed by the Board of Assessors of the College of Midwives and stated the competencies that the midwife had to demonstrate before the supervising midwife could sign the documents stating that the midwife was competent to practise independently. No specific number of births was required except a midwife must have been observed at a minimum of one birth. To be deemed able to practice independently in both settings (home and hospital) they must have had current practice in both of these settings or have successfully completed supervised practice in those settings where they did not reach currency standards. Manitoba's supervision process is quite different from Ontario and British Columbia. These provinces set the number of times a specific service must have been performed before supervision will be terminated. For example, a midwife must have attended 20 home births

as primary midwife before being allowed to practice independently even if her supervisor has assessed her as competent to function under her own responsibility after 10 births.

Reason for the decision

The MIC had to take into consideration the various situations midwives in Manitoba might have faced. Community trained midwives did not have access to hospital admitting privileges so had not had the opportunity to attend hospital births. Nurse midwives, with the exception of a very few, had not had an opportunity to be primary care provider with women during birth. A few nurse-midwives were working in a transfer of function capacity at Health Sciences Centre in Winnipeg and were allowed to provide primary care to women in labour and during birth according to protocols set by the physicians. Most immigrant midwives, especially those, who could not get registered as a nurse in Manitoba, were not practising as midwives. A few who also had nursing qualifications were working on the labour floors at hospitals in the province. The rest had all but given up hope of working as a midwife and were working in unrelated fields. As far as the MIC could ascertain no immigrant midwives were providing home birth services. Limiting access to registration to those with current practice experience would have severely reduced the number of registerable midwives.

Impact of the decision

Only two midwives were registered without any requirements for supervision. They had both in hospital and out of hospital birthing experience, one in a birthing centre and the other had been providing home births in Manitoba while she continued to work as an obstetrical nurse.

Many midwives required supervision in one discrete area only. For example, most of the community midwives only required supervision at hospital births, whereas the nurse midwives required supervision at home births. Quite a few of the midwives required supervision in all aspects of midwifery care because they did not have currency of practice or had never practised in Manitoba. Finding adequate supervisors was an issue in that so many of the midwives required some form or other of supervision. Fortunately a midwife who was under supervision in one area could still supervise someone in an area that she was not under supervision for. Therefore the nurse midwives could supervise the community midwives in hospital and the community midwives could supervise the nurse midwives at home births. A midwife did not have to be under supervision for a specific length of time. If a midwife were assessed as competent after being observed at one birth, she could be signed off by her supervisor and her supervision requirement was lifted. As a result of this flexibility, many midwives were off supervision in the course of the first few months of practice and were then available to assist with the supervision of other midwives. Those midwives who were immigrants to Canada and had never

practised in Canada tended to require more intense support and usually a longer time to complete their supervision.

North American Registry of Midwives

The decision to allow midwives to register who do not have current practice was another stumbling block when the MIC approached the North American Registry of Midwives' board about the use of their examination. NARM had a requirement that you must have been practising within the past 10 years in order to be eligible to sit their exams. The MIC had midwives who had not practised for many more years than that who were inquiring about registration. After negotiation with NARM, an agreement was reached that became part of the Manitoba exemption, that those without currency would be allowed to take the examination if they had successfully completed the Manitoba Upgrading Program at the Health Sciences Centre. Nevertheless women would have to meet the North American Registry of Midwives' currency criteria if they wanted to receive their Certified Professional Midwife (CPM) designation from them.

Mutual Recognition Agreement

The Agreement on Internal Trade (Canadian Government, 1995) is a federal agreement that speaks about the free movement of goods and services across provincial and territorial boundaries. The Agreement aims to:

> enable any worker qualified for an occupation in a province or territory to be granted access to employment opportunities in that occupation in any other province or territory. (Chapter 7)

The Agreement on Internal Trade was signed in 1995 and required professions in all provinces and territories to come to an agreement about the free movement of their members. These agreements are called Mutual Recognition Agreements or Labour Mobility Agreements. On July 14 and 15, 2000 meetings of all of the midwifery regulatory bodies as well as representatives of the unregulated provinces and territories began working with representatives of the federal and provincial governments to come to a workable agreement. There were significant similarities between legislation, registration requirements and core competencies across Canada. Each province had built their version of midwifery practice on the work that had been done in other provinces thus much of the agreement was relatively easy to come to terms on. The Agreement (College of Midwives of Manitoba, 2001) makes movement between provinces easier by guaranteeing registration to a midwife moving between regulated provinces (British Columbia, Alberta, Manitoba, Ontario and Quebec) under the following conditions:

1. An applicant who has general registration at the time of application, and has practised one year or more in a regulated jurisdiction will be eligible for registration without additional assessment subject to the following requirements:

> a) The applicant provides proof of good professional conduct from the Canadian jurisdiction(s) in which they are currently or have been previously registered setting out any relevant information on the applicant's conduct;
>
> b) The applicant meets clinical experience requirements as outlined in Appendix A (p.4).

These clinical experience requirements specifically address birth numbers. The required birth numbers as per the *Agreement on Mobility for Midwifery in Canada* (Appendix A, 2001) were 60 births, 30 of which were done with the midwife in question providing continuity of care (midwife provides minimum of 4 antenatal visits, labour care, birth care and three postnatal visits). Forty of the sixty births must have been ones that the midwife was the most responsible caregiver for during the intrapartum period. Of these forty births ten would have to occur in hospital and ten out of hospital. The other requirements under the agreement were:

> (c) The applicant satisfies other non-competency registration requirements specified by jurisdictional law, regulations and by-laws;
> (d) The applicant has completed and submitted the prescribed application form with related documents;
> (e) The applicant's current and past registration(s) have been verified and
> (f) The applicant pays the fees required. (p. 4)

Those applicants who do not meet the above criteria may be required to undergo other more arduous and expensive assessments including written examinations and skills assessments and the regulating body is under no obligation to accept them. At the time the Agreement was being negotiated

these assessments were costing in the range of one to two thousand dollars and required several weeks of examinations.

The ability of midwives to register without current experience was unique to Manitoba. In order to circumvent this difficulty with respect to the Labour Mobility Agreement a clause was inserted stating that only midwives who were registered and had one year of experience could apply for registration in another province under the Agreement. The interesting dilemma is that after one year of experience if the midwife had registered in Manitoba without current birth experience she would not likely have the birth numbers required under the Agreement. No one from Manitoba has tested the Mutual Recognition Agreement so it is yet to be seen how this situation might be handled.

D. Summary

Midwifery legislation in Manitoba protects the title 'midwife' as well as the substantial acts of a midwife which pose potential harm to the public. These acts are detailed in the Regulation to the Act in order to be more efficiently updated. The importance of midwives functioning as autonomous health care providers within the health care system is reflected in the legislation.

In order for the process of registration to be fair and to have the ability to register all midwives who had the requisite skills, knowledge and judgement to perform midwifery competently in Manitoba the entrance to

practice requirements were left up to the College of Midwives to decide. The College decided that it was not a specific diploma, degree or certificate that it was looking for but really a set of competencies that would indicate that a person could practise midwifery safely. Several accommodations were made in order to allow for a broader range of midwives to register. Those midwives who did not have current practice or who did not have current practice in one birth site or the other could register with the condition that they would be supervised until they demonstrated competence in that setting. The supervision requirements were developed based on a competency model, which meant that as soon as a midwife was deemed competent by their supervisor they could have the condition removed from their registration. This is in contrast to other provinces who have specific numbers attached to supervision requirements.

This accommodation created some difficulties with the Mutual Recognition Agreement discussions amongst provinces but ultimately a solution was reached allowing Manitoba midwives the opportunity for expedited movement between provinces under the agreement.

Chapter seven

Home Birth

A. Home Birth in the Legislation

The issue of home birth has been the cause of major controversy. The literature supports the safety of home birth in the situation where the woman, the pregnancy and the fetus are healthy and she is attended by a trained care provider who has access to emergency services (Tew, 1985, Hinds, 1985, Taffel, 1984, Bortin, 1994, Mehl, 1977, Mehl-Madrona, 1997, Tyson, 1991, Wiegers, 1996, Woodcock, 1990, Janssen, 2002). Home birth is being revived in countries such as the United Kingdom due to release of a major report, *Changing Childbirth* (House of Commons, 1992) which stated that the practice of requiring all women to give birth in hospital could not be supported on the basis of safety. The recommendation by the Working Group that home birth must be a part of midwifery practice was supported by all members of the MIC, but as part of a larger concept encompassed by the term 'out of hospital birth'. Out of hospital birth according to the MIC definition, includes births in homes, nursing stations, birth centres and small hospitals that do not have onsite access to consultant physician care. Yet, home birth created the most controversy and therefore is the primary focus of this Chapter.

The MIC wanted to protect women's right to choose the place where they would give birth, but it was not immediately clear how best to protect

home birth as an option for women under the midwifery legislation. After consulting with the legislative council for Manitoba Health, it was decided that the best way to preserve home birth and yet also move the legislation through the legislative process was to not speak to it directly in the Act itself.

Policy Decision Ten: Not to enshrine home birth in the act.

Home birth is covered in the Regulation but under the broader term, out of hospital birth. The Midwifery Regulation states that:

> A midwife shall comply with the standards of practice approved by the college, including standards concerning the following:
> Out-of-hospital births. (Section 15(b))

As long as "out of hospital" births are a required standard in the Regulation, the college will have to have a standard of practice on out-of-hospital births and midwives will have to comply with it.

Reasons behind the decision:

When planning how best to protect the provision of home birth services, several possible options were considered. Home birth could have been written into the Act, home birth could have been written into the Regulation or home birth could have been left up to the College to address through the process of setting standards.

The Act is the place where home birth would have been most well protected. Changes to the Act can only be made by the Legislative Assembly and public consultation would be required for these changes to be made.

Once the Act was passed it would have been very difficult to make home births illegal. Placing home birth in the Act, however, ran the risk of having it become the centre of debate and possibly an impediment to the passage of the Act. The College of Physicians and Surgeons and the Manitoba Medical Association, as well as many individual physicians had expressed serious concerns and had described home birth as an unacceptably dangerous activity that should not be permitted. The MIC did not underestimate the political power of the physician lobby or its ability to make the issue so uncomfortable that the Minister might not be willing to put the legislation forward.

The community midwives, that is the midwives providing home birth services at the time the legislation was being developed, were very concerned that not providing any protection for home birth in the legislation would leave it too exposed. The second option was to not mention home birth in legislation and leave it up to the Council of the College of Midwives to make sure that this option was protected through the process of developing standards. Standards are documents that outline the practices a midwife must follow and are developed and passed by the Council of the College of Midwives. Some standards are required by law and are specifically named in the legislation. Those not mentioned may be developed at the discretion of the College. If out of hospital birth was not mentioned in the required standards portion of the Regulation (Section 15) there was a risk that a

future College of Midwives might decide that home birth was not an option that they wanted to preserve. As the governing body of midwifery, they could act unilaterally and forbid this practice. While not a likely situation, particularly with the consensus decision making model in place, it was a possible one and worried some people.

The Regulation offered more protection for home birth. Regulation can only be changed by cabinet, which requires a wider hearing of the proposed changes than standards development does. There was still some risk with home birth being specifically mentioned in the Regulation as the Regulation were being sent out for consultation with the various stakeholder groups, which would include physicians.

The decision was made to use the words 'out of hospital birth' instead of 'home birth'. The main difference between out of hospital and in hospital births, as seen by the MIC, was that the skill set of the midwife had to be somewhat different. A midwife working outside the hospital setting might have to care for a complicated birth situation while waiting for or during transportation to hospital. Such a situation might occur not only at home, but also in a birth centre, northern nursing station or a small hospital without consultant physician services. Protecting all these forms of out of hospital birth was seen as important. An additional advantage was that the term 'out of hospital' did not provoke as emotional a response as the term home birth. The Midwifery Implementation Council finally decided on subsuming home

births, within the broader category 'out of hospital births', and including it in the Regulation where it would be protected but less provocative.

Impact of the decision:

Early in its existence the MIC had commissioned a review of the literature on home birth for use by the MIC and its members (Marshall, 1995). In order to better understand physicians' opposition to home birth, the Council sent a letter to the College of Physicians and Surgeons of Manitoba requesting copies of the literature on the dangers of home birth. The College of Physicians and Surgeons referred the letter to their Maternal Perinatal Morbidity and Mortality Committee who replied by referencing the position statement of the Society of Obstetrics and Gynecology. After reviewing the available literature, the MIC decided that the physicians' reaction to home birth was quite complex. Their strong emotional reaction to home birth was seemingly based on the belief that the hospital with its technology and its specialists must be the safest place to give birth. While accepting that 'normal' births were very safe, physicians had also been trained in the philosophy that birth is only normal in retrospect and that disasters can happen in a moment. While not sharing these beliefs, the MIC acknowledged their power over the attitudes of the physicians.

A second report on home birth was commissioned by the MIC in 1997 (Bourgeault 1997). It updated the previous review but focused more specifically on issues that should be considered when developing the standard

of practice for midwives doing home births. Bougeault (1997) also cautioned that ultimately the parents should decide where their child should be born.

The Midwifery and Consequential Amendments Act was passed unanimously by the Legislature of Manitoba. No amendments were made to the Act after it was approved by the Midwifery Implementation Council and sent forward to government. No physicians appeared before the committee to speak against home birth, while many women and their babies attended these hearings and spoke strongly in support of the inclusion of home birth as an option under regulated midwifery. Although the MIC was always clear that home birth was a part of the model of midwifery care being proposed, it was able to avoid the passage of the Act from becoming the centre of this contentious and acrimonious debate.

B. Place of Birth Exemption

Policy Decision Eleven: Midwives may choose to limit their practices to one birth setting.

All provinces with regulated midwifery require registered midwives to attend births at a woman's home and in hospital. This has meant that if a midwife did not want to practice in one or the other of these settings she could not register with any College of Midwives in Canada. Even registered midwives had to attend a required number of births in each setting, in order to maintain their registration.

In Manitoba nothing in the Act or the Regulation requires that a midwife attend births both in and out of hospital. However the standards of the College of Midwives require 10 out of hospital births for registration (College of Midwives of Manitoba, 1997b) and the *Standard for Continuing Competency* requires 10 out of hospital births for continued registration (College of Midwives of Manitoba, 1997c). In order to accommodate qualified midwives who did not feel ready to provide out of hospital birthing services the following compromise was reached.

The Regulation to the *Midwifery and Consequential Amendments Act (1997)* contains the following clause:

> Election to practise in specified setting
> *5* For three years after this regulation comes in to force, a person who is eligible for registration as a practising midwife under section 4 may elect to be registered as a midwife who attends births only in a specified setting. Once registered such a midwife is entitled to practise in accordance with the election unless his or her registration is cancelled, suspended or not renewed or further conditions have been placed on it. (Section 5)

This clause means that any midwife who registers between June12, 2000 and June 12, 2003 may chose to practice in only one birth setting. For example a midwife may choose to attend only women birthing in hospital. Equally a midwife could choose to limit her practice to providing home birth services or only working in a birthing centre. Once a midwife makes this choice she can continue providing care in only one setting until she retires from practice or chooses to change this situation.

Reason for the decision

Out of hospital birth is one of the pivotal issues in midwifery regulation in Canada. Ontario set the stage by making home birth a critical element of midwifery practice. Alberta and British Columbia followed suit and required all midwives to provide home birth services as part of the package of midwifery care. Despite literature that is reassuring with respect to the safety of planned home births many health professionals continue to oppose women giving birth outside of the hospital. If there was a requirement for home births in Manitoba, many nurse midwives stated that they would not register.

The dilemma for the Midwifery Implementation Council was that they were committed to out of hospital birth, but also were committed to registering as many qualified midwives as possible. A meeting was held to discuss this issue with a group of nurse midwives, most of whom were employed as labour floor nurses in hospitals in Winnipeg. This meeting was an opportunity for the nurse midwives to express their concerns to the Midwifery Implementation Council. The chair of the Council and the chair of the practice committee attended the meeting, which was facilitated by a professional facilitator hired by the MIC. The nurse midwives concerns were varied. Some of them felt that home birth was not safe, based on their observation of births in hospitals that had appeared to be progressing normally and then suddenly went wrong. They did not want to risk this type of occurrence at home where technology and specialist physician back up is

not readily available. Some were worried because they had not been trained to provide home birth care. Depending on where and when the nurses had done their midwifery training, home birth may not have been a part of their education. Others simply argued that a birth was a birth and questioned why the MIC was so concerned about whether or not they attended home births anyway.

In Manitoba another group of midwives identified concerns with providing home birth services. Immigrant midwives who had trained in countries where home birth was not a service were particularly concerned and felt that by asking them to do home births the MIC was setting up a barrier to their registration.

The issue for the Midwifery Implementation Council and for the government was that the supporters of home birth (both midwives and consumers) were adamant that registered midwives must provide this service. The demand for home birth service had been pretty consistent at approximately 60-70 births a year (Vital Statistics 1995) even when only a few midwives were providing this service and were at constant risk of prosecution for practising medicine without a license.

The Midwifery Implementation Council needed to find a compromise between protecting home birth services to Manitoba women and ensuring that as many qualified midwives as possible registered and were able to provide midwifery care. They initially looked to see what other provinces had

done. Ontario had not allowed anyone without recent, Ontario home birth practice into the one-year up grading and evaluation program necessary for registration that they ran at the Michener Institute in Toronto. This meant that those midwives who had chosen to practice in hospitals and not flaunt the law were denied the opportunity to register in Ontario. The MIC had heard from Ontario midwives that this approach had caused problems including a shortage of midwives post registration.

The Council discussed this issue at several of their meetings. One major obstacle to resolving this problem was the concern that home birth services must be protected in the future. Several MIC members argued that should midwives who did not provide home birth become a majority on Council, home birth could be in jeopardy. While they recognized that it might be difficult to expunge 'out of hospital birth' from the Regulation, the College could adopt policies, standards and guidelines that were so restrictive that the provision of home birth services might become impossible.

A compromise was finally reached and a limited window of time was created to allow midwives, who did not want to do home births, to register and also circumvent the home birth requirements for continued registration (College of Midwives of Manitoba, 1997c). It was decided that to be fair the Regulation should allow for a midwife to make this election with respect to either in or out of hospital births. For this reason the Regulation does not say

that a midwife may elect not to attend home births, but rather that a midwife may elect to attend births only in a specified setting.

These decisions were translated into the Standard entitled *Registration with Election to Limit Practice* (College of Midwives of Manitoba 1997d). This policy reiterates the right of the midwife who makes this election to practise in the setting of their preference and to be exempt from any requirements to maintain registration that relate directly to the site of practice in which she does not provide care. It goes on to discuss other limitations and expectations that go along with this choice.

To ensure that the client's right to choose their birth place is preserved all midwives must offer clients information on all of their choices for birth place. If the client chooses to birth in the setting that the midwife does not practise, than she must be referred to a midwife who can provide care in that setting.

To address the concern about decision making the following provision was made in the College standard. Midwives who had taken advantage of this election retain their right to be involved in decision making and can hold office within the College. However they are not allowed to vote on policies which directly affect midwifery care in the setting in which they do not practise. This means that midwives who do not provide home birth services would have no input into the decision making with respect to policies or procedures that would affect home birth practice.

It was agreed that those midwives, who elect to limit their practice, may teach in a midwifery education program, but must limit their teaching to classes that do not deal with the birth site in which they have chosen not to work. This reduces the possibility of bias against this site being transmitted to students in a teaching program. It also means that only a midwife who is familiar and comfortable with a given birth place is able to teach aspiring midwives about the practice of midwifery in that setting.

In recognition that all midwives will need to be able to speak knowledgeably about all birth settings, so that clients will be able to make a decision about where they want to have their baby, the following requirement was created by the College of Midwives. Every midwife who choses not to attend births in a given birth setting must attend 5 births in that setting as soon as possible after registration, either as an observer or as a second attendant.

The MIC was hopeful that once midwifery had been established and midwives had enough experience with being the primary care provider that they would want to provide care to their clients in all settings. To plan for this eventuality, there is an opportunity within the policy for midwives to upgrade their skills and attend births in all settings. Before this could happen, a midwife would have to apply to the College for a change in her registration. Once the application had been processed, a supervised practice contract would be set up to allow her to attend births in that setting under

the supervision of another midwife. Once the supervising midwife decides that the midwife has the skills, knowledge and judgement to provide competent care in that setting, the condition will be lifted from her registration. From that time on she would be able to provide care in all settings.

With this policy in place the MIC was able to come to consensus on the Election to Practice in a specified setting clause of the Regulation.

Impact of the decision

The impact of this solution was threefold. Firstly it allowed for registration of several midwives who would not have otherwise registered. Secondly it required a special exemption for Manitoba midwives who were writing the NARM examinations as a prerequisite to registration with the College of Midwives of Manitoba and thirdly it complicated negotiations on the Mutual Recognition Agreement.

In the first year following the coming into force of the *Midwifery and Consequential Amendment Act* twenty-six midwives registered with the College of Midwives of Manitoba as practising midwives. Six were nurse midwives, but only one elected to limit her practice to hospital births. Two other midwives who were immigrants to Canada chose to limit their practice to hospital births. It had been years since they had practised midwifery and they felt more comfortable practising only in hospital. Within 2 years of proclamation, only one midwife in Manitoba has chosen not to broaden her

practice to include home births and two are under supervision in order to remove this caveat from their registration. No registered midwife had limited her practice to an out of hospital setting.

By creating an opportunity for midwives who did not wish to attend births at home, the MIC partially countered, those physicians who have argued, that midwives should not be forced to attend births at home. Some of this criticism has continued however, because this option is only open to midwives who registered in the first three years after the Act came into force. This time period was chosen, by the MIC, on the assumption that all of the existing midwives interested in registering would have done so within this time period. As newly trained midwives would be prepared to provide births in all settings, there would be no need for the election to practice in a specified setting to continue.

North American Registry of Midwives (NARM)

The clause exempting home birth experience created some potential difficulties with access to the North American Registry of Midwives examination process. NARM required 10 home births as primary midwife in order for a midwife to qualify to take their examination. The MIC negotiated with NARM to provide for an exemption for midwifery candidates applying from Manitoba. This exclusion for Manitoba midwives, which became known as the Manitoba exemption, formed a part of a special agreement negotiated with the NARM to allow potential candidates without home birth experience to

write the examinations. It was explained to NARM that many midwives in Manitoba had not had the opportunity to attend home births because it had been illegal. As well they were sympathetic to the MIC's attempts to register as many competent midwives as possible whether they were currently wishing to provide home birth services or not. The compromise was that if a Manitoba midwife did complete the examination process, but did not have home birth experience, she would not receive the Certified Professional Midwife (CPM) designation that NARM awards to midwives who complete their exam process successfully. They would however allow the midwife three years to attend 10 home births, at which time they would be eligible to receive their CPM designation from NARM.

Mutual Recognition Agreement

The clause in the Manitoba Regulation that allowed for the registration of midwives who did not want to practise in all settings posed a challenge to the negotiation of this agreement. British Columbia, Alberta and Ontario required both in and out of hospital (home) births for the maintenance of registration. The Ontario Regulation (1992) states that of the 60 required births for initial registration

> 10 shall have been in a residence or remote clinic or remote birth centre, of which five will have been as primary midwife (Section 4(1) 2.ii (4))
>
> 10 shall have been in hospital. (Section 4(2) ii (3))

The British Columbia requirements for registration are outlined in their by-laws (Part 5, Section 45.1 (2) iii and iv) and require that 5 births must be in a hospital setting and 5 births must be in an out of hospital setting (British Columbia By-laws December 1996). Alberta was revising their registration requirements to reflect those of Ontario. Both Quebec and Manitoba came to the table with issues that might have adversely affected the movement of midwives from their jurisdiction due to the requirements of both Ontario and British Columbia that midwives have current experience in both birth settings, in and out of hospital. The difference was that the Manitoba situation was a voluntary one in the sense that midwives were choosing to limit their practices. In Quebec, the problem was that midwives did not have hospital privileges due to what were being termed 'administrative' issues. Midwives, in Quebec were unable to perform hospital births and were restricted to working in birth centres. The opposition to midwifery among Quebec physicians was quite extreme. The physicians controlling hospital admitting privileges refused to extend them to Quebec midwives. As a result, Quebec midwives were unable to meet the in hospital requirement of the other provinces.

Participants in the discussion of the agreement felt that it was inappropriate to exclude midwives who in every other respect meet the requirement of the Agreement on Mobility from the opportunity to use this much less complicated way of moving between provinces. After a long

discussion, it was agreed that the following would be added to the Agreement:

> Where the applicant meets all of the requirements with the exception of home/out of hospital/hospital experience due to provincial/territorial barriers which may be legislative, jurisdictional or administrative in nature, the applicant's clinical experience will be accepted under the MRA (the Agreement) with the understanding that temporary conditions will be applied to address these requirements. (Section 1(b) p. 4)

The understanding was that these conditions would be of the nature such that if a midwife did not have experience in one particular birth setting, that her registration would allow her to practise independently in all other areas of practice. The jurisdiction to which she moved could require that she have the supervision of another fully registered midwife, in that setting, until such time as she was deemed competent to practise independently.

Each province recognized that they had a slightly different way of determining competence. Manitoba requires that a midwife be observed in a particular setting until such time as her supervising midwife assesses that she is competent to practise independently. This might mean she is observed at one birth or twenty births, whatever it takes. On the other hand, British Columbia and Ontario set out a specified number of births a midwife must attend in each setting before the condition prohibiting independent practise in that setting could be removed.

Manitoba had great difficulty in accepting the birth numbers for currency as outlined in the Agreement on Mobility (see page 131). These

numbers had originated in Ontario and had been adopted by British Columbia and Alberta as their standard for initial registration and for continuing currency of experience. Each of these three provinces had decided that if a midwife met or exceeded these birth numbers in the previous five years, then they would be considered to have current experience and remain eligible for registration. When asked how it was determined that these were the numbers that ensured that a midwife was competent, the reply was that the numbers were drawn from the European Economic Community requirements. Further research looking at the published requirements for midwifery training (Official Journal of the European Communities, 1989) found that the requirements for registration as a midwife in all European countries were as follows:

> The student should personally carry out at least 40 deliveries; where this number cannot be reached owing to the lack of available women in labour; it may be reduced to a minimum of 30 provided that the student participates actively in 20 further deliveries. (Article 27)

This document also requires that midwives have had experience with prenatal examination, postnatal examinations of women and their newborns, care of women and newborns with pathologic conditions requiring special care, experience or simulated experience with breech births and suturing of tears and episiotomies. There is also a clause that states that the midwife will have training related to the:

> Supervision and care of 40 women at risk in pregnancy or labour or post-natal period. (Article 27)

When the question of the number of births was raised with the Registrar of Midwives in Ireland, Ursula Byrne, her reply was that it was very difficult for midwifery students to reach the target of 30 births. The problem was falling birth rates coupled with the number of medical, midwifery and nursing students, who had to attend a required number of births in order to meet their own registration requirements.

The EEC documents do not require experience in different birth settings (such as home or hospital). As well there is no requirement for births in a continuity of care situation. The MIC concluded that the birth numbers included in the Mutual Recognition Agreement were a made-in-Canada requirement. They were not based on any research showing that a midwife can safely practice only after she has done 30,40 or 60 births, or had provided continuity of care to a certain number of women. Manitoba reluctantly acknowledged the commitment of other provinces to protecting the continuity of care requirement as an important aspect of the Canadian model of midwifery care. Several unregulated jurisdictions, however, agreed that these numbers were high and might become a barrier to registration for women from low volume obstetrical areas such as northern areas of Canada or smaller provinces. The MIC challenged the other provinces at the Mutual Recognition Agreement talks to revisit the numbers set in the Agreement.

C. Summary

Out of hospital birth in Manitoba is defined as a birth that occurs at a place that does not have access to consultant physician services. In effect this means that an out of hospital birth is one that occurs at someone's home, at a birth centre, at a nursing station or at a small hospital. The MIC wished to protect women's right to birth where they chose and therefore sought to protect these options through the legislative process. Out of hospital birth is mentioned in the Regulation to the Act as an area of practice that requires a standard set by the College of Midwives.

In order to be inclusive with respect to the registration of skilled midwives, the College decided to allow midwives to choose not to provide care in a specific birth setting within the first three years following proclamation of the Act. This means that Manitoba is the only province that allows midwives to practice in only one birth setting. All other provinces require midwives to provide birth services in and out of hospital.

Chapter Eight

Aboriginal Issues

In Manitoba in 1995-96 there were 16,046 births (Vital Statistics, 1996). It is estimated that 25 % of these births were to women of Aboriginal descent. Many Aboriginal women both urban and rural are living in conditions of poverty with its attendant problems of poor nutrition, poor health, and therefore poor outcomes related to pregnancy. These important facts highlighted the need for the MIC to ensure that the system of regulated midwifery in Manitoba included Aboriginal women in meaningful ways.

The Working Group had recommended that more consultation with Aboriginal communities was essential to the successful implementation of midwifery in Manitoba. From their limited consultation with the Aboriginal community and from reviewing information from Ontario, their report made the following observations:

> There is a critical need for training and education of local (aboriginal) community persons in healthcare fields, including training as midwives.
>
> Midwifery employing local personnel and located in northern and remote communities can help address the dislocation stress and high costs associated with the policy of flying pregnant women out for birthing.
>
> Midwifery care can contribute to better maternal and child health, enhance bonding between parents and child and help reclaim traditional knowledge and self-respect within communities.
>
> Training must be accessible to persons in northern, rural and remote communities, to encourage and support local people towards this education.

> The issue of midwifery must be placed in the much broader setting of addressing the basic health care needs and the extreme poverty of the majority of Aboriginal and Metis communities.
>
> Planning for training education and delivery of services must take local conditions into account. Authentic consultation with local communities at all planning stages is crucial. (Working Group Report, p. 57)

The provinces of Alberta, Ontario and British Columbia, who had all passed legislation prior to Manitoba, had dealt with the question of Aboriginal midwifery in a number of ways. None seemed to satisfactorily address the issues identified by the Aboriginal women consulted by the MIC. These women argued that how midwifery was governed raised a number of issues critical to Aboriginal people. These included the protection of Aboriginal midwifery skills and knowledge, but also how Aboriginal women would be included in the legislative process as both providers and receivers of midwifery care.

A. Inclusion in Legislation

Policy Decision Twelve: To set up a committee to advise the council on issues related to Aboriginal midwifery and issues related to the provision of midwifery services to Aboriginal women.

The MIC Equity committee developed a consultation process that would allow them to reach as many Aboriginal women as possible. The task was challenging partly because midwifery was not on the agenda of most

Aboriginal communities. Their priorities included self-government, violence and abuse, suicide, diabetes and access to general health care. Another barrier was that leadership of the Aboriginal peoples was mostly male and, while not opposed to midwifery, neither were they particularly interested in the issue. Based on the advice of Aboriginal women the MIC decided to speak first with women in the communities and based on what was learned from these women, the Council might decide to approach the leadership directly.

Determining how to get to as many women as possible was the first challenge. The MIC knew they wanted to include all Aboriginal women, including First Nations women (treaty and non-treaty) and Metis women in the consultations. A small number of Inuit women live in Manitoba in the northern communities and in Winnipeg. Many more Inuit women give birth in Manitoba in northern hospitals and in Winnipeg. However the MIC did not specifically target them for consultation, as their absolute numbers are low. The first meetings were with women from Manitoba Native Affairs, the Original Women's Network, Native Women's Transition Centre, Indigenous Women's Collective, the Dakota Ojibway Tribal Council and the Aboriginal health consultants at Manitoba Health. The most urgent question was what was the best way to proceed with this consultation. The advice was to get out and speak to as many women as possible. The MIC was cautioned however that they could not assume that one Aboriginal community had the

same issues as another. Communities vary in language, culture, access to medical services, politics, religion, size and demographics. It would be important to try and get input from women from a variety of communities to actually develop a good understanding of the issues. Early on it became evident from preliminary consultations that the issue of aboriginal midwifery and its relationship to the legislation was a complex one. Due to this the MIC did not submit the legislation in 1996 as was planned but decided to delay the legislation for an extra year to consult more broadly with the aboriginal community and leadership.

The MIC decided that the questions asked during consultations would revolve around recommendations related to practice, education and the legislation. For the purpose of this thesis I will focus on the Aboriginal women's recommendations with respect to the legislation.

Three contracts for consultation processes occurred, one in northern Manitoba, one with Metis women and one with Aboriginal women living in Winnipeg. Aboriginal women in the southern part of the province were consulted using a different process.

The MIC hired Freda Albert, an Aboriginal woman to conduct a consultation process in northern Manitoba in 1996. In total 200 women from 20 different communities were involved in this consultation process. The consultation process was an amalgam of one on one telephone conversations, video presentations and a northern conference in Thompson,

Manitoba that members of the MIC attended. The consultation process included a discussion of what midwifery was like in the past, what the current status of midwifery was, what their vision of midwifery would be, concerns they had about midwifery and recommendations for the MIC. This report (Albert,1997) contains a wealth of information from elders, elder midwives and other women about their experiences with birth and with midwifery from times gone by. The final outcome of this process was a resolution passed by the group of Aboriginal women who met in Thompson on June 13 and 14th of 1996.

> The resolution reads with respect to the legislation:
>
> Be it Resolved - That the proposed wording of the midwifery bill as it related to Aboriginal people be taken to the Aboriginal people for consultation.
>
> Be it Resolved - That Aboriginal midwives already practising or who did practice traditional midwifery, be permitted to practice and teach traditional midwifery on and off their home reserves/communities if they are recognized by their Elders of their community as midwives.
>
> Be it Resolved - That northern Aboriginal midwives sit on the council and committees of the College. (Albert, 1997 p.32,33)

Audreen Hourie, a Metis woman, did the consultation with the Metis women. She spoke with approximately 30 women in the Metis community. She notes that there are approximately 100,000 Metis people living in 150 communities in Manitoba, mostly in Southern Manitoba. Approximately 6% of these people are over the age of 65 and that 60 % are under the age of 25 years

meaning that there are few Elders and a lot of young families with a high birth rate.

In her report Hourie (1997) details the results of this consultation process. She found that a few traditional Metis midwives still provide care but would be reluctant to come forward. The Metis tradition of midwifery is described as:

> caring, sharing and nurturing....providing physical, mental, emotional and spiritual care to the Mother and her family. (Hourie, 1997 p. 2)

Metis are described in the report as "quick to consider adapting to outside influences including midwifery services" (p.2). However, they are also "just as quick to resist change to core values and principles" (p.2). The report warned that:

> should the legislation, regulations, education and practice ignore the aspirations of the Metis there is no doubt that a resistance would build against an alien and forced midwifery service (p.2).

She did note a deep desire to return to home and community birthing to get away from being transported to larger centres to give birth. The report quotes several women as they talked about their dissatisfaction with the status quo. The status quo is described as being little prenatal care, a hospital birth with a physician whom you do not know in a city you are not familiar with and then being sent home with little idea of what you should be doing with your new baby.

> They said I should not be up. I was taken back to my room and strapped to my bed (p.3).
> It's like going to the hospital to have a baby removed, the same as having a growth removed (p.4).
> I was left alone on a narrow cot (p.2).

One woman expressed concern about the motives of bringing midwifery back to the communities:

> Do you think that this (midwifery legislation) is just a way for government to cut back on the budget for health expenses? (p.4)

The group recommendations from the Metis consultation were:

> That traditional Metis midwives and the practice of traditional Metis midwifery be respected and protected by and in the legislative process including regulations regarding midwifery.
>
> That the legislative process enhance and protect the practice of traditional Metis midwifery and that there be provisions to ensure that the practice of traditional Metis midwifery is not subjected to a sunset clause or be phased out and discontinued.
>
> That the midwifery legislative process recognize and respect the mother as the primary decision maker in the birthing process.
>
> That the midwifery legislative process recognize and respect the mother's right of choice regarding care, the caregiver, and the place of birth.
>
> That the midwifery legislative process recognize and respect the health and wellness context of birthing for women, their babies, families and communities as defined by the women, taking into account their physical, mental, emotional, and spiritual well-being.
>
> That midwives be recognized as primary caregivers providing an insurable service that supports women before, during, and after giving birth, but that midwives do not control the birthing process. (p.7)

An Aboriginal woman, Sheila Sanderson, who had previously been a member of the MIC, did the urban Aboriginal consultation. She conducted one hour interviews with eleven Aboriginal women in Winnipeg who had either been identified as leaders with respect to Aboriginal women's health issues or were consumers of midwifery services. The interviewer found it difficult to focus these women on midwifery practice and birthing in the city environment. All of the women focused on talking about midwifery as it relates to their home communities. There was general support for midwifery. One woman was quoted as saying,

> Reclaiming of birth at a community level is therefore not simply just that. It offers each community a chance to use their own resources, knowledge, traditions, and teachings to educate their young people and become less reliant on the current system of evacuating mother-to-be. Individuals would become more involved in the continuity of life within their communities. Women from the community would have a chance to help other women from that same community throughout their pregnancy, through their labour, and during the postpartum period.....With this change (midwifery) it is felt that communities would be in a position to not only reclaim birth, but to rediscover where life comes from. Having birth returned to the communities will allow for balance to return in the cycle of life. (Sanderson, 1997 p.3)

The recommendations based on these interviews with respect to legislation were:

- A centralized administrative centre be established to watch over both the quality of services provided and the funding required to provide (these)
- That the advisory committee for the Aboriginal woman/women sitting on the Board of the College of Midwives have some real decision-making powers; that they are not simply there for consultation.

- That the mandate of the Advisory Committee be flexible over time.
- That the board of the College of Midwives be at least 9 members. At least one of the consumer representatives and one of the health practitioners should be Aboriginal.
- That a mechanism for networking with Aboriginal women from other provinces who are involved with midwifery be established. (Sanderson, 1997 p.7)

An Aboriginal consultant and the midwifery co-ordinator, both Manitoba Health employees consulted Aboriginal women in southern Manitoba. They visited with women at several key First Nation's communities in the southern part of the province. They also hosted a two day sharing circle, information and consultation meeting at Red Willow Lodge in southern Manitoba. One concern that came forward in this consultation which was also expressed at other consultations was would this be a move "backward or a second rate service" Barker 1997 p.4). The women expressed the opinion that given the diets and societal changes that have arrived in communities, they do not want a complete rejection of what current maternity care may offer for prenatal diagnosis or surgical care. A meshing of traditional practices, skills, knowledge and modern medical practices would be the ideal situation. (Barker, 1997)

In March of 1997, while this consultation was being carried out, recommendations from the Adult Health Care Initiatives Conference were made to the Assembly of Manitoba Chiefs. This conference included health care workers from 62 First Nations communities and was held by the Dakota

Ojibway Tribal Council (DOTC). The process began with a presentation by the MIC and then the participants developed recommendations that went forward from the DOTC to the Assembly of Manitoba Chiefs. In all 12 recommendations went forward. Those that specifically related to the midwifery legislation were:

> That midwives should be available to First Nations women who choose to use their services.
>
> That the proposed Midwifery Act which makes provision for an Aboriginal Advisory Committee to work with the Council of the College of Midwives on issues concerning midwifery for Aboriginal women be supported. This advisory committee should be established immediately to oversee the appropriate implementation of midwifery in First Nations communities and advise the MIC on unique educational needs. Funding should be provided for representatives to this committee.
>
> That Aboriginal midwives (including women from the North) be represented on the Council of the College of Midwives, on the Standards Board, on the Ethics Committee, and on the Discipline Committee.
>
> That Aboriginal midwives already in practice or who did practice traditional midwifery be permitted to teach traditional midwifery on and off reserve/communities if they are recognized by the Elders of their community as midwives. (p.2)

The actual resolution of the dilemma of how to include Aboriginal midwifery and the needs of Aboriginal women within the framework of regulated midwifery is fairly well described by the resolution that went to the Assembly of Chiefs. The Legislation does not set out a separate category for Aboriginal midwives. The legislation, regulation and by-laws lay out exactly how Aboriginal persons will be involved in the regulation of midwifery.

B. Kagike Danikobidan

The Aboriginal Advisory committee also called Kagike Danikobidan is established in the Act which states that:

> The council shall establish:
> a standing committee to advise the college on issues related to midwifery care to aboriginal women (Section 8(5) b)

This committee is also mentioned in Section 8(1) which states that one of the members of the standing committee mentioned above shall be a member of the council of the college. The Regulation requires that one person on the committee to select public representatives shall be appointed by the Aboriginal Advisory Committee.

The by-law identifies the name of the Standing Committee on Issues Related to Midwifery Care to Aboriginal Women as Kagike Danikobidan. This name was given to the committee by the first chairperson of the committee Heather McKay. She translated it to mean, "always making grandparents" (McKay, 1997).

The Bylaw in Section 16 lays out the composition of the committee and sets out the processes to be followed by the committee including the consensus process of decision making as outlined in Appendix E. The purpose and duties of Kagike Danikobidan are outlined in the Terms of Reference statement attached to and forming part of the by-law. The purpose of the committee was stated as:

> to provide the College with a perspective on midwifery that is deemed desirable and acceptable to Aboriginal women. Members of the

committee will work to strengthen, enhance and advocate for their rights and interests. Consideration will be given to the unique educational, legal, clinical, cultural and political forces affecting Aboriginal women.

The duties of the committee as outlined in the by-law include:

- promote equal access to midwifery care for Aboriginal women;
- promote equal access to midwifery education for Aboriginal women;
- advise on the standards of practice for midwifery care from the perspective of Aboriginal women;
- promote respect for Aboriginal cultures and traditional teachings;
- promote the preservation of traditional knowledge and skills, which provide a holistic approach to midwifery care including physical, mental, spiritual and emotional aspects;
- advocate for and advise the College on issues of importance to Aboriginal women;
- provide advice and direction to representative of Kagike Danikobidan to the Council;
- provide membership on the following committees: Education, Standards, Board of Assessors, Public Selection ; and
- identify the human, physical and financial resources required to carry out the tasks and activities of Kagike Danikobidan, and report these requirements to the College (Bylaw Terms of Reference p.9).

There was great concern expressed that Kagike Danikobidan should not just become another Aboriginal advisory committee that had no power and was ignored by the body they were advising. The Aboriginal representative to the Council, Heather McKay, was very concerned with this issue. After debating the best way to ensure that Kagike Danikobidan would have meaningful

input, a special clause was put into the by-laws with respect to decision making at council when Aboriginal midwives or midwifery services might be affected. Section 8.8 and 8.9 of the By-laws state:

> Decision Making and Matters Affecting Aboriginal Women
>
> 8.8 When the Council is required to make a decision which has a direct effect on either the provision of midwifery care or the delivery of midwifery education/training programs to Aboriginal women, Council shall:
>
> A) consult with Kagike Danikobidan on the issue in question; and
>
> B) decide the issue in a manner which considers the view of Kagike Danikobidan.
>
> Where Disagreement Arises on Issues Affecting Aboriginal Women
>
> 8.90 Where Kagike Danikobidan informs Council that it disagrees with a decision made by the Council, Council shall undertake one or more of the following steps:
>
> A) hold another meeting to reconsider the matter;
>
> B) hold a joint meeting with Kagike Danikobidan to further discuss the matter;
>
> C) set up a joint committee consisting of equal representation from Council and Kagike Danikobidan to explore possible solutions for resolving the matter; or
>
> D) use the services of an independent mediator to assist in developing an acceptable solution to the matter. (Bylaws p.8).

These sections of the Act, Regulation and By-law set the foundation for the participation of Aboriginal people in the regulation of midwifery.

There is no exemption for Aboriginal midwives in the legislation. The information the MIC received during consultations was that on Aboriginal land the Chief and Council would have the ability to decide who they would allow to practise midwifery. If they were satisfied that an Aboriginal woman had

the skills to practice they could grant her the right to do so. However she would not be able to practice off of Aboriginal lands without being registered with the College of Midwives. Therefore there was no need to specifically exempt Aboriginal midwives practising on Aboriginal land.

Reasons behind the decision:

Each of the provinces had approached the issue of Aboriginal midwifery differently.

Ontario entered into consultations with Aboriginal people shortly before the legislation was passed. Aboriginal persons in Ontario were very upset by this perceived slight and lack of consideration for the Aboriginal midwives situation. The Ontario Federation of Indian Friendship Centres Report (1991) expressed dismay over the lack of time allowed to adequately study the issue of Aboriginal midwifery. The Association of Iroquois and Allied Indian (1991) wrote:

> Whereas our membership has serious concerns that imply that Aboriginal Rights are not addressed in any part or form of this proposed legislation; and Whereas it has always been our traditional and hereditary part of our customs to carry through with midwifery regardless of the circumstances involved...(we) demand that a First Nations Specific exemption be added to the legislation (Barker 1997 p.5)

The Union of Ontario Indians (1991) reported that the Aboriginal health workers were very concerned that the legislation did not recognize traditional medicine people.

A Resolution by the Ontario Federation of Indian Friendship Centres stated that:

> In lieu of exemption from the proposed Act the following recommendations are presented: that the proposed legislation be amended to promote the creation of an Aboriginal Council of Midwives which would provide appropriate training by Aboriginal midwives for Aboriginal midwives: That the proposed legislation be amended to provide for the creation of a separate and distinct Aboriginal Advisory Council which would seek to return regulation and control of health care services to the Aboriginal communities (Barker 1997 p.7)

In light of this opposition and due to the lateness of the consultation process, the Ontario legislation passed in 1994 had an exemption clause for Aboriginal midwives working on Aboriginal lands (reserves).

British Columbia midwifery legislation distinguishes between a traditional Aboriginal midwife and an Aboriginal midwife. Traditional Aboriginal midwives can only work on reserve whereas a midwife identified as an Aboriginal midwife has special training in Aboriginal practices in addition to her standard training as a midwife. She may practice anywhere in British Columbia. The By-law of the College of Midwives of British Columbia sets up a Committee on Aboriginal midwifery that consists of three Aboriginal persons appointed by the Board of the College. This committee is to recommend by-laws to the board regarding the following matters:

> (a) a class of tradition aboriginal midwives and classes of aboriginal midwives;
> (b) requirements for the registration of traditional aboriginal midwives and aboriginal midwives;
> (c) standards, limits or conditions for the practice of midwifery by aboriginal midwives;

(d) standards of professional ethics for aboriginal midwives;
(e) standards of education for aboriginal midwives;
(f) requirements for continuing education for aboriginal midwives; and
(g) procedures to be followed by the committee (College of Midwives of British Columbia p.12).

The committee has the ability to nominate a person for each committee of the board. Decision making for all the committees of the British Columbia College of Midwifery is to follow Robert's Rules of Order with a preponderance of votes necessary for decisions to be made. As no member of the Aboriginal committee would be on the board any recommendation that came from this committee would not have a voice to speak for it. Furthermore, the members of committees appointed by the Aboriginal Committee could be outvoted at the committee level. As a result, their issues may not ever even make it to the attention of the Board of the College where the decision making power resides. Alberta did not carry out any consultations with Aboriginal people and there is no mention of them in their legislation, regulation or by-law.

The process of consultation in Manitoba was important but was not without its difficulties. Most Aboriginal women were only beginning to explore the possibility of midwifery and bringing midwifery back to the communities. Many of the women the MIC spoke to either through the contract persons or personally were only hearing about midwifery regulation for the first time and had not really had time to consider it and make recommendations. For some it was very difficult to grasp what midwifery in

this context meant. One woman commented that "prenatal care could be by Aboriginal people (midwives)" (Sanderson 1997 p.11). She could not fathom more power being given to a midwife. Another wondered "how will it work if the woman has her baby suddenly and there are no Doctors. Will it be legal for the Midwife?" (Sanderson, 1997 p.11) Once again there was a question as to whether a midwife would actually have the permission to provide complete care during birth. Unfortunately there was not enough time or resources to go back to these same women after a period of time to get their reactions and suggestions.

Impact of the decision:

The legislation, regulation and by-law leave the door open for effective input from the Aboriginal community. A voice at Council, membership on committees and a supporting Aboriginal advisory group all could have significant influence due to the by-law requiring consensus decision making at both the Council and committee levels. The success of this system depends on who is on Kagike Danikobidan and who is elected to the Council and committees. The person(s) need to be able to understand the issues and feel confident enough to exercise their rights within the consensus decision-making model. The Aboriginal women's community in Manitoba has many issues to deal with and midwifery is only one. Finding women who are willing to sit on Kagike Danikobidan has been a challenge.

Delaying the legislation by a year allowed the MIC to gather a lot more information and support for the midwifery regulation process in Manitoba. By the time the Aboriginal governing bodies received recommendations on midwifery the MIC had all ready developed a legislative solution that had been endorsed by many Aboriginal women. Presentation to the Aboriginal governing bodies was done by Aboriginal women on behalf of the MIC which added a lot of weight and credibility to the recommendations. A result of this was that there was no backlash from Aboriginal communities to the regulation of midwifery as set out in the Manitoba legislation.

C. Summary

The legislation sets out the composition of the governing body of midwifery in Manitoba. The inclusion of an Aboriginal Advisory Committee, Kagike Danikobidan, and mandated membership on committees of the Council and the Council itself ensure that Aboriginal women's voices will be heard within the governance structure of midwifery.

The consensus decision-making model is critical to the success of Aboriginal representation as it allows for a stronger voice in decision making. In Councils and Committees that use Robert's Rules of Order to make decisions committee members who might hold a minority view could be voted down, this cannot happen in a consensus decision making model.

Chapter Nine

Governance Model

A. College of Midwives

As has been discussed, the primary purpose of the development of legislation to govern midwifery was to benefit the public, or more precisely to protect the public. One of the most important tasks necessary to realizing this goal was the development of a governing structure for the midwifery profession. This chapter will describe the structures that govern midwifery according to the Midwifery and Consequential Amendments Act, its Regulation and By-law including the statutory provisions that speak to the inclusion of public representatives within the governance structure.

The College of Midwives includes all midwives and midwifery students registered under the Midwifery and Consequential Amendments Act. The governing structures of the College include the Council of the College which is the final decision making body of the College and the committees which advise the Council on matters that will be coming before them for decisions. The committees are the Standards Committee, the Education Committee, the Complaints Committee, the Inquiry Committee, the Public Education Committee, the Nominating Committee and the Board of Assessors. The terms of reference for these committees are included in Appendix F. The configuration of the governing structures of the College was seen as critical to the ability of the College to govern midwives and midwifery practice

effectively. The MIC was committed to mandating the membership of both the Council and committees so that the voices of women including Aboriginal women would be heard and listened to. The membership on the Council is defined in the Act (Part 3, Section 8). It states that the council shall consists of a minimum of 3 midwives elected from the membership of the College, one of whom shall be a rural midwife. As well the council must include two public representatives and a representative of the Aboriginal advisory committee. The Act and Regulation also includes direction with respect to public representation on College committees.

B. Public Representation

Growing pressure by the public, and more lately by the government, to increase public representation on the governing bodies of self-regulated professions reinforced the Midwifery Implementation Council's decision to enshrine public participation in the governance of the College. Concerns have been raised that self-regulated professions have been too insulated. Accusations have been expressed that instead of protecting the public their role has been to protect the profession and their membership. Public representation on the committees and the governing bodies is seen as a possible solution to this problem.

Policy Decision Thirteen: Public input into the affairs of the College is critical to a responsive midwifery system in Manitoba.

Three decisions were made in order to facilitate public input into the workings of the College of Midwives. The first was to include public representatives on the governing council and the standing committees of the College of Midwives (See Appendix F) The second was to hold annual public meetings and the third was to allow members of the public to attend meetings of the College or the Council.

There was strong support by the Midwifery Implementation Council for public representation in the affairs of the College. Bill 7, The Midwifery and Consequential Amendments Act Part 3, Clause 8(1) states that the Council shall consist of at least six persons of whom at least two are public representatives. Clause 8(5) goes on to require the establishment of a standing committee for the purpose of recruiting and selecting public representatives to serve on the council and standing committees of the college. A public representative is defined under the Act as:

> a person who is not and never has been registered under this Act and who is not a member of a health profession regulated by an Act of the Legislature for which the minister has statutory responsibility (Midwifery Act, Definitions).

The regulation sets up a separate arms length committee with the responsibility for selecting public representatives. The Committee shall consist of the following members:

(a) one person appointed by the Women's Health Clinic;
(b) one person appointed by the College who is a member of the College;
(c) one person appointed by the standing committee established under clause 8(5)(b) (the committee which advises the College on issues related to midwifery care and aboriginal women)
(d) two persons who have used the services of a midwife who are not members of the college. (Section 17(1))

The committee is given the task of developing the criteria and the process for nominating and selecting public representatives to serve on the council and college committees. It is the intent that the committee acts as an arms length committee. As with all committees of the College of Midwives this committee is to use the consensus model as delineated in Schedule one of By-law No. 1 of the College to make any decisions (See Appendix E)

The Terms of Reference for the Selection Committee are included in By-law No.1 as follows:

Duties of the Committee
The duties of the Selection Committee include:
(a) identification of the qualifications required by public representatives for the Council and for each of the College committees;
(b) establish a process for recruiting and compiling a list of persons who are interested in representing the public on the Council or on one of the College committees;
(c) develop criteria for selecting public representatives from this list to serve on the Council and on each College committee;
(d) provide the College with public representatives to serve on the Council and on each College committee; and
(e) fill vacancies left by public representatives who may resign or be removed during their term of office on the Council or on a College committee.

In total the committee has to select a minimum of ten public representatives, two for the Council, one for the Complaints Committee, two for the Inquiry Committee, one for the Board of Assessors, one for Standards Committee, one for the Education Committee and two for the Public Education Committee. Other public representatives may be required if the College appoints any additional committees.

The MIC was committed to public accessibility to the College of Midwives. Public input was felt to be critical as a way to attempt to prevent the practice of midwifery from getting too far away from the needs and desires of the women who would be using the services of a midwife. The Legislation states that:

> The College shall:
>
> a) permit members of the public to attend meetings of the college and the council, except where it considers that a private meeting is necessary in order to consider matters of a confidential nature or of a personal nature concerning an individual:
>
> b) make its by-laws available to the public; and
>
> c) hold an annual public meeting to explain the role of the college and to invite public comment. (Part 3 (6))

Reasons behind the decision:

The issue of public representation on the governing bodies of self-regulating professions has garnered attention in the past decade (Pew Health Professions Commission, 1995). The Commission found that adding public representatives to the boards of self governing professions has been seen as

the solution to the problem of a lack of public accountability of these organizations and the perception that they were more concerned with self interest than public protection. The commission also commented on the reluctance of many professional organizations to include public representatives. This is usually based on the argument that such representatives do not have the technical abilities to be able to deal with issues relevant to the profession. Rockwell (1993) points out that public representatives are supposed to challenge and complement board decision making through the provision of a critical, non-professional perspective, not to be technical experts.

The MIC was committed to including public representatives but several decisions had to be made with respect to the issue of public representation. One debate was whether public representation means consumer representation. Does a person have to have used the services of a midwife to be able to fulfil the role of a public representative? Must a public representative be a woman or could the partner of a woman who used the midwife also be considered a consumer? The MIC decided that it was not necessary to be a consumer or a woman to fulfil the role of public representative and that a unique perspective on the work of the College might be provided by someone who had never used the services of a midwife.

The importance of providing an opportunity for representation of rural women's issues was recognized by the MIC. In a province as large as Manitoba, geographical and regional variations may make policies and standards developed by the College problematic in some areas and not others. For example, if the College decided to create a standard that

required that a midwife be no further than 30 minutes from her clients, this would not be problematic for urban midwives but would seriously curtail the number of women a midwife could serve in a rural setting. Rural representation on council and on committees will help to ensure that standards that get passed are relevant to the rural areas and are not unduly biased towards the urban practice of midwifery.

Does public representation within a professional body make the profession more concerned about the protection of the public and less about the protection of the profession? It would be difficult to measure the impact of public representation on a specific profession. The MIC was cognizant of the limitations of having a few public representatives attempting to influence the direction and decisions of the College of Midwives. Public representatives may have varying abilities to influence the College. It may also be difficult for a few individuals to adequately represent the needs of the variety of women who would be looking to access the services of a midwife or who may be interested in attaining registration as a midwife. The clause of the Act, which allows for the public to attend meetings of the college and the council, provides another venue for community involvement. It will also allow women with specific issues that they wanted addressed by the College or with concerns about a direction the College is taking, to attend a Council meeting.

The public meeting that is required by the Act and must occur yearly is another vehicle for receiving public input and reaction. If women are not

comfortable or are unable to attend College meetings to express their concerns, then the public meeting provides them with another forum in which to raise any questions they have with the College or any of its committees, policies or decisions.

Impact of the decision

The committee to select public representative spent the better part of a year deciding how to select public representatives and choosing the first representatives for the various committees and the Council. The process included advertising in provincial and community based newspapers, encouraging people to apply for a position with the College. Potential candidates were interviewed by the Committee to Select Public Representatives and if chosen were placed on the College committee best suited to their skills, knowledge and interest.

The College recognized the difficulties that public representatives might have with integrating into the College structure. Many of the College committees had had the same membership for several years as holdovers from the MIC days. Instead of requiring that each committee be responsible for the orientation of the public representatives, the College decided that several key council members and the executive director would hold a general orientation for all public representatives. This meeting oriented them to the history of the College, the legislation pertaining to the regulation of midwifery in Manitoba and the committee structure that supports the legislative role of

the College. The meeting also offered the opportunity for the public representatives to meet each other with the hope that they might become a resource or support for each other as they became the first public representatives in the new College structure.

C. Summary

Public input into the College of Midwives was felt to be important to ensure that regulated midwifery in Manitoba would keep in touch with the community and meet the needs of the consumers. Many professions had been criticised for becoming too insular and more interested in protecting their members than protecting the public. Strong public input into the College would help to circumvent this problem.

Chapter Ten

The Complaints Process

The MIC was committed to a complaints process that was truly responsive to the persons who were complaining about the midwifery care they received. This required public involvement in the complaints process, the development of innovative complaints resolution processes such as mediation, a process that kept the complainant informed as to what was happening with the complaint and provided useful information to the complainant on the resolution of their complaint by the College. Recognizing that the complaint process is stressful for the midwife and that not all complaints are reflective of poor practices by the midwife, the MIC was also concerned that the process was fair to midwives. The largest section of the Midwifery and Consequential Amendments Act deals with the complaints process and the possible outcomes resulting from a complaint.

A. A Fair and Transparent Process

Policy Decision Fourteen: The complaints process must be transparent, fair and have public input.

The complaints process is outlined in Part 5 of the Act, which is, entitled "Enforcement of Standards". The process of filing a complaint with the College of Midwives requires a written statement naming the individual about whom the complaint is being made and the specifics of the complaint. The

Registrar, who is a midwife and an employee of the College, receives the complaint. Her role is to review the written documentation with respect to the complaint and present it to the Complaints Committee. The Complaints Committee includes the following members:

> (a) one member of the council who is a midwife;
> (b) one member of the council who is public representative;
> (c) one member of the college who is not a member of the council. (Part 5, Section 18)

Having two members who are sitting on the governing body of the College was felt to be important as they were all ready very familiar with the governing requirements of the College and could also provide a direct liaison with the Council.

The Act states that:

> Any person may make a complaint in writing to the registrar about the conduct of a midwife, (Section 19(5))

It was decided that not only should clients be able to make a complaint about a midwife, but another midwife, a nurse, a physician or any other individual should be able to make a complaint to the College of Midwives and the College should have the right and obligation to investigate it. This decision was made based on experience of the College of Physicians and Surgeons. The College could only investigate a complaint laid by a patient and was unable to investigate complaints from one physician about another physician. The wording in the midwifery legislation was felt to be broad enough that any complaint could be investigated. There was debate over the requirement that

all complaints should be in writing. This however was felt to be necessary, as otherwise there would be no written record of the nature of the complaint. If a person had difficulty with the written part of the complaint the College should make arrangements for someone to assist them with the process.

The Complaints Committee will usually ask the Registrar to investigate the complaint. If a complaint is particularly complex, the Committee may arrange for a special investigator. Investigations might begin by requesting records from the midwife in question, or by collecting further information from the complainant, or by interviewing the people involved. The College has the right to get a court order to get records if the midwife under investigation refuses to supply them. The investigator is able to investigate any other matters related to

> the professional conduct or the skill in practice of the investigated person that arises in the course of the investigation (Section 21(4))

This section of the Act gives the investigator and the College latitude to act on other serious issues that may arise during the course of the investigation. Limiting the investigation to the issue under complaint would not be in the best interests of protecting the public. Once the investigation is complete, a report goes from the registrar or the special investigator to the Complaints Committee for a decision. The timeline for dealing with a complaint and the necessary points of communication to the complainant are detailed in the Act and Regulation.

After reviewing this report, the complaints committee has several options. It may decide to refer the issue to the inquiry committee, or it may ask for the voluntary surrender of the midwife's registration. It may censure the midwife or it may decide to refer the matter to mediation but only if:

> the complaints committee determines that the complaint is strictly a matter of concern to the complainant and the investigated person and both parties agree to mediation. (Part 5 Section 22(1) (e))

Mediation offers a less adversarial approach to resolving the conflict between the complainant and the midwife.

The Complaints Committee may also enter into an agreement with the midwife that:

> provides for one or more of the following:
> (i) assessing the midwife's capacity or fitness to practise midwifery.
> (ii) counseling or treatment of the midwife.
> (iii) monitoring or supervision of the midwife's practise of midwifery,
> (iv) the midwife's completion of a specified course of studies by way of remedial training
> (v) placing conditions on the midwife's right to practise midwifery (Part 5, Section 22(1)(f))

The possible conditions that might be imposed on a midwife's ability to practice include:

a) limit his or her practice
b) practise under supervision;
c) not engage in sole practice;
d) permit periodic audits of his or her practice;
e) permit periodic audits of records;
f) report to the complaints committee or the registrar on specific matters;

g) comply with any other conditions that the committee considers appropriate in the circumstances (Part 5, Section 26)

If after investigation the Complaints Committee feels that the nature of the issues under consideration are so concerning that it may be necessary for the registration of the midwife to be revoked, then the case must be referred to the Inquiry Committee. The Inquiry Committee is the body set up to deal with the most serious complaints that come before the College. The Inquiry Committee, according to the Act is to be made up of:

> (a) one person who is a midwife and a member of the council who is to be the chair;
> (b) two persons who are members of the college but are not members of the council; and
> (c) two persons who are public representatives. (Section 32(2))

Section 32(3) explains that no one who has taken part in the review or investigation of the complaint can be a member of the Inquiry Committee set up to review the case. An inquiry hearing is an expensive and complicated procedure involving a lawyer acting for the College, and for the complainant and another lawyer to defend the midwife. The inquiry committee sits as a pseudo-jury hearing the case as put forward by the complainant's lawyer and the midwife's lawyer. In keeping with the commitment to making the complaint resolution process as transparent as possible the Act states that

> A hearing shall be open to the public unless the inquiry committee is satisfied that:
> a) matters involving public security may be disclosed;
> b) financial or personal or other matters may be disclosed at the hearing that are of such a nature that the desirability of avoiding public disclosure of those matters in the interest of any person

affected or in the public interest outweighs the desirability of adhering to the principle that meetings by open to the public;
c) a person involved in a criminal proceeding or a civil suit or proceeding may be prejudiced; or
d) the safety of a person may be jeopardized. (Section 36(1))

Once all the evidence has been heard the inquiry committee makes a ruling on the case. The inquiry committee may make the following judgements:

The investigated person:

a) is guilty of professional misconduct;

b) has contravened this Act, the regulation, the by-laws or the code of ethics of the college;

c) has been found guilty of an offence that is relevant to the midwife's suitability to practice;

d) has displayed a lack of knowledge of or lack of skill or judgment in the practice of midwifery;

e) has demonstrated an incapacity or unfitness to practise midwifery; or

f) is found to be suffering from an ailment that might, if the midwife continues to practise, constitute a danger to the public (Section 42)

If one of these findings is reached then they can make one or more of the following orders:

(a) reprimand the investigated person;
(b) cancel the certificate of registration of the investigated person for a stated period;
(c) cancel the certificate of registration of the investigated person until
(i) the investigated person has completed a specified course of studies or supervised practical experience, or
(ii) the committee is satisfied as to the competence of the investigated person to practise midwifery;

(d) accept in place of the cancellation of the certificate of registration, the investigated person's undertaking to limit his or her practice;

(e) impose conditions on the investigated person's entitlement to practise midwifery, including conditions that he or she

(i) practise under supervision,

(ii) permit periodic inspections of his or her practice by a person authorized by the committee to carry out inspections;

(iii) permit periodic audits of records,

(iv) report to the committee on specified matters,

(v) not engage in sole practice.

(f) require the investigated person to satisfy the committee of his or her competence to practise midwifery;

(g) require the investigated person to satisfy the committee that a disability or addiction can be or has been overcome, and cancel the certificate of registration of the investigated person until the committee is so satisfied;

(h) require the investigated person to take counseling;

(i) direct the investigate person to waive, reduce or repay money paid to the investigated person that, in the opinion of the committee, was unjustified for any reason; and

(j) cancel the certificate of registration held by the investigated person (Part 5, Section 43)

An appeal process firstly to the Council of the College of Midwives and then to The Court of Appeal of Manitoba is outlined in the Act to allow recourse to midwives or complainants who do not agree with the findings of the Complaints or Inquiry committees (Sections 47 (1-3) Section 48 and 49).

Reason for the decision

The handling of complaints against registered members of a health profession is a critical element of their mandate to protect the public. Complaints whether they are from other midwives, other health practitioners or the public may be the first indication to the College that there are

difficulties with either an individual midwife's practice or with the College's policies with respect to the practice of midwifery.

The process for dealing with a complaint in the Midwifery Act is very similar to the one described in the Medical Act that governs Manitoba physicians. The advice the Midwifery Implementation Council was given by government lawyers was that this was a process that had been proven and that recent proposed amendments were meant to improve it even further. When the College of Physicians and Surgeons were informed that midwives would be subjected to the same process with respect to the processing of complaints they approved. The College of Physician and Surgeons of Manitoba had advised several improvements to the process. One of the frustrations they had had over the years was that only one penalty could be imposed for a particular offence. For example if a practitioner was alcoholic and had borrowed money from one of her clients the College might have chosen to impose a combination of penalties. They might have liked to require an alcohol treatment program, boundary training with respect to appropriate practitioner/client relationships and a period of suspension until the other requirements had been met. The wording of the Medical Act at that time made it necessary for them to choose one penalty only. They would end up having to suspend the physician because it would be the safest course when what they really needed to do was also address the treatment and training issues to do the most effective job of protecting the public (and

getting the practitioner back into service if she was successfully rehabilitated). The Midwifery Act allows for combinations of penalties to be imposed. The Complaints Committee and the Inquiry Committee are able to impose several different remedies to a given situation. This provides the committees with enough latitude to impose penalties that will best address the issues at hand.

Once a decision has been made by the Complaints Committee or the Inquiry Committee both the midwife, who was investigated, and the person who filed the complaint are required to receive a notice explaining the decision with respect to the complaint as well as the reasons for the decision (Part 5, Section 22(3)). The public has been very critical of professions in that once a complaint has been laid the complainant receives very little information about what the outcome of the complaints process was. The MIC felt it was very important that the complainant not only be informed about the outcome but also have access to the reasons behind the decision so that they can better understand how their complaint was dealt with.

The Complaints Committee needed a remedy for serious complaints that suggested that the midwife under question represented an ongoing risk to the public. In this case the Committee can direct the registrar to suspend her registration pending the outcome of the complaints proceedings (Part 5, Section 28(1)). This section was felt to be necessary as it gives the College

the ability to protect the public from midwives who are potentially dangerous while an investigation is being carried out.

The Act states that the complaints committee may disclose any information of criminal activity discovered during the course of the investigation. This means that the College can inform the police if a criminal action is uncovered during their investigation (Part 5, Section 31). This ability adds to the protection of the public.

The basic tenant of the Act is that hearings should be open to the public. The only time a hearing may be closed is if the inquiry committee thinks that there are serious concerns that someone will be harmed by the very fact that the hearing is a public one. Examples where a hearing may be closed to the public are if there are death threats against one of the persons involved in the hearing or the complaint involves a minor who may be harmed by the public nature of the proceedings. If a hearing is to be closed to the public the reasons for this must be available to the public in writing. As well the inquiry committee may reconsider closing a hearing at the request of any person.

This ability to hold closed hearings caused a lot of discussion amongst the MIC members as there was concern that it might leave the principle of an open process vulnerable to becoming secretive by invoking this clause in every single circumstance. However on debating the issue and discussing it with the government lawyers and the College of Physicians and Surgeons it

was felt that it was necessary to have this ability in the best interests of all involved. There may be times when requiring all hearings to be open may cause undue and unnecessary hardship to the persons involved in a hearing.

There is provision within the Act to bar publication of matters disclosed at the hearing at the discretion of the inquiry committee (Section 36(2). Once again this clause is present to protect persons involved in the hearing from undue hardship. No order can be made to ban the publication of any information that by law must be included on the public portions of the register of midwives. This would include the outcome of the complaint process and any conditions that are placed on a midwife's registration as the result of a complaint proceeding. These pieces of information must be available to the public.

Impact of the decision

The complaints process was not a contentious part of the legislation of midwifery. The similarity to the process defined by the College of Physicians and Surgeons meant that physicians were reassured that midwives would be held to the same standard and dealt with by similar processes in the case of a complaint by a client. The legislation also allowed for complaints to be laid by another professional. This meant that physicians and nurses, who are the two professions who seem to have had the most concern about the introduction of regulated midwifery, have a clear process for presenting their complaints.

One type of complaint that was not considered by the legislation was that of a complaint about a specific midwifery standard or action, not against a particular midwife. Neither the Act, Regulation nor By-laws address the issue of complaints other than a complaint against a specific midwife or midwives. This type of complaint should have been addressed somewhere in the structures defined by the legislation governing the regulation of midwifery. Not having a process addressed means that the College will have to sort out exactly how these issues should be handled and it is not clear if the way they will chose to handle it will be seen as appropriate by the person who lodges the complaint.

B. Summary

The complaints process is a very important part of the protection of the public in a self-regulatory system. The Midwifery and Consequential Amendments Act builds upon the process used by the College of Physicians and Surgeons and thus was seen as a comfortable process by other professionals bodies.

A process for dealing with complaints against a standard or some activity that midwives engage in rather than a complaint against a specific midwife is not addressed in the legislation.

Chapter Eleven

Conclusion

The development of midwifery legislation in Canada is a new and challenging field of endeavour. In 1997 Manitoba became the fourth province to pass midwifery legislation. At the current time six provinces have passed legislation and four of these provinces have publicly funded midwifery providing services to their constituents. Although there are variations to the type of legislative system that each province uses to regulate their health professionals, there are also many areas of commonality in the legislation governing midwifery in this country.

It is important that a record exist of the rationale for the policy decisions that have shaped the development of midwifery in Canada. Several other provinces and territories are contemplating the passage of midwifery legislation. The legislation of the provinces that have already done so is going to affect the model of midwifery care and regulation that is proposed in these jurisdictions. Each province will soon be reviewing their legislation and making changes that will improve the statutes with respect to midwifery. Without an accurate record of the reasoning behind the clauses of existing regulation, there is the danger that the new legislation, or the new clauses being contemplated, will be a retrogressive step rather than an improvement on the original.

Midwifery legislation is meant to support and reflect the model of midwifery that is envisioned to be the ideal model to safely serve the needs of the public. It should be flexible and inclusive so that the practice of midwifery is protected because this should protect the public as well. One of the concerns of regulation is that the heart and soul of midwifery would be lost in the regulatory process. This does not need to be so. Regulation provides a framework that should support the practice of midwifery with a heart and soul. The heart and soul comes from the standards and policies that the Colleges of Midwives produce and enforce not from the legislation. It takes midwives and consumers working with the regulatory body to make the regulation of midwifery responsive to the needs of consumers.

The Manitoba Legislation is unique in its approach to several areas of legislation. The use of consensus decision making by the Midwifery Implementation Council and the decision to have the Council of the College of Midwives use this decision making process was unique in Canada. The requirement for an arms length committee to select public representatives is another area in which the legislation provides a unique solution to the difficulty of choosing public representatives. At the time of the development of the Midwifery Act the option of mediation, as a dispute resolution procedure for complaints was unique among health profession legislation in Manitoba.

Policy decisions were the starting point of the development of the legislation. Manitoba's legislation is similar to other provinces but also deviates in significant ways in order to meet the unique needs of the midwives and women in Manitoba. The exemption for midwives who did not wish to practice in all birth settings is an excellent example of adapting to the unique situation in this province. The small size of the midwifery community meant the MIC had to approach registration issues creatively but with the utmost respect for the need to protect the public.

Manitoba's approach to the issue of Aboriginal midwifery and services to Aboriginal women was developed with the input of many Aboriginal women. The plan to ask women what they wanted first and then to approach the Aboriginal governing organizations was an important step. This approach allowed for a grass roots solution to the difficulties the Council faced when trying to develop a way to support Aboriginal midwifery and Aboriginal women who were giving birth. Whether this solution will prove to be satisfactory waits to be seen.

The commitment to basing registration eligibility on the midwives ability to demonstrate competence rather than her ability to produce a certificate is a step forward in midwifery regulation. This approach allows for the registration of a qualified midwifery practitioner without formal qualifications who can demonstrate that nevertheless she can provide safe care to the women of Manitoba. This option provides an area of flexibility in

the legislation and the regulation of midwifery that leaves the door open for women who for whatever reason need to follow a midwifery educational path that is unique or eclectic. Allowing for multiple routes of entry to practice is more likely to produce a multitude of styles of midwifery practice, which in turn will meet the needs of a larger range of Manitoba women. This policy decision which underpins the legislation with respect to entrance to practice requirements begs for evaluation. Currently Manitoba does not have a university educational program for midwives unlike Ontario, British Columbia and Quebec. The result of this is that in the next few years, until a program is developed, most of the new registrants in Manitoba will come through an assessment process. This process will define whether or not the woman applying for registration has the skills, knowledge and judgement necessary to carry on the practice of midwifery in Manitoba. An evaluation comparing the success of midwives who come through an assessment process versus those that enter practice through a baccalaureate program would be very interesting.

As this paper is being written the Regulation to the Midwifery and Consequential Amendments Act is in the process of being reviewed. The lists of medications, tests and procedures clearly need some fine-tuning. Some common medications used with respect to pain control and the treatment of minor infections were omitted on the first iteration of the Regulation. Consultant obstetricians have been asking midwives to order tests that they

are not allowed to order under the current regulation. Clearly it would smooth the referral process if midwives had the legislated ability to order these tests so as to be able to provide the results to the physician at the time of the consultation.

One could argue that now might be the time to look at strengthening the support for home birth in the legislation. Two years have passed since midwives began practising in Manitoba under the legislation. During this time close to 150 home births have been attended by midwives in Manitoba without any major mishaps. Perhaps the medical profession has become more comfortable with the practice of midwifery and would not provide so much opposition to the inclusion of a stronger statement on home birth in the new Regulation. This will be for the College of Midwives to decide.

The complaints process is clearly delineated in the legislation, what is not described is the process of responding to complaints about the practice of midwifery in general or about specific midwifery practices. A process to be followed for this situation might serve to provide a consistent approach to these issues that both the complainant and the College could understand.

Research into the effect of regulation should not only look at this issue in a general sense to address the question of whether regulation is a good or a bad thing for midwifery. Evaluation of midwifery in Manitoba should be directed at looking at the effects specific portions of the legislation have had on the practice of midwifery. Does the legislation have the desired effect

that the underlying policy decision was trying to achieve? If so is the policy decision still relevant and beneficial to the practice of midwifery and the development of the legislative framework.

As with any new regulated profession much remains to be learned about the processes that work and the direction that needs to be taken to ensure that midwifery is seen as a profession that not only protects the public but also remains responsive to the needs of the population it serves. Ongoing research and evaluation must be undertaken to provide a level of vigilance which will help to ensure that regulated midwifery does not become a service that only meets the needs of its practitioners.

Appendices

Appendix A

Creating an Act and Regulation

Legislation is a global term referring to primary law made by the parliament of Canada or the legislature of a province. An Act is referred to as primary legislation as it is law made directly by the legislature. Regulations and By-laws are referred to as subordinate legislation as the authority to make them is delegated by the legislature (in the Act) to a body such as the Cabinet, a Crown agency or governing body of a profession for example.

An Act or Statute is the name given to a Bill that has been passed by the Legislative Assembly (the House). An Act is the highest form of statute law and sets out government policy in very, broad general terms. There are two types of Acts, those that apply to private persons or organizations, such as *The Southwood Golf and Country Club Act,* and those that apply to the public at large which is the type of Act *The Midwifery Act* is. The primary objective of Acts that govern professions in Manitoba has moved toward protection of the public and away from simply defining a profession and limiting the substantial actions of that profession to only members registered with the governing body of that profession.

Regulation is law made under the authority of the power delegated in an Act. This regulation details issues such as administrative policies to make the Act work and other details that are expressly laid out in the Act as areas

that may be addressed in Regulation. A regulation made outside of the areas expressly set out in the Act is invalid and would be found so by a Court.

The process of developing a Bill and then having it become an Act is a long and formal one which requires the work and cooperation of many persons including the public, government employees, politicians and in the case of an Act that affects a profession, members of that profession and their governing body. There are two types of Bills, a Government Sponsored Bill and a Private Members Bill. Government Bills are put forward by the government and are sponsored by the appropriate Minister. Private Members Bills are put forward by a member of the opposition party or by a government back-bencher. The Bill with respect to midwifery was a Government Bill sponsored by the Minister of Health.

How a Government Bill Becomes Law

Every bill passes through a series of stages in the Legislative Assembly before it becomes law. The following details the process for the passage of a Government sponsored Bill such as Bill 7, the bill respecting the regulation of Midwifery in Manitoba.

The Bill goes through a long process of consultation and development before the drafters within government prepare the final wording of the Bill that will be presented to the house. This consultation process includes working closely with the primary stakeholders and may include consultation with other stakeholders as required. It is not necessary to have consensus

with respect to all the clauses of the Bill. However it is important that the Minister sponsoring the Bill be aware of any disagreements with respect to the portions of the Act and why the decision was made to proceed in the way the Bill describes. The Minister is briefed by government Legislative Council on this issue before the Bill is introduced to the House.

Once there is agreement that the Bill is ready to go to the House a request is made by the Minister to place the bill on the agenda of the House, called the "Order Paper". Two days notice must be given before first reading of the Bill. The Government's House Leader's staff consults with the sponsoring Minister before directing Legislative Council to put notice of the Bill on the Order Paper. The House can give unanimous consent to shortening the notice period or waiving notice entirely, but this only happens in exceptional circumstances such as a Bill affecting the management of a natural disaster.

At First Reading the Minister sponsoring the Bill makes a motion in the House that the Bill be introduced and given first reading. He or she may give a brief explanation as to the purpose of the Bill but the Bill is not actually read aloud. At this time there is a vote in the house to approve that the Bill be printed. This vote is a formality and does not imply any acceptance of the substance of the Bill.

After first Reading the Bill is printed and the Clerk of the House distributes it in the House to the members of the legislative assembly. In

practice they may actually be printed prior to the vote taken at First Reading and then are distributed to the members within hours of First Reading. Once the Bill has been distributed to the House it is available to the public through the Queen's Printer.

Second Reading is the most important stage of the passage of a Bill. The purpose of Second Reading is to allow debate on the principle of the Bill and its broad purposes. This stage cannot occur less than two days after distribution of the Bill in the House. This allows the members time to review the Bill and prepare for Second Reading. The "Second Reading Speech" by the sponsoring Minister begins the second reading debate. Any member of the Legislative Assembly may speak to the Bill. The debate on second reading is to be confined to the basic principles of the Bill and should not address individual provisions in the Bill. After debate ends, a vote is taken and the Bill is given second reading and referred to a committee of the House for a detailed review.

The committee stage involves the Bill being gone over clause by clause by either a standing or a special committee. This committee is made up of both government and opposition members and includes the Minister who is sponsoring the Bill. Department officials and/or the Legislative Council may sit with the Minister at the committee meetings to provide advice to the Minister and other officials. Members of the public are able to comment on the bill either in person or in writing. Following the public presentations, the

Minister and the Opposition members consider the Bill clause by clause. Amendments can be proposed at this stage but only amendments that are within the scope of the Bill are admissible.

The final stage of passage of a Bill is the report stage and Third Reading. Once the committee review stage is passed, the chairperson of the committee reports to the House on the committee's deliberations, including any proposed amendments. Further amendments may be made at this stage but this is a rare occurrence. A Bill is given third reading after it is reported and voted on.

Royal Assent must be given to all Bills by the Lieutenant Governor. This is a formal ceremony that takes place in the House. The Bill becomes a statute (Act) once Royal Assent is given. It becomes the law unless within the Act there is a provision that states that the Act comes into force on a specific date or a date that will be set through a proclamation made by the Cabinet at a future date. This proclamation is called an Order in Council. The proclamation is published in the Manitoba Gazette that is available to the public. Until an Act comes into force it is not a law.

The Statues passed during a legislative session are published in a volume at the end of each session. They are also published in a loose-leaf form that contains all of the amendments to the date of publication. The updated loose-leaf form is published approximately three to four months after the session of the House ends.

Source: Paper prepared for the Midwifery Implementation Council by H. McLaren, (1995) Legislative Counsel, Manitoba Health.

Appendix B

Manitoba Working Group on Midwifery

The Working Group recommends that:

1. Midwifery be implemented as a regulated profession in Manitoba

Practice of Midwifery

The Working Group recommends that:

2. Midwifery services be available in a variety of settings in accordance with the principles outlined in the Philosophy of Care and the Scope of Practice documents.

3. Midwifery be available to all Manitoba women as an insured service.

4. Midwives be granted hospital privileges in accordance with their scope of practice.

5. There be ongoing assessment of pregnant women who wish to have a home birth, based on the Guidelines for Medical Consultation and Transfer of Primary Care.

6. Midwives conducting home births are responsible for having well-maintained equipment, supplies and drugs that may be required during all phases of the intrapartum and postpartum period.

7. Midwives conducting home births establish a back-up system, which includes another midwife who can assist at the birth, a physician available for

consultation or transfer of primary care, and access to regional emergency transportation systems.

8. A home birth registry be established to collect relevant Manitoba data for future policy development.

Foundations of Midwifery

The working group recommends that:

9. The Core Documents Philosophy of Care, Code of Ethics, Scope of Practice and Core Competencies and Guidelines for Medical Consultation and Transfer of Primary Care be adopted for the implementation of midwifery in Manitoba.

Midwifery Education

The working group recommends that:

10. Manitoba establish a four year (academic) Baccalaureate degree in midwifery.

11. Manitoba explore the option of developing a jointly administered program (intra-and/or inter-provincial).

12. The Philosophy of Midwifery Care and the Scope of Practice/Core Competencies documents provide the foundation for the midwifery education program.

13. There be multiple routes of entry to midwifery education.

14. Individuals have opportunities to challenge courses offered in the program for advanced credit.

15. Midwifery education be comprised of both theoretical and clinical components.

16. Clinical experience be acquired in the variety of settings in which a midwife is expected to practice.

17. The clinical experience of a student requires attendance at a total of 60 births. She will be the primary caregiver at no less than 40 births, 30 of which must occur within a program of continuity of care.

18. The curriculum content be based on the Core Competencies and draw from both the basic sciences and the humanities.

19. The education program reflects the principles of adult education and respects both the needs and the unique contribution of each individual.

20. The underlying philosophy of the program and the curriculum content reflect and respect the multi-cultural nature of the province.

21. Faculty in the midwifery education program be predominantly comprised o practicing midwives.

22. All faculty in the midwifery program responsible for teaching theoretical or clinical components have equal participation in the design, implementation, and ongoing evaluation of the curriculum.

23. The educational program be sensitive to the historical under-representation by certain groups in post-secondary institutions owing to socio-economic, cultural and language barriers.

24. Proactive outreach strategies be implemented to raise awareness of the program within specific communities and to encourage participation in the program.

25. The program incorporates flexible screening policies and selection criteria that take into account life experience and academic record.

26. Appropriate financial assistance be offered to facilitate the participation of individuals for whom cost is a barrier to education.

27. The program be designed to accommodate the difficulties experienced by individuals who live in remote/isolated areas of Manitoba.

28. The delivery of the program utilize appropriate distance education technologies and techniques.

29. Students may engage in part-time or accelerated study.

30. Successful education models which have facilitated the participation of historically under-represented groups be reviewed for their applicability to midwifery education.

31. Post-secondary institutions in Manitoba be invited to indicate their interest in preparing a proposal for developing and implementing a four year (academic) Baccalaureate degree in midwifery.

32. An assessment and upgrading program be developed for individuals who currently practice a range of midwifery skills to assist them in obtaining registration as a midwife.

33. An assessment and upgrading program be developed for individuals who currently practice a range of midwifery skills to assist them in obtaining registration as a midwife.

Regulation

The working group recommends that:

34. Midwifery be a self-regulated profession.

35. A self-governing body be established to regulate the profession of midwifery in Manitoba, and that this governing body establish the structure for regulating midwives in Manitoba.

36. A mechanism of dual licensure be established to enable eligible individuals to be licensed both as midwives and as registered nurses.

37. All midwives be covered by liability insurance for all settings.

Interim administrative structure and tasks

The working group recommends that:

38. During the introduction of midwifery and until such time as a permanent regulatory body is established, an interim governing body, the Midwifery Implementation Council be established.

39. Representation on the Council include midwives and other health care professionals, consumers, and women's health representatives.

40. Four Committees be appointed (reporting to the MIC) with responsibility for issues of Legislation, Education, Practice, and Equity/Access.

41. The Midwifery Implementation Council, in consultation with an approved educational institution, be responsible for developing selection criteria, program content, and a method of assessing competency for individuals currently practicing midwifery skills who wish to become registered midwives.

42. As follow-up to the consultation process initiated by the working Group, the Equity/Access Committee undertake a consultation process with Aboriginal and Metis representatives, traditional midwives, healers, community and other health workers (Including a cross-section of Aboriginal and Metis women) pertaining to the legalization and practice of midwifery in Manitoba.

43. Prior to the introduction of regulated midwifery, an information/education campaign be undertaken by Manitoba Health regarding the range and scope of practitioners available to provide maternity care in Manitoba.

Legislative Implications

The working group recommends that :

44. The Provincial Legislature forthwith table enabling legislation for the creation of a self-governing body for midwifery together with such amendments to existing legislation are required to facilitate the work of midwives."

The Acts which would require modification include: The Medical Act, the Pharmaceutical Act, the Hospitals Act, the Health Services Insurance Act, the Blood Test Act and the federal Narcotics Control Act.

Source: Report and Recommendations of the Working Group on Midwifery to the Minister of Health. February 1993. Manitoba Health Publication.

Appendix C

Terms of Reference for the Manitoba Midwifery Implementation Council (MIC)

1. Develop enabling legislation as well as amendments to related provincial acts.

2. Design a regulatory structure responsible for the legal enforcement of licensing regulations and standards of practice.

3. Develop selection criteria, program content, and a method of assessing competency for individuals currently practicing midwifery skills who wish to become registered midwives.

4. Develop guidelines for a degree program and work with the selected institution(s) on the further development of this program.

5. Develop standards of practice for midwifery.

6. Develop guidelines for the introduction of midwifery practice in a variety of settings and invite proposals for midwifery services from individuals, community groups and institutions based on these guidelines.

7. Address issues of equity and access for both the practitioner and the consumer.

8. Undertake an extensive consultation process to ensure appropriate representation in developing the foregoing (e.g., Attorney General's Department, legal counsel, insurance industry, selected educational

institutions, Aboriginal and Metis representatives, traditional midwives, healers, community and other health workers)."

Source: Manitoba Health Press Release. May 5,1994.

Appendix D

Membership of the Original Manitoba Midwifery Implementation Council (MIC)

The following were the members of the original Midwifery Implementation Council:

1. Chair of the Legislation Committee - Yvonne Peters BSW LLb. Ms. Peters is a lawyer actively involved in disability rights work.

2. Chair of the Education Committee - Joan McLaren Phd Ed.. Dr. McLaren is an expert in competency based training, teaching methodology and program evaluation. She is the former Director of Program and Staff Development at Red River Community College.

3. Chair of the Practice Committee - Kris Robinson. Ms. Robinson is a nurse-midwife, trained in the United Kingdom, and a previous member of the Working Group. She is currently a Clinical Nurse Specialist employed at the St. Boniface Hospital. She was founding President of the Association of Manitoba Midwives. The Association of Manitoba Midwives was the association of nurse-midwives which was supported by the Manitoba Association of Registered Nurses.

4. Chair of Equity/Access Committee - Margaret Haworth-Brockman. Ms. Haworth Brockman is a midwifery consumer with both home and hospital birth experience. She is past President of the Manitoba Association for Childbirth and Family Education and had previous experience as a child birth

companion. The Manitoba Association for Childbirth and Family Education is a community based childbirth education organization which also supplies labour companions.

5. Dianne Tokar - Ms. Tokar is a rural woman who farms cattle near Minitonas, a community in central northern Manitoba. She previously lived in far northern community and had to be evacuated to a southern centre to give birth to her daughter.

6. Gillian Andersson - Ms. Anderson was a nurse - midwife, trained in Scotland. She was also a member of the Association of Manitoba Midwives.

7. Akaterini Zegeye-Gebrehiwot - Ms. Zegeye-Gebrhiwot is an Ethiopian midwife who trained in Greece in a direct entry program. She is a past member of the Immigrant Women's Association Board and is currently training as a visual artist.

8. Lorna Grant M.D. FRCP.- Dr. Grant is an Obstetrician. She was formerly associated with the midwifery project at McMaster University in Hamilton Ontario. Formerly from Winnipeg she had recently returned to practice at St. Boniface Hospital, a tertiary care teaching hospital.

9. Anessa Maize - Ms. Maize is a community midwife. She was trained by a combination of formal and informal apprenticeship and was primarily self taught. She was providing home birth services at the time the Council was appointed. Ms. Maize was a member of the Traditional Midwives Collective. The Traditional Midwives Collective was the organization representing

midwives and aspiring midwives who were working outside the law in the community providing home birth services and hospital labour support services.

10. Ina Bramadat PhD - Dr. Bramadat is a nurse. She was the Associate Dean, Undergraduate Programs University of Manitoba, Faculty of Nursing when she was appointed to the council.

11. Sheila Sanderson - Ms. Sanderson is an Aboriginal woman and a consumer of midwifery services. She was originally from Le Pas, a northern Manitoba community and is currently living in Winnipeg.

12. Madeline Boscoe - Ms. Boscoe is a women's health advocate and is interested in community development. She is an employee of Women's Health Clinic, a feminist community health clinic in Winnipeg, Manitoba and is a nurse by training.

Frank Manning , M.D. FRCP was named an ex-officio member by the Minister of Health as he was the chair of a special provincial task force on Obstetrical care in Manitoba. He did not attend any meetings of the council but received copies of all the minutes of the meetings.

Source: Manitoba Health Biographies of Midwifery Implementation Council members. January 1995.

Appendix E

Decision Making Policy of the College of Midwives of Manitoba

Decisions made by the Council and committees of the College shall follow the process set out in this Schedule.[1]

1. Overview

1.1 Definition of Consensus

1.1 Consensus means that all persons involved in making a decision unanimously agree to support a decision made by such persons.

1.2 Components of Formal Consensus

1.2 Formal consensus has a clearly defined structure. It requires a commitment to active cooperation, disciplined speaking and listening, and respect for the contributions of every member. Likewise, every person has the responsibility to actively participate as a creative individual within the structure.

1.3 Objective

1.3 The objective of this Policy is to establish a formal consensus model for making decisions by the College.

2. Key Principles

2.1(a) Trust

- Be open to new ideas.
- Acknowledge and respect personal and cultural differences

2.l (b) Respect

- Listen to other members without interruption.
- Respect both emotional and logical concerns.
- Focus on the action and not on the personal characteristics of individuals

2.1(c) Unity of Purpose

- Ensure that all members have a basic understanding of the goals and purpose of the group.
- A common understanding of the goals and purpose of the groups should serve as a starting point for decision making.

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[1] The process set out in this Policy is adapted from, C. T. Lawrence Butler and Amy Rothstein. On Conflict and Consensus: A Handbook on Formal Consensus Decision Making "(2nd edition, August 1991), Food Not Bombs Publishing.

- The establishment of a common understands does not preclude a variety of opinions on how to achieve the goals and purpose.

2.1(d) Cooperation

- Focus on developing a shared responsibility in finding solutions to all concerns,

2.1(e) Commitment

- Accept personal responsibility to act in a manner that demonstrates respect, good will and honesty towards the group.
- Recognize that group needs may take precedence over individual desires.

2.1(f) Active participation

- Consensus is a process of synthesis, not competition, thus, all sincere comments are important and valuable.
- Stubbornness, closed-mindedness, and possessiveness should be minimized to avoid defensive and argumentative behaviour that may disrupt the process.
- Promote trust by creating an environment in which every cont4ribution is considered valuable.

2.1(g) Equal Access to Power

- Because of person differences (experience, assertiveness, social conditioning, access to information, etc.) and political disparities, some people inevitably have more effective power than others.
- Attempt to balance this inequity, everyone needs to consciously attempt to creatively share power, skills, and information.
- Avoid hierarchical structures that allow some individuals to have a stronger voice than others.
- Egalitarian and accountable structures promote universal access to power.

2.1(h) Patience.

- Consensus cannot be rushed.
- Sometimes, when difficult situations arise, consensus requires more time to allow for the creative interplay of ideas.
- Consensus is possible as long as each individual acts patiently and respectfully.

2.1(i) Equity

Ensure that all decisions respect and uphold the college's commitment to equity.

3. Steps for Decision Making Using the Consensus Model

3.1 Step 1: Introduce the Proposal Requiring a Decision

Ideally, proposals that require a decision should first appear on the agenda as an information item only. The issues to be considered should be outlined in a written proposal. Introduce the matter to be decided. Explain the reasons leading to the need for a decision. Address the benefits of the solution being proposed. Address any existing concerns. Discuss how the proposal will affect the college's commitment to equity.

At this stage, the chair of the meeting should restrict questions to those that seek greater clarification and comprehension of the proposal. This stage is not the time to express comments or concerns. If possible, once the proposal is introduced and clarified, table the matter to another meeting for further discussion and decision. This procedure gives members more time to consider the proposal.

3.2 Step 2: General Discussion

Encourage broad discussion which takes the whole proposal into account. Discussion at this stage often has a philosophical or principled tome, purposely addressing how this proposal might affect the group in the long run or what kind of precedent if might create. It is important to ensure that one concern does not dominate other concerns. If necessary remind participants of the principles set out in this Policy to be followed when developing a consensus. If there is general approval either the chair of the meeting or a member can call for consensus. To call for consensus, the chair of the meeting should ask members if there are any unresolved or outstanding concerns.

One method of determining if all concerns have been addressed is to invite each participant to make a statement regarding her position on the matter in question. If no further concerns are raised, consensus is achieved.[2]

3.3 Step 3: Identify Concerns

[2] It is important to note that the question is not "Is there consensus?" or "Does everyone agree?"

Identify all the concerns related to the decision in question. Techniques such as brainstorming can be used to develop a written list of concerns. Attempts to resolve concerns should be resisted. All concerns reasonable or unreasonable, should be identified and respected. After all the concerns are listed, it may be helpful, where possible, to group concerns under common themes.

3.4 **Step 4: Resolve Concerns**

Identify individual concerns or groups of concerns. Questions and comments are encouraged to help clarify the concerns. Each concern(s) should be discussed and resolved separately. After each concern has been thoroughly discussed or when the time allotted for each concern runs out, call for consensus.

4. Closing Options

When consensus cannot be reached, one or more of the following closing options may be used.

4.1 Send to Committee

4.1 If a decision can wait, send the proposal to a committee which can clarify the concerns and bring new, creative resolutions for consideration by the group.

4.2 Stand Aside (Decision Adopted with Unresolved Concerns recorded)

4.2 When a concern has been fully discussed and cannot be resolved, it is appropriate for the chair of the meeting to ask those persons with this concern if they are willing to stand aside: that is, acknowledge that the concern still exists, but allow the proposal to be adopted. The unresolved concern can then be recorded as a component of the decision.

4.3 Declare Block

4.3 If all the steps have been followed and a consensus cannot be reached, the chair of the meeting may declare a block. The decision is then either removed form the agenda or tabled to another meeting for further discussion.

5. Call for Majority Vote

5. In certain circumstances, a decision may be essential to protect the public or to preserve the regulation of midwifery in Manitoba. Where a good faith effort has been made to follow the steps set out in this policy and consensus is blocked, the chair of the meeting may call for a majority vote as specified

in the by-law. Unless it is absolutely impossible, at least twenty-four (24) hours should elapse from the time of a block to the time when a vote is taken.

Source: College of Midwives of Manitoba, Bylaw No. 1, Schedule 1.

Appendix F

Terms of Reference of College of Midwives of Manitoba Committees

1. The Complaints Committee

Purpose of Committee

The purpose of the Complaints Committee is to consider and act on complaints about a midwife's professional competence or conduct. Complaints can be made by anyone including the registrar of the College. (Note: The Complaints Committee is not set up to deal with complaints about a person who holds herself out as a midwife but who is not registered as a midwife as required by the Act. Those complaints must be prosecuted by the College. In such instances the College should seek legal advice about how to proceed with such a prosecution.

Duties of the Committee

Upon the receipt of a complaint the committee may:

a) dismiss the complaint;
b) attempt to resolve the complaint informally;
c) request a preliminary investigation to obtain more information; or
d) pursue any of the actions indicated in section 22 of the Act.

Where a complaint cannot be satisfactorily resolved, it may be referred to the Inquiry Committee.

2. The Inquiry Committee

Purpose of Committee

The purpose of the Inquiry Committee is to hear and decide on complaints referred to it by the Complaints Committee.

Duties of Committee

The duties of the Inquiry Committee include:

a) conduct and oversee hearings concerning complaints about midwives (Note:such hearings are usually held in public);
b) consider the evidence of both the complainant and the investigated midwife (Note: the Act sets out many of the requirements which the

committee must follow to ensure that the hearing is fair to both the midwife and the complainant);
c) at the conclusion of the hearing, determine if the complaint is valid; and
d) make an order regarding if and how the midwife must practice midwifery in the future.

3. The Board of Assessors

Purpose of Committee

The Board of Assessors reviews and advises on applications for registration made by midwives. The Board of Assessors approves education processes for midwives intending to register in Manitoba. Members of the Board of Assessors are expected to be able to participate in review of the applications, regular review of the assessment processes and consider other acceptable routes to registration for midwives.

Duties of Committee

The duties of the Board of Assessors include:

a) approve applications for registration including annual applications for renewal;
b) determine in which category of registration the applicant is eligible to practise;
c) determine if and what conditions should be placed on a midwife's certificate of registration or renewal including the duration of such conditions;
d) review and recommend to the Council revisions to the registration process;
e) establish criteria for accepting applications for the assessment and upgrading process; and
f) establish a process for assessing and evaluating the qualifications of midwives trained outside of Manitoba.

4. The Standards Committee

Purpose of Committee

The purpose of the Standards Committee is to define and review the practice standards of the College, conduct periodic practice audits and ensure that the needs of the community are met by the College and its members.

Duties of Committee

The duties of the Standards Committee include:

a) review of standards of midwifery practice;
b) establish and maintain the annual continuing competency requirements;
c) recommend to the Council requirements for continuing education'
d) consult with the public regarding the quality of services provided by midwives;
e) monitor demographics of the women served by midwives;
f) order practice audits of midwives;
g) review reports of practice auditors;
h) act on the findings of a practice audit report; (eg. meet with midwives experiencing problems to determine appropriate courses of action); and
i) recommend to the Council names of persons who could serve as practice auditors.

5. The Education Committee

Purpose of Committee

The purpose of the Education Committee is to ensure that the College recognizes appropriate, high-quality education programs for Manitoba midwives. On behalf of the College, the committee will advise on and approve education programs for midwives.

Duties of Committee

The duties of the Education Committee include:

a) develop a system for assessing foreign qualifications to establish equivalency and reciprocity;
b) liaise with Board of Assessors to advise on which routes of education for midwives are acceptable for qualification;
c) advocate for development of education program for Manitoba midwives (opportunities);
d) ensure that midwifery education institutions adhere to the equity in education policy;
e) investigate the feasibility of a refresher program;
f) work with education institutions in an advisory capacity; and
g) consider and approve training and education programs including, but not limited to apprenticeship programs and institution-based education programs.

6. The Public Education Committee

Purpose of Committee

The purpose of the Public Education Committee is to develop strategies for promoting midwifery to the public, to other health professions, and government agencies and to liaise with other health professions in the promotion of midwifery.

Duties of Committee

The duties of the Public Education Committee include:

a) develop public education strategies aimed at the general public, health professions, and government agencies. These strategies may include:

    - developing public information packages on the practice of midwifery,
    - organizing an annual public meeting to explain the role of the College and to invite public comment on the work of the College.
    - meeting with health professions to promote midwifery and to develop professional relationships,
    - consulting and working with midwifery organizations to determine where and what information is needed on the practice of midwifery.

b) review demographics information from the Standards Committee to identify those populations of women in the province which are not being served and plan public education materials to reach those populations and
c) ensure that the College's commitment to equity is reflected in all public education strategies and activities.

7. Kagike Danikobidan – The Standing Committee on Issues related to Midwifery Care to Aboriginal Women

Purpose of Committee

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

given to the unique educational, legal, clinical, cultural and political forces affecting Aboriginal women.

Duties of the Committee

The duties of Kagike Danikobidan include:

a) promote equal access to midwifery ca4re for Aboriginal women;
b) promote equal access to midwifery education for Aboriginal women;
c) advise on the standards of practice for midwifery care from the perspective of Aboriginal women;
d) promote respect for Aboriginal cultures and traditional teachings;
e) promote the preservation of traditional knowledge and skills, which provide a holistic approach to midwifery care including physical, mental, spiritual and emotional aspects;
f) advocate for and advise the College on issues of importance to Aboriginal women'
g) provide advice and direction to representative of Kagike Danikobidan to the Council;
h) provide membership on the following committees: Education, Standards, Board of Assessors, Public Selection; and
i) identify the human, physical and financial resources required to carry out the tasks and activities of Kagike Danikobidan, and report these requirements to the College.

7. The Nomination Committee

Purpose of the Committee

The purpose of the Nominations Committee is to oversee the nominations process for the election of members to Council and to recommend to the Council College members to serve on College committees where required.

Duties of Committee

The duties of the Nominations Committee include:

a) encourage members to keep in mind the College's commitment to equity when nominating candidates for election;
b) ensure that candidates are nominate for election to Council;
c) assist members, where nominations are not forthcoming, to nominate candidates for election;
d) establish criteria for selecting college members to serve on College committees; and

e) ensure that appointments to College committees respect the College's commitment to equity.

8. The Selection Committee

Purpose of Committee

The purpose of the Committee is to recruit and select public representatives to serve on the Council of the College and on the committees of the College.

Duties of Committee

The duties of the Selection Committee include:

a) identification of the qualifications required by public representatives for the Council and for each of the College committees;
b) establish a process for recruiting and compiling a list of persons who are interested in representing the public on the Council or on one of the College committees;
c) develop criteria for selecting public representatives from this list to serve on the Council and on each College committee;
d) provide the College with public representatives to serve on the Council and on each College committee; and
e) fill vacancies left by public representatives who may resign or be removed during their term of office on the Council or on a College committee.

Source: College of Midwives of Manitoba, Bylaw No. 1, Terms of Reference Addendum.

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