



British Columbia
Centre of Excellence
for Women's Health

Vancouver, BC
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Pushing for Change

Challenges of Integrating Midwifery into the Health Care System

Part of the series
Perspectives on Midwifery

By Jude Kornelsen

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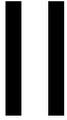
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Executive Summary

Nearly two years after the legalization of midwifery in British Columbia there are still challenges to its successful integration into the health care system. These challenges come from some physicians and nurses who choose not to work with midwives, actively oppose home birth and refuse to take on patients either during pregnancy or afterwards if they have chosen a midwife as their primary caregiver. This paper considers the current relationship between midwives, physicians and nurses from both a professional and interpersonal perspective, looks at specific objections put forward by the medical and nursing communities and considers the way the objections have had an impact on client care. The paper proposes recommendations for improving interprofessional relationships and thus the obstetrical care offered to birthing women in British Columbia.



Introduction

The legalization and subsequent regulation of midwives and the practice of midwifery in British Columbia on January 1, 1998 was the culmination of an arduous struggle for legitimacy by midwives (through their professional body, the Midwifery Association of B.C.) and consumers (through the Maternal Health Society, Campaign for the Legalization of Midwifery, and then later, the Midwifery Task Force) that stretched back to the 1970s. The move towards state recognition accelerated in 1991 when the Royal Commission on Health Care and Costs was struck and the Health Professions Council recommended midwifery be legalized as an autonomous profession in 1993. This move – and the subsequent announcement in May 1993 of the government's intention to integrate autonomous midwifery into the health care system – resulted in renewed debates among the medical community about whether or not the establishment of the new profession was warranted, given (among other reasons) the move towards fiscal responsibility in the health care sector and the small numbers of constituents midwives would serve.¹ It also precipitated a minority of community midwives to publicly oppose legalization and break away to form their own organization (The B.C. Community of Midwives).

Nevertheless, in 1993 the Ministry of Health formed the Midwifery Implementation Advisory Committee (MIAC), made up of representatives from professional medical organizations, government and academia², and in 1995 established the College of Midwives of B.C. The availability of government funding for midwifery through the provincial health care plan was announced in April 1996 and the first assessment of potential registrants began in May of the following year. Applicants who successfully completed the assessment process began accepting publicly funded clients on January 1, 1998.

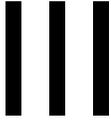
But the integration of midwives into the health care system has not gone smoothly. Resistance has been mounted from some members of the medical community and anxiety has been expressed on the part of the nursing community. In some instances, this has translated into difficult relations. The resistance has taken the form of public condemna-

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tion (letters from physicians to the editors of local newspapers and television news interviews) and private interactions with midwives and the public. Some physicians have also expressed either a reluctance to work with women who want midwives or a reluctance to take on obstetrical clients altogether. These interprofessional conflicts have the potential to weaken the profession of midwifery and challenge the long-term availability of accessible midwifery care. The two key professions of medicine and nursing have had an impact on midwifery on both a professional and interpersonal level. Examples of the former include the influence that professional associations and powerful individuals have exerted on decision-makers over such issues as funding, midwives' scope of practice, hospital admitting privileges and revisions to protocols. On an interpersonal level, both professions have played a large part in determining the reception midwives have received as they integrate into the health care system (for example, the extent to which they have introduced midwives into the culture of the hospital).

Ultimately, if the relationships are antagonistic, the profession of midwifery will be in jeopardy as will women's ability to choose the type of maternity care they desire. This paper will explore the relation-

ships between midwives and physicians and midwives and nurses from a structural (professional) and interpersonal (interactive) perspective.



The Trajectory of Interprofessional Relationships

The sometimes-acrimonious situation that physicians and midwives find themselves in currently is not without precedent. It may even be argued that the roots of current interprofessional conflict could be found more than 100 years ago when physicians began to organize as a profession in order to entrench themselves in the culture of childbirth. They were so successful that it is easy to forget that for much of our history childbirth was almost exclusively a woman's event.

If we consider the issues that arose when formalized medicine was on the ascent (the mid-19th century) and compare them to issues that have been articulated today, we see a recurring theme of the desire for physicians to become involved in childbirth for economic reasons. Indeed many physicians were candid in expressing their feelings and attitudes towards midwives, many of which were blatantly self-serving. As one physician said, "Legalizing the midwife will...work a definite hardship to those physicians...who have become well trained in obstetrics for it will have a definite tendency to decrease their sphere of influence."³ And the techniques used to sway public opinion away from the midwife – found primarily in vicious propaganda campaigns that played on emotional issues such as the suggestion of midwives' lack of safe practice – may be more sophisticated today, but originate from the same impulse.

Although the history of relations between nursing and midwifery is more recent, it also influences current relations between the professions. That is, in an attempt to create a distinction from the dominant model of childbirth, midwives characterized nurses as participants in the "medical model". Part of this included a critique of their education, which was assumed to focus on illness instead of health. This was due in part to nursing training being hospital-based. During the 1960s, we saw a large-scale move of nursing education programs from the hospital to the colleges and universities. This move reaffirmed nursing's commitment to a broad understanding of health and illness and established a new focus on health promotion and preventative care as applied to

The contemporary resurgence of midwifery has not been due to a change in practitioners' attitudes so much as the confluence of other social movements that have challenged these attitudes.

families and communities, as well as individuals. This holistic approach may lead perinatal nurses to feel they have more in common with midwives than midwives feel they have with nurses. The strategy of distancing themselves from nursing was essential for midwives as it enabled them to build an autonomous profession with its own identity. However, as an unintended consequence, this strategy has contributed to the illusion of radically different philosophies of care, and caused much discord between the professions.

The contemporary resurgence of midwifery has not been due to a change in practitioners' attitudes so much as the confluence of other social movements that have challenged these attitudes. For example, the "second wave of feminism" that began in the 1960s and gained strength during the following decade combined with the notion that medicine had usurped control over women's bodies was instrumental in midwifery's revival. Women demanded the right to choose not only their practitioner but also place of giving birth, regardless of the lack of support from the medical community when the choice to birth at home was made. Echoing the historical roots of midwifery in Canada,⁴ women began to form communities to support each other during birth at home. These informal communities

quickly developed into organized and skilled ones made up of practitioners who gained both empirical and academic training in British Columbia and outside of Canada.

The increasing move towards the professionalization of midwifery during the 1980s and 1990s, however, did little to sway the reception midwives received from the medical and nursing communities who expressed an overwhelming opposition to midwifery care, which by necessity only took place at home. There was a more general acceptance of hospital-based midwifery care, but there was only one place in British Columbia that allowed midwives to be the primary care providers during labour and delivery – B.C. Women's (formerly Grace) Hospital.

The main objections put forward were:

- the perceived inherent dangers of home birth;
- the dangers of having unregulated practitioners provide maternity services, and
- the lack of standardized training that midwives had.

These objections were manifest on a professional level by both physicians' and nurses' professional bodies condemning both home birth and midwifery.⁵ Interestingly,

on an interpersonal level, before midwives were registered they enjoyed more positive relationships with physicians as they were able to choose the ones who were supportive of midwifery in both practical and philosophical ways. Clearly there were physicians who showed their support of midwifery by providing concurrent prenatal care to midwifery clients, ordering tests and diagnostics where necessary, and taking over client care should a transfer from home to the hospital be necessary. There were also physicians – known as “angel-docs” – who actively supported midwives when they did transfer to hospital and who actively argued the case for midwifery among their peers. The relationships midwives enjoyed with nurses were more random as they had no control over whom they would encounter if a client transferred from home to the hospital. Interprofessional relationships pre-registration can be summarized in the following way:

	Professional	Interpersonal
Physicians	Negative	Positive due to self-selection
Nurses	Negative	Predominantly negative due to random assignment

IV

Negotiating Autonomy: Midwives' Scope of Practice

It is clear that prior to legalization, the small number of midwives who were practicing enjoyed some positive interpersonal relationships. However, the negotiations around midwives' scope of practice prior to legalization precipitated a deterioration both professionally and interpersonally between physicians and midwives and, to a lesser extent, nurses and midwives. The legalization of midwifery and its subsequent regulation have been pivotal points in its history, moving it from the periphery of the health care system to a place firmly within the system. There have been many consequences to this move – both intended and unintended – that have had both a positive and negative impact on the profession and the women it serves. It could be expected that one of the positive consequences would be a newfound collegiality between physicians, nurses and midwives, due to the concerns over unregulated practitioners that regulation addresses. This, however, has not been the case, as both medicine and nursing continue to express reservations over several aspects of autonomous midwifery, many of which were debated prior to the passage of the legislation that governs the profession of midwifery. It is useful to look at some of the issues that arose during discussions between stakeholders and the Health Professions Council prior to legalization, as the areas of contention and disagreement that were not resolved to the satisfaction of all groups involved have hindered interprofessional relationships post-registration.

A. Home Birth

The most heated topic of debate was – and continues to be – home birth. The medical and nursing communities, although perhaps supportive of the notion of choice and autonomy for birthing women and their families, rejected the possibility of home birth because of perceived dangers it posed to the mother and child. Jack Burak, President of the Society of General Practitioners of B.C., expressed it this way: “We have no objection to midwives doing deliveries in safe, hospital environments, but we strongly oppose government funding of home births which have

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not been proven to be safe and where there is no back up system of immediate support.”⁶ Specifically at issue were:

- the lack of immediate emergency support;
- concerns about the efficacy of using ante-partum risk assessment tools to predict intrapartum risk (thus the difficulty in predicting who will be “low-risk” during delivery), and
- whether or not current training for midwives provided them with the competency to handle even non-life threatening pathologies should they arise at home.

Taken together, these variables suggested to physicians that home birth is an inherently unsafe undertaking with the risks far outweighing the benefits. Home birth advocates, however, pointed to the growing literature supporting the safety of home birth. The debate over safety will not be entered into here, as there is a body of work dedicated specifically to this cause and indeed it is doubtful whether it can be settled presently. As O’Connor notes:

“Both obstetricians and the home birth movement base their models of childbirth in part on cumulative empirical evidence, i.e., observation over time of large numbers of births. However, the two groups’ observa-

tional claims are mutually disconfirming in that they strongly disagree on the fundamental definition of the event which is their focal point.”⁷

O’Connor goes on to note that each group uses statistics to support certain claims and criticizes the other for the selective use of statistical information, leading to the accusation that each finds the other’s arguments to be “guided more by self-interest than by reliable observation and information.”⁸ The important point to note here is that home birth has been included under midwives’ scope of practice as defined in the Health Professions Act, in spite of widespread opposition by the medical community.⁹ This has come about due to a confluence of factors, most notably the consumer demand for the choice of place of birth combined with the government’s general agenda to move health care out of institutions and “closer to home” where possible.¹⁰

B. Role of the Physician

Beyond home birth, the College of Midwives of B.C. held firm in its articulation of what autonomous midwifery would look like in B.C. when negotiations on the specifics of the midwifery legislation were taking place. One area of disagreement was whether or not women would have to see a physician before going to a midwife early on

in the pregnancy. The College of Physicians and Surgeons (CPS) put forth this stipulation during negotiations and the Midwives Association of B.C. and the Midwifery Task Force opposed it due to the obvious “gate-keeping” role it allowed the physicians to assume. They did agree, however, to the compromise whereby midwives must “advise clients to consult a medical practitioner for a medical examination during the first trimester of pregnancy.”¹¹

C. Other Concerns

Similarly, during negotiations midwives proposed to do well-woman gynecological care (including birth control counselling, fitting diaphragms and prescribing oral contraceptives), but were limited in scope. That is, they may provide care for up to six weeks post-partum and may not prescribe birth control pills. The list of drugs and diagnostics that could be prescribed by midwives in general was also curtailed, some being eliminated altogether and others requiring a physician consult prior to prescribing. Another crucial point in the regulations was the recognition of the “grandparent” clause, whereby midwives who had been practicing prior to registration could continue to practice upon demonstration of skills and competencies regardless of the nature of

their previous training. Although this is standard practice when existing professions are introduced into the health care system in Canada, being upheld in the context of midwifery legislation was crucial because of the questions by the medical profession that midwives should have compulsory nursing (or other formal) training.

The process of negotiations prior to legalization resulted in a scope of practice and level of autonomy that maintained the integrity of midwives’ philosophy of care. It is exactly these regulations defining midwifery practice that have contributed to adversarial interprofessional relationships and made midwives’ integration into the health care system challenging, at best. Perhaps part of the resistance by physicians post-registration is due to their perceived alienation (even if self-imposed) from the process leading up to legalization. For example, the British Columbia Medical Association (BCMA) chose not to participate in the Midwifery Implementation Advisory Committee until the very end of the committee’s tenure, after many crucial decisions had been made. This may have been due to the disbelief that the legalization of midwifery would proceed without them, or from a lack of interest. Dr. Arnold Shoichet, a family physician, wrote, “Although the government’s intention to [legalize midwifery] was known for some time

before, most doctors in the province did not, at first, identify personally with the issue.”¹² Nevertheless, midwives were legalized as a fully funded, autonomous profession with the right to self-governance. Interestingly, both historically and in other jurisdictions, there have been compromises between autonomous practice and physician-support for midwifery. It is useful to look at some examples to understand this dilemma because of the potential impact on the future of midwifery.

V

Autonomy Versus Interdependence: The Delicate Balance

Historically, the licensing of midwives goes back to the Middle Ages in England where they were licensed by the church in order to ensure they were of “strong moral character” and willing to take an oath of office. Receipt of such license was not based on a demonstration of competency or dependent upon the completion of an educational program.¹³ It wasn’t until much later – 19th century England – that the licensing of midwives was undertaken as an exercise to gain political advantage by the midwives themselves. Historian Jean Donnison describes the arduous fight for legalization that the British midwives underwent,¹⁴ several parts of which are worth noting here.

Firstly, after several unsuccessful attempts at securing midwifery as a legalized, regulated profession, it was realized that any successful campaign must have the cooperation – or at least the acquiescence – of the medical profession. Donnison notes that “it followed, therefore, that any bill which was to have a chance of passing into law would have to propose to register midwives at a lower level than doctors, and that in consequence it would encounter resistance among midwives themselves and from the women’s rights movement.”¹⁵ The Matron’s Aid Society was formed to try to get such a bill passed.

Midwives realized also that in order to gain credibility with the public they had to be selective in their approval of members, and set down a strict code for membership based not only on clinical qualifications but also on personal attributes. Also, under the bill that was put forward, midwives were to be examined and governed exclusively by medical practitioners. No midwife could sit on the central board; instead boards would be staffed by medical men, many of whom “had never taken an examination in midwifery at all.”¹⁶ Under these (and other) restrictive conditions, the Midwives Bill, which became an act in 1902, was passed (despite the opposition of some trained midwives).

The current situation in the United States has many parallels to the historical situation in England. Nurse-midwives in the United States

Since the 1960s, there has also been an active lay, or empirical, community of midwives in the United States who attend birthing women at home.

were virtually absorbed into the medical system during the 1940s and 1950s in their bid to gain acceptance. Gaskin suggests that although they are “officially” sanctioned to attend low-risk births in hospitals, they occupy a subservient position to physicians and thus are restrained in practice due to a lack of professional autonomy. Rothman agrees, commenting that “the American [nurse] midwife is placed in an extraordinarily demanding position, caught between the needs of the physicians who control the institutions in which she may work and the needs of the clients she serves.”¹⁷ This is further exacerbated by the litigious climate in the United States which has led to severe restrictions on scope of practice by insurance companies. Aside from – or perhaps because of – these limitations, a further obstacle exists in the general reluctance by the medical community to forge relationships with nurse-midwives. The Ontario Task Force report, on the other hand, argues that there has been an increased demand for certified nurse-midwives (CNMs) in the United States in the private sector among a “growing number of assertive, well-educated, affluent women who want childbirth to be an emotionally rich experience.”

Since the 1960s, there has also been an active lay, or empirical, community of midwives in the

United States who attend birthing women at home. The level of training is highly variable in this community, ranging from those who have completed certified midwifery school programs to those who are self-taught. Some of the empirical midwives work legally while others do not (each state has a different law regarding empirical midwives; they have legal recognition in 10 states, are clearly prohibited from practicing in nine, and are “tolerated” in about a dozen).¹⁸ It is interesting to note that in states where lay midwives are legally recognized, they are subject to more restrictive regulations than CNMs. They do not have hospital admitting privileges anywhere in the country nor are they covered by health insurance. Clearly, the situation of CNMs in the United States is an example of where compromises have led to a lack of professional self-definition and the articulation of a clear mandate for the public and other health professions. It has also dichotomized regulated and lay midwifery. CNMs early attempts to gain the acceptance of the medical profession have had the inadvertent consequence of impeding their integration as autonomous practitioners into the medical system.

Most comparative writing on childbirth practices contrasts the American situation with the situation in the Netherlands, as it boasts both a

legalized, state-supported midwifery program which sees midwives as independent practitioners responsible for the regulation of their profession and the second-lowest infant mortality rate (next to Sweden). The Dutch midwives have been providing obstetrical care since they were licensed in 1885 and are currently paid through the state health insurance system.¹⁹ For normal pregnancies and delivery, in fact, both state and private insurance plans will only pay for midwifery care (unless no midwife is available in the area).²⁰ Midwives in private practice may attend births at home or may have contracts with hospitals for admitting privileges (usually both). Midwives in private practice frequently work in small groups (two to eight midwives), “have a great deal of autonomy and exercise a high level of responsibility.”²¹ Interestingly, there does not appear to be an “alternative” or underground midwifery practice as seen in the United States and England.

Several factors have been attributed to the unique position of midwifery in Holland, including a radically different attitude about childbirth expressed by birthing women when compared to their North American counterparts. This attitude sees birth as a normal, healthy process and surgical procedures as unnecessary in uncomplicated instances. The

practice of midwifery itself has been protected by government policies and programs such as the establishment of midwifery schools, midwives’ inclusion under the national health insurance program and the official acceptance of home birth. Cecilia Benoit has leveled critiques against the profession of midwifery from an occupational perspective, however. She argues that fee-for-service in home settings does not necessarily lead to occupational autonomy for birth attendants as they do not have a guaranteed salary, and the nature of their work makes other part-time employment almost impossible.²² Benoit also suggests that the nature of midwifery practice, geared as it is towards home birth, creates a lack of a professional community for midwives as they work in isolation.²³ A final critique leveled against the system by Benoit is that “given the absence of a career ladder, a midwife no longer able to cope with the rigors of solo practice has little choice but to retire altogether.”²⁴ Even in a system where independent practice is guaranteed, the way in which midwives are paid affects their ability to enact their philosophy of care.

Clearly, the range of conditions in which the regulation of midwives may take place determines whether or not midwives will practice autonomously or under the gaze of the

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medical profession and whether they will be supported or thwarted in their activities. When midwifery demands autonomy and self-governance, it risks alienating the medical profession. When midwifery capitulates to pressures exerted by medicine and nursing and is not self-governed, it is liable to be influenced by the codes and traditions of these professions. But how has the legalization and regulation of midwives in B.C. affected interprofessional relationships? In British Columbia midwives held firmly to their vision of autonomous, self-regulated midwifery and a scope of practice that encompassed all activities – including home birth – necessary to fulfil their philosophical mandate. Ironically, this commitment has inadvertently alienated parts of the medical and nursing communities due to the perceived threat that midwifery poses to their practice. The alternative of being subjugated to medicine and nursing is obviously untenable, which demands consideration of the question: how can midwives gain the support of the dominant players in the health care system without sacrificing the crucial elements of independent practice? It is useful to keep this dilemma in mind as we consider the current state of interprofessional relationships, from both a professional and inter-personal perspective.

VI

Midwives and Physicians

A. Payment

On a professional level, the relationship between physicians and midwives since regulation has been rocky. As soon as the specifics concerning midwives' remuneration were announced late in 1997, they became a lightning rod for physicians' expression of displeasure with midwives in general. This was largely because of the nature and the timing of the announcement. When the remuneration was announced the British Columbia Medical Association was nearing the end of its fiscal year and had overspent its budget. To compensate for the shortfall, doctors planned "reduced activity days"²⁵ rather than working for free. These days had the secondary effect of drawing the attention of physicians (and the public) to the perceived provincial under-funding of medical services.

The situation was further inflamed when the government chose to present the fee schedule for midwives (in January 1998) in terms of dollars per course of care (without explicating the difference in the course of care they offered when compared to physicians) instead of in terms of yearly income. As Dr. Arnold Shoichet notes, "What appears to affect physicians most about the introduction of midwifery (aside from the unresolved debate about the issue of home birth) is the perceived discrepancy... between what midwives and physicians receive for the care of a woman through pregnancy."²⁶ This way of presenting their compensation overemphasized their income and led to a situation where physicians felt demoralized and undervalued. Consequently, midwifery became unnecessarily drawn into what should have been a matter between BCMA and the government, a dispute that ultimately called their whole model of care into question.

Ten months later, the effects of the nature of the announcement were still evident. For example, at the 15th Annual Obstetrics, Antenatal Care and Menopause conference in October 1998, a panel discussion entitled "Midwives and Home Births – Sorting out the Politics and Evidence" was presented by members of the Society of Obstetricians and Gynecologists of Canada (SOGC), the B.C. Chapter of the College of Family

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Physicians and the College of Physicians and Surgeons of B.C. Questions were posed to determine attitudes of the approximately 200 physicians in attendance and to generate discussion. The first question, which the audience was asked to respond positively or negatively to, was:

“Though I acknowledge that physicians are underpaid for the intimate and laborious work that we do in attending births, I am capable of separating the concerns that I have with the funding of midwives from the issues of care and collegiality.”

Although there was agreement, it was not unanimous. And although this was not necessarily a representative sample and cannot be generalized to the larger community of physicians in British Columbia, it did provide insight into the political inclination of some physicians towards midwifery. Further evidence of physicians’ inability to separate the two issues was expressed through letters to the editor in the local press. One physician wrote, “One wonders why the government wishes to pay midwives more than twice what it pays doctors for less experienced service.”²⁷

Another said, “I am angry, frustrated and humiliated. Even worse, when the midwives have complicating problems, I will be called in to deal

with them.”²⁸ Similar frustration was expressed during the Home Birth Demonstration Project Tour, where questions concerning remuneration were raised at 13 of the 14 sites visited.²⁹ The researcher observing the tour noted that “anger was expressed about the introduction of midwifery into the health care system in the face of cutbacks.”³⁰

Although physicians in some instances have directed resentment over their fee schedule at midwives, in many other instances it is clear that physicians can distinguish between the issue of remuneration and their professional relationship to midwives. For example, Dr. Nan Schuurmans, past president of the SOGC said, “Obstetricians are not angry at the midwives nor do they oppose public payment to midwives... The debate over midwives did convince obstetricians that they need a big raise.”³¹ Likewise, a Vancouver family physician noted that she had no problem with midwives’ model of care and is considering registering with the College of Midwives to see if she can become a midwife and get paid their rate.³² The controversy around midwives’ remuneration was an unintended consequence of the government’s lack of insight into the recent animosity expressed towards midwifery by physicians. It also showed a lack of sensitivity to the

potential impact midwives would have on physicians' sense of their value as highly trained professionals. Clearly, although some physicians are not able to separate their concerns over remuneration from their attitudes and feelings, others are. The issue of home birth, however, is less amenable to this separation.

B. Home Birth

A second statement concerning home birth was presented at the 15th Annual Obstetrics, Antenatal Care and Menopause conference in October 1998. Again, responses indicating agreement or disagreement were solicited. The statement was:

“Home birth has always been practiced in Canada and British Columbia prior to the regulation of midwives. As physicians we are not asked to attend home birth. Our role is to be available in hospital for the women and newborns of B.C. when transfer is necessary.”

In this instance there was substantial disagreement and the statement itself was cause for a heated discussion. The issues focused on the perceived inherent danger of home birth and the legal liability of physicians who accept transfers from home. The response to the notion of home birth at the conference was consistent with the observa-

tions of the Home Birth Demonstration Project Tour. Lyons notes:

“Home birth was one of the most emotionally charged areas during the tour, the obvious concern being fear of a bad outcome for the mother or baby. At several sites practitioners recounted emergency situations in which they felt the baby would not have survived without the resources present in the hospital.”³³

Lyons goes on to argue, however, that fear about the safety of home birth was usually based on physicians being part of or seeing a critical situation in the hospital and then extrapolating it to the home. A letter to the editor of The Vancouver Sun provides a clear example of such a situation:

“The healthy mother was 26 years old with a normal pregnancy. As expected, all went smoothly except for a vaginal tear, which I repaired while the nurse weighed the baby... The hemorrhage started without warning. A stream of blood as wide as my forearm gushed from the woman's womb with every heartbeat. Her face turned white as she began slipping into shock. I started to call out orders, but this team didn't need any – they'd seen this before. Nurses appeared, IV's glided into veins, oxytocin was injected to staunch the life-threatening flow. With one hand on the women's abdomen

When physicians cannot support a fundamental tenet of midwifery care – the right of women to choose their place of giving birth – it is difficult for them to develop supportive, respectful, trusting relationships with midwives.

and one inside her, I squeezed her uterus as though my life depended on it. Within ten minutes, things were under control. ...I don't know if that patient realized how close she came to dying."³⁴

Others working in hospitals can describe equally grave situations. Again, the issue of safety is not the focus of this discussion, and indeed it is doubtful whether it can be definitively put to rest by either side. Instead, it is important to note reasons why physicians, in general, do not support home birth. Along with the safety issue is the issue of legal liability. In her observations of the Home Birth Demonstration Project Tour Lyons noted that "physicians expressed fear about the prospect of being called to consult when they do not support home birth and do not have the support of their regulatory College."³⁵ Indeed the very lack of support by physicians' regulatory college (found in official policy statements against home birth) is an impediment to the support of midwifery. That is, there is a perceived conflict between the official policy of their professional organizations and the legislation permitting home birth in British Columbia. As one obstetrician attending a Home Birth Demonstration Project (HBDP) meeting commented, "We are being asked to

collaborate where those that guide us say it is not safe."³⁶

It was noted earlier that during initial hearings by the Health Professions Council all professional medical associations voiced objections to the inclusion of home birth within midwives' scope of practice. The positions did not change post-registration. This leads to a situation where physicians are being presented with literature from the HBDP which supports the safety of planned home birth when it is attended by well-trained professionals, while their organizations state that home birth poses an increased risk to mother and baby.³⁷ When physicians cannot support a fundamental tenet of midwifery care – the right of women to choose their place of giving birth – it is difficult for them to develop supportive, respectful, trusting relationships with midwives.

—🕒 **Recommendation**

There must be a reconciliation between physicians' professional bodies and the reality of home birth in British Columbia. As noted earlier, there is a discrepancy between official position statements on home birth put forward by SOGC, BCMA, and CPS and the implicit position of the Ministry of Health (through its sanctioning of home birth). This

Physicians' lack of understanding and knowledge about midwives' training and experience has been an impediment to their consideration of midwives as contributing members of the health care team.

lack of coherence in regards to policy adds more confusion to an already confused debate and also provides a justification for physicians to refuse to work with midwives. To rectify this, the professional bodies must take a leadership role in welcoming midwives into the health care environment. —

C. Training and Relationships

Another issue raised by members of the medical community in their argument against the inclusion of midwives in the health care system is the adequacy of midwifery training. Past president of SOGC, Dr. Nan Schuumans, points to higher rates of obstetricians' referrals from midwives than from family doctors to support the claim of inadequate training.³⁸ In a more comprehensive critique, Dr. James Goodwin takes objection to the assumption that within a three-year baccalaureate program, the graduating midwife should have gained knowledge of all the skills necessary to identify risk and manage obstetrical emergencies.³⁹ He suggests that it is even more unlikely when one considers that the program is intended primarily for direct-entry midwives with no previous formal training.⁴⁰ There were several responses to Goodwin's assertions that point out both logical fallacies and factual misinformation including

the confusion between cases transferred from home and those that remained at home.⁴¹ Nevertheless, his views represent those of other practicing physicians. A specific area of concern raised both in the HBDP Tour and at a recent antenatal conference is whether midwives are adequately trained in newborn care. Physicians' lack of understanding and knowledge about midwives' training and experience has been an impediment to their consideration of midwives as contributing members of the health care team.

On a professional level this notion of team-based or multidisciplinary care has not characterized physician-midwife relations due to physicians' reluctance to welcome midwives as part of the obstetrical health care team. On an interpersonal level, however, satisfying relationships have been forged despite systematic obstacles that discourage such relations. For example, as part of a larger study into midwifery practice post-registration⁴² we recently asked registered midwives to describe their relationships with physicians. Most said relations were "good", "fine", or even "supportive". When the midwives were pressed further, however, we consistently heard that relations are good with a select group of physicians that they have chosen to work with. When asked what the odds were of finding a

supportive physician from the community of practicing physicians, answers ranged from “1 in 10” to “1 in 2”, depending on the community. One in 10 aren’t very good odds, especially in the smaller rural communities where there may only be 10 physicians providing obstetrical care.

How is this reluctance – or refusal – to work with midwives manifest in practice? There are several areas where physicians’ negative attitudes hinder patient care. They include: discharging patients from care if they chose midwifery or home birth, the reluctance or refusal to accept transfers from midwives,⁴³ lobbying hospital boards to refuse to grant admitting privileges to midwives, and refusing to accept obstetrical patients altogether. Of course, it is not in physicians’ best interests to refuse to accept transfers of patient care from midwives as they would be legally culpable for not following through on a course of care. Such situations appear to be relatively rare. If a transfer is accepted, however, the attitudes and actions of the physicians determine to a large extent the nature of the experience for all those involved. Those who accept transfers with reluctance and are inclined to attribute blame to the midwife increase the tension for the midwife and the client/patient. In a climate where there is a predisposition against

home birth and distrust of midwives in general this scenario is played out frequently. We can see this in the attitude that upon transfers to hospital, physicians are “picking up the pieces” or “cleaning up.”

Weitz and Sullivan’s study on the re-emergence of midwifery in Arizona found that the continuing conflict between midwives and physicians sometimes had concrete consequences for midwives and their clients.⁴⁴ These included the “often frustrating and upsetting experience of seeking medical prenatal care,” and medical personnel “punishing” midwifery clients for attempting home birth. The punishment noted was both verbal and physical. For example, medical personnel at the hospital frequently “harangued” home birth clients for risking their lives, and one midwife recalled a situation where a physician refused to stitch a vaginal tear after a home birth, saying, “if you can give birth yourself, you can sew up yourself.”⁴⁵ Although not quite as dramatic, the conflicts that are played out in the patient-care arena in B.C. have similar undertones.

On the HBDP Tour, Lyons noted that several physicians said they would discharge a patient if they chose to have a home birth.⁴⁶ Not as drastic but equally as detrimental is the gate-keeping role that many

Currently in B.C.,

competition

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physicians play with patients who inquire about midwifery care. Often unsupportive physicians express doubts over midwives' competency through blatant verbal condemnations or in subtle ways (such as a raised eyebrow or shift in intonation). Raising the stakes even higher, many physicians across the province (and, in fact, across the country) have opted out of obstetrical care altogether. For example, many physicians in the Mission area stopped taking new maternity patients as of April 15, 1998. Although their protest had as much to do with the fee schedule as with their objections to midwifery, the end result is the same. As Linda Knox, acting president of the Midwives Association of B.C. said, "To withhold maternity care and limit the alternatives to pregnant women because [doctors] have a fee dispute is untenable."⁴⁷ The situation in British Columbia is particularly contentious due to the relatively high numbers of physicians who do obstetrical care.⁴⁸ Dr. Michael Klein noted the potential for this situation to develop several years before legalization:

"In provinces like British Columbia, where family doctors usually provide maternity care, there is a risk that midwives and general practitioners will adopt a competitive rather than a

cooperative stance, to the detriment of both professions and the public."⁴⁹

—🕒 Recommendation

The safe practice of midwifery demands a model of shared care where midwives can refer clients to medical practitioners while, in some instances, still maintaining an active role in their care. Although some relationships have been fostered between midwives and medical practitioners, many midwives (especially in rural areas) still find themselves without medical colleagues with whom they can share care should the need arise. Physician incentives for teamwork should be implemented to encourage cooperation between the professions. 🕒—

Currently in B.C., competition overrides cooperation. Perhaps the answer lies not in reducing the number of physicians providing maternity care, but in recasting the debate to focus on woman-centered care as opposed to interprofessional competition over territory. Physicians aren't the only profession vying for territory in the maternity care environment. We will now turn to a discussion of nurses' relationships to midwives.

VII

Midwives and Nurses

Nurses may have an even more complex relationship to midwives than physicians do because of their parallel histories which, at times, have converged. There is significance to the fact that both are women-dominated professions and both have been – and are – fighting for occupational turf in a largely male-dominated medical system. The situation is further complicated by the fact that nurses may see their philosophy of practice as similar to midwives. In addition, many have taken advanced obstetrical training, or may have trained abroad to become a “nurse-midwife”, but until they successfully complete the registration process cannot participate fully in midwifery practice.⁵⁰ The training does, however, lead to the appearance of a shared professional domain. But in B.C., the three practices – perinatal nursing, nurse-midwifery and community midwifery – must struggle to reconcile their historical and philosophical positions especially in regards to their distance to (or from) the medical profession. As Regi Teasly notes:

“Lay midwives have sought an occupational niche outside, or on the perimeter of, the physician-dominated medical division of labour. Having grown out of the home birth movement, independent midwives seek to attend deinstitutionalized births for a self-selected clientele that advocates the option of deprofessionalized maternity care. In contrast, nurse-midwives have taken up the strategy of professionalization in order to locate occupational turf in the medical division of labour.”⁵¹

To this we can add perinatal nurses who, while being pivotal to the care of birthing women in B.C., have not been recognized for the skills and competencies that their specialization brings. Further discriminations must be made within the profession of nursing where some practitioners prefer to work within the structures of the hospital environment with a dependent rather than autonomous practice, while others strive for the independence that the newly registered midwives have attained. Working with the structure of the hospital leads to a more general acceptance of the medical system which is what much of the literature critical of nurse-midwifery focuses on. For example Katz-Rothman says, “Nurse-midwives operating in the medical establishment... have a hard time as

The confusion created by this context of similar but distinct areas of practice has been exacerbated by the lack of professional standing accorded to foreign-trained nurse-midwives, many of whom have had rigorous training and extensive practical experience.

advocates of the childbearing couple.”⁵² This is true of perinatal nurses in B.C. as well.

Although the practices of midwifery, nurse-midwifery and perinatal nursing differ in a fundamental way, we must not assume that hospital-based practitioners are not interested in following a woman-centered model of client care based on informed decision-making and minimizing technological intervention. Instead, we must consider the institutional constraints and the historical legacy each profession brings with it which make it difficult for them to do this.

These constraints include the norms, guidelines and rhythms of the hospital and midwives place of subservience within the medical hierarchy. As Rothman notes:

“The American midwife is placed in an extraordinarily demanding position, caught between the needs of the physicians who control the institution in which she may work and the needs of the clients she serves. She seeks to maintain her professional identity, while balancing these two forces.”⁵³

Creative solutions to the perceived excessive use of medical intervention by nurse-midwives in a hospital setting have been observed by the authors. Examples include releasing the pressure on a vacuum extractor to allow a woman more time in

second stage and delaying acting on orders for an epidural for a woman who was almost fully dilated. Clearly the hospital-based nurses and midwives in these instances were working within a framework anti-theoretical to the one put forward by medicine. However, their place within the medical hierarchy prevented them from openly voicing objections, should they arise (or from openly supporting practices such as home birth). This adherence to the dominant model of childbirth is not without professional benefits, however – the main one being the support it garners from physicians and the institution. For example, in his article “Where to Be Born Safely. Professional Midwifery and the Case Against Home Birth”, James Goodwin comments on his “long and rewarding experience with excellent hospital-based midwives.”⁵⁴

The confusion created by this context of similar but distinct areas of practice has been exacerbated by the lack of professional standing accorded to foreign-trained nurse-midwives, many of whom have had rigorous training and extensive practical experience. It should be noted, however, that licensing in other jurisdictions does not guarantee licensing in B.C. As noted earlier, these practitioners can apply to register with the College of Midwives of British Columbia

Like the physicians, the nurses surveyed by and large took an adamant stand against home birth, thus also against those midwives who practiced at home births and who set the requirements for registration to include home birth.

(CMBC). Kornelsen, Dahinten and Carty administered a survey to 211 hospital and community nurses working in the field of obstetrics to solicit their attitudes and knowledge about midwifery. The findings from the survey inform our discussion of the relationship between nurses and midwives in B.C. The survey noted several obstacles to registration reported by labour and delivery nurses (some of whom were foreign-trained midwives).⁵⁵ They included:

- the philosophical rejection of home birth as a viable option for many birthing women;
- the perceived discrimination by the CMBC against those practitioners who don't support home birth, and
- the objection to being part of a group that condones "working beyond the law".⁵⁶

One respondent commented, "I refrained from practicing as a midwife because it was not legal, so my training and experience are not current. It makes me crazy that people willing to work outside of the law are current!" Regarding the perceived bias of the CMBC, another respondent wrote:

"The slant of the College of Midwives of B.C. is not towards obstetrical nurses becoming certified. That has become obvious as we see who they have accepted and who they

have not. Until the focus changes from home births, obstetrical nurses will not be accepted."

More pragmatic obstacles included:

- the cost of upgrading training to meet the criteria established by the CMBC;
- the lack of a training facility in B.C.;
- geographical isolation, and
- lack of hospital and professional support.

Like the physicians, the nurses surveyed by and large took an adamant stand against home birth, thus also against those midwives who practiced at home births and who set the requirements for registration to include home birth (CMBC). This leads to a situation where many labour and delivery nurses, some of whom are foreign-trained nurse-midwives, perceive preferential treatment being given to colleagues whom they believe to have less training and experience. This is a recipe for hostility and professional jealousy and the breakdown of interprofessional relationships, and perhaps best answers Lois Muzio's question, "Why should nurses who value professional autonomy oppose midwives in their efforts to establish a self-governing, self-educating profession?"⁵⁷

Although perhaps not as politically influential as physicians, the relationship of nurses to midwives is a crucial one in determining the ease with which midwives can integrate into the hospital environment.

Many respondents also expressed pragmatic concerns relating to job security and satisfaction that the introduction of midwives in the health care system raises:

“I can see midwives’ practice affecting nursing employment. The type of clients midwives will attract even with hospital births will probably go home very quickly. The days postpartum in the hospital and the early discharge visits made by our staff will be reduced.”

Another respondent anticipated changes in the nature of her work:

“As a nurse, I foresee more attention spent on administrative, hospital-focused duties if the midwife is providing all care to labouring patients. Providing labour support is one of the aspects I enjoy most.”

Not only did many respondents foresee a shift towards more administrative work, many also feared that when they did participate in patient care, they would be relegated to problematic situations which were out of the domain of midwives. As one respondent said, “We want to see natural deliveries and labours also. We like to coach women in breathing, help her find positions for comfort, encourage her to shower, etc. We do not thrive on being invasive!”

Nurses are often described as being on the “front line” of obstetrical care. They work closely with their birthing patients from the time the women arrive at the hospital and after they have given birth. They are the intermediaries between birthing women and other medical practitioners and can influence the nature of the experience. They also provide the most direct interface between midwives and the hospital. Although perhaps not as politically influential as physicians, the relationship of nurses to midwives is a crucial one in determining the ease with which midwives can integrate into the hospital environment. Their attitudes towards midwives are important.

Kornelsen, Dahinten and Carty’s study found that nurses working in obstetrical care had concerns about the introduction of midwives into the health care system. Generally, the concerns were of a professional nature, focusing on whether or not midwives would have an impact on nurses’ job security and satisfaction, what position nurses would be forced to assume in the medical hierarchy, and how it would change their relationship to physicians. Distinct from these concerns, but also a factor contributing to their interprofessional relationships, were feelings of animosity towards midwives due to previous negative encounters pre-regulation and the perception of

preferential treatment during the registration process to those midwives who had attended births at home prior to registration. They also felt there was a bias against those who had nursing training. Negativity towards midwifery was also a product of misinformation or lack of information altogether.

When asked what could be done to contribute to the best possible working relationship between nurses and midwives, almost all respondents articulated the need for more and better communication both between midwives and nurses and between nurses and stakeholders within the hospital (i.e., more directives from the hospital administration regarding official policies concerning midwives and directives from their professional organization). Many nurses did have a positive impression of midwives based on positive previous interactions. Most of the positive interactions, however, occurred with perinatal nurses who had midwifery training from other jurisdictions and were now working within the hospital environment. This dynamic is understandable: most nurses have not had the opportunity to work with community-based midwives prior to regulation, thus do not have the same level of familiarity that they have with nurse-midwives. The situation between nurses and midwives, although currently

strained, seems more hopeful than the one between physicians and midwives. That is, it allows for the possibility that once nurses become more familiar with midwives and have opportunities to work with them on a regular basis and become informed about their model of care, scope of practice and range of competencies and skills, a collegial relationship could develop. As one nurse commented, “I think we must all realize that we have the same goal – a healthy, happy start to life for these new babies and families.”

VIII

Changing Status, Changing Relations?

Earlier we described interprofessional relationships prior to the legalization of midwifery from a professional and interpersonal perspective. We can now juxtapose these experiences with experiences post-legalization:

Interprofessional Relations Post-Registration

	PRIOR TO REGISTRATION		POST-REGISTRATION	
	Professional	Interpersonal	Professional	Interpersonal
Physicians	Negative	Positive due	Fluid	Variable: self-selection is impossible
Nurses	Negative	Predominantly negative due to random assignment	Improved	Improved but variable

Interestingly, although relations have not improved vastly from a professional perspective a shift has taken place on an interpersonal level. The overall relationships between midwives and physicians post-legislation can be described as “variable” because of the lack of discretion midwives have over which physicians they will have contact with. Where previously midwives developed a referral system with physicians who were openly supportive, they must now contend with the wide range of physicians with whom their increased (and changing) client load brings them into contact.⁵⁸ Nurses’ concerns over midwifery arose in large part from a lack of information – or misinformation – concerning midwives’ training, competencies and scope of practice precipitated by their lack of contact with midwives prior to legalization. Many of the concerns expressed by the nurses have dissipated during the past 18 months as the two professions have had the opportunity to work alongside each other, exemplifying the ability of personal contact to counteract ideological (professional) positions.

—🕒 Recommendations

Most physicians and nurses do not have a clear understanding of midwives' scope of practice and the competencies, skills and training that have enabled them to carry it out. In-services and professional development programs directed at presenting information about midwives and their scope of practice are needed, including regular updates. They may be administered by hospitals with support from Regional Health Boards and the Ministry of Health.

Physicians, midwives and nurses working in obstetrics acquire many of the same skills and competencies in their training. Interdisciplinary educational opportunities, where appropriate, would facilitate a shared understanding of obstetrical care and allow physicians, midwives and nurses to establish professional contacts. 🕒—

IX

Midwives need to collaborate with other maternity care providers in the interests of their clients.

Where Do We Go From Here?

Earlier we posed the question “Can midwives gain support of the dominant players in the health care system without sacrificing crucial elements of independent practice?” as a way to point to the apparent conflict between legislated autonomous practice and medicine/nursing support for midwifery. When we observe both historical precedents and the present situation we can see that from a professional perspective neither physicians nor nurses welcome the addition of midwifery into the health care system largely because of the perceived threat of professional competition in various areas of care. Although relations may be more positive on an interprofessional level – especially between nurses and midwives – they are still strained. Given this reality, perhaps a more useful question may be “What can be done to make the integration of midwives into the health care system in British Columbia more efficacious?”

There is a growing literature on interdisciplinary collaboration in health care. The literature has grown out of health care administrators’ desires to increase the cost-effectiveness and efficiency of the system, but also out of a belief that better client outcomes should result if each practitioner contributes specific knowledge and skills to the clinical situation. But what does collaboration mean? In their discussion of the meaning of collaboration, Lindecke and Block write that “collaboration is a process of shared planning and action towards common goals with joint responsibility for outcomes.”⁵⁹ They go on to point out that the Webster’s Dictionary presents another meaning: “to cooperate or assist, usually willingly, with an enemy of one’s country.”⁶⁰

Midwives need to collaborate with other maternity care providers in the interests of their clients. For example, if a client becomes high risk and a transfer of care to an obstetrician is warranted, it would be hoped that the midwife and obstetrician could each contribute to an optimal experience for the client. Likewise, if a medical situation developed during pregnancy, the midwife and the client’s family physician need to communicate with openness and respect to ensure the most satisfactory outcome. However, collaboration is not always easy. Stapleton

notes⁶¹ that many barriers exist among health professionals with different educational backgrounds, different ways of constructing knowledge and different positions of status in a system that is still hierarchical. Physicians still maintain the most power and status within the maternity care system and historically have not been welcoming to newly regulated practitioners whether they be chiropractors, naturopaths, acupuncturists or midwives.

What, then, are the critical attributes of the collaboration process? According to Stapleton, the attributes include open, honest communication as a vehicle to express trust and respect.⁶² Much of the distrust between midwives and physicians comes from their different ways of viewing the childbearing woman and the experience of pregnancy, birth and the postpartum period. Shifting to a frame of valuing that which each can offer is a tremendous challenge. In order for physicians to shift their current view of midwives, they need to have knowledge of midwives' training, experience (competencies), knowledge of practice style and scope of practice. Stapleton notes that for there to be true collaboration "each profession must have autonomy within his or her scope of practice" and must have a "healthy level of self-worth and a great deal

of professional confidence and maturity."⁶³ They are, however, unlikely to be truly collaborative unless there is a concerted effort both at the professional and interpersonal levels to effect change.

—🕒 Recommendation

Practitioners in British Columbia could benefit from focusing their attention on their community of interest – that is, birthing women. This may be accomplished through attention to outcomes as opposed to practice domains. 🕒—

Although there are concrete moves that hospital administrators and government policy makers can take (such as regional health boards withholding funding from hospitals until they grant midwives admitting privileges) there needs to first be a conceptual shift in the way the conflict is viewed. For example, both physicians and midwives must recognize that interprofessional conflict goes beyond superficial issues (such as remuneration and home birth) and instead reflects larger ideological positions. As Oakley says, "These oppositions represent something that goes far beyond the domains of obstetrics and midwifery; we are talking about a very deep-seated cultural divide."⁶⁴ Some of these oppositional positions include notions about knowledge

**Beyond the fissures
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construction (whether it resides within the patient or within empirical science or a combination of the two), conceptions of risk, and the role of technology. The question of technology calls on larger belief systems involving a) an awareness of the change in our relationship to the process of childbirth that the introduction of technology precipitates and b) whether or not the benefits of its use outweigh the changes it incurs. Each model attracts practitioners with allied belief systems (who in turn support and contribute to the realization of the model). As Stapleton notes, “There is a natural tendency to automatically discount any perspective that does not fit well with one’s own, either because of not valuing the perspective or not understanding it.”⁶⁵ The differences in and of themselves need not be problematic, and may in fact be seen as contributing to a plurality of choices for birthing women, each of whom may be able to find a practitioner who supports her notion of childbirth.

—● Recommendation

Regional Health Boards must take a leadership role in carrying out the policies set by the Ministry of Health. Regarding the granting of hospital admitting privileges to midwives, the Health Boards must insist privileges be granted to midwives

and initiate and facilitate this process. It is recommended that funding be withheld from hospitals which fail to comply. —●

Beyond the fissures between the divergent ways of conceptualizing pregnancy and childbirth, we need to recognize that the health care environment in general is in a state of flux. Government initiatives have been undertaken to respond both to changing notions of health and illness (which includes a general move towards a more holistic model of health care) and to fiscal constraints. The medical profession is also responding to these realities. Friction occurs, however, when the responses of the government and the medical profession are not congruent (either due to differing articulations of the problem, different ways of addressing the problem, or timing.) Within this environment of change, we see shifting professional boundaries that demand a re-adjustment of professional categories. Physicians no longer have attendance at childbirth as part of their exclusive domain. Likewise, however, no longer do midwives have a monopoly over the “midwifery” model of care, as it has been adopted by progressive physicians, nurse-midwives, nurses and to some extent, doulas. All practitioners involved in maternity care need to recognize that we are in transition

as we respond to challenges to the very nature of our health care system, and that in times of transition, instability and uncertainty are inevitable.

The most useful point to keep in mind may be the most obvious: the government of British Columbia has included the profession of midwifery in the Health Professions Act. It is now a legal profession entitled to the same rights and privileges accorded to all other health care professions. Likewise, the government has initiated the Home Birth Demonstration Project not to address questions of the safety of home birth, but to determine the best way to integrate it into the medical system. Neither midwifery nor home birth is likely to be rescinded. Although physicians may choose to engage in political activity to change the status of midwifery and home birth in British Columbia, currently they must accept midwifery and home birth as part of maternity health services in B.C.

If we establish a foundation based on the points just noted – the need for physicians and midwives to “agree to disagree” over their approaches to maternity care, the need to recognize that we are in a state of transition which causes disruptions to the system and a recognition of the fact of midwifery

in B.C. – we can move on to the call to revisit concepts which are basic to collaboration but have been lost in the current debate. These include the need for respect and compromise, cooperation, and the need to work collaboratively, all of which are embodied in the notion of professionalism. Ultimately, all practitioners must serve their constituents – birthing women. The desire to fulfil this commitment must motivate their actions, and actions that are deleterious to this notion must be abandoned. There are a few additional recommendations that can facilitate this.

—🕒 Recommendations

The Ministry of Health, in conjunction with the Midwives Association of B.C. and the Midwifery Task Force must mobilize a public relations campaign to introduce the medical and nursing community, hospital staff and paramedical professionals involved in obstetrical care to midwifery. They must take on an active role to counteract the campaign that has been waged through the media, and actively seek ways of building bridges between the communities.

Concurrently with the informational campaign, work must be done on the level of individual practitioners – both midwives and physicians – to foster relationships with the medical staff

in the hospitals and communities in which they work. They need to adopt an attitude of cooperation and collegiality by sharing information about their style of practice, philosophical positions and explaining reasons for the chosen course of care for their patients/clients. Through increased communication of this nature and the example set by the care given to patients/clients, increased mutual respect will develop. ●—

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Endnotes

¹Prior to legalization it was estimated that less than one per cent of the province's birthing population used the services of community midwives (Burtch 1992). It was difficult to estimate what percentage of the birthing population would access midwifery care if it were legalized, publicly funded, and practiced both in homes and in hospitals.

²MIAC had representation from the following organizations: BC College of Physicians and Surgeons, BC Chapter of the College of Family Physicians of Canada, BC Reproductive Care Program, Registered Nurses Association of BC, BC Nurses Union, Midwifery Program at BC Women's Hospital, BC Health Association, Associated Boards of Health, Emergence Services and the Midwives Association of BC. There was also a representative of Aboriginal midwifery on the committee as well as the Associate Dean of Health Sciences at the British Columbia Institute of Technology. The British Columbia Medical Association declined to participate until near the end of the committee's tenure.

³Huntington 1915, found in Devitt, Neil, "The Statistical Case for the Elimination of the Midwife: Fact versus Prejudice" (*Women and Health* 4, 1, 1979), p. 92.

⁴Mason, Jutta, "A History of Midwifery in Canada" (*Report of the Task Force on the Implementation of Midwifery in Ontario*, 1987).

⁵In their 1995 policy on midwifery, the College of Physicians and Surgeons of B.C. stated: "There is at this time no place for planned home delivery in the province of B.C." In June 1997, they issued a separate policy on home births which states in part, "The College of Physicians and Surgeons of B.C. does not believe that home births can be conducted with sufficient assurance of safety at this time, whether a midwife or a physician is in attendance." Likewise, the Society of Obstetricians and Gynecologists of Canada Policy Statement on Midwifery notes, "The SOGC is opposed to home births because of potential risks to mother and fetus" (September 1997). The Registered Nurses Association of B.C. is ambiguous in its position, stating, "RNABC supports home births only as part of the B.C. government's Home Birth Demon-

stration Project. This project should provide clarification of the issues associated with home births and provide guidance on future policy related to home births in B.C.”

⁶*The Vancouver Sun*, April 24, 1996, B1.

⁷O’Connor, and B. Bonnie, “The Home Birth Movement in the United States” (*The Journal of Medicine and Philosophy* 18, 1993), p. 166-167.

⁸Ibid.

⁹Despite the crucial role that home birth plays in contemporary midwifery practice, it would be in error to present the two as synonymous as many midwives are able – and choose to – practice in the hospital setting adhering closely to the midwifery model of care. Hospital-based practice allows midwives to work with the vast majority of the birthing population in Canada who, although desirous of midwifery services, prefer to birth within the hospital setting. Home birth is not, however, as Dr. James Goodwin describes, “an irrelevant function of [the] movement.” Goodwin, James, “Where to be Born Safely. Professional Midwifery and the Case Against Home Birth” (*Journal SOGC* 19 11, 1997), p. 1179-1188.

¹⁰B.C. Royal Commission on Health Care and Costs, 1990.

¹¹College of Midwives of British Columbia “Midwives Regulations”, p. 2. This has become a troublesome stipulation for many physicians as it is not clear whether they are in fact required to perform a *physical* examination and if they are, the reasons for such an examination. There are also questions regarding physicians’ liability in the subsequent course of care for the women who go on to be seen by a midwife for the duration of their pregnancy.

¹²Shoichet, Arnold, “Midwives and Medicine: Shifting a Delicate Equilibrium” In *Family Matters: The Newsletter of Family Physicians, BC Women’s* (April 1999), p. 8.

¹³DeVries, Raymond, *Regulating Birth: Midwives, Medicine and the Law* (Philadelphia: Temple University Press, 1985), p. 29.

¹⁴Donnison, Jean, *Midwives and Medical Men: A History of Inter-professional Rivalries and Women’s Rights* (London: Heinmann, 1977).

¹⁵Ibid., 116.

¹⁶Ibid., 105.

¹⁷c.f. Annandale, Ellen, “How Midwives Accomplish Natural Birth: Managing Risk and Balancing Expectations” (*Social Problems* 32, 2, 1988), p. 102.

¹⁸Ibid., 44.

¹⁹Kitzinger, Sheila, *The Midwife Challenge* (London: Pandora 1991), p. 231.

²⁰Task Force 1987:47.

²¹Ibid.

²²Benoit, Cecilia, *Midwives in Passage* (St. John's, Newfoundland: Institute of Social and Economic Research 1991), p. 29.

²³Ibid., 31.

²⁴Ibid., 31.

²⁵"RAD" days were ones in which physicians would not see patients in their offices or perform elective procedures or diagnostics. Only those services deemed essential would be performed.

²⁶B.C. Family Practice Journal, p. 8.

²⁷*Vancouver Sun*, December 22, 1997, A1.

²⁸*Vancouver Sun*, January 2, 1998, A2.

²⁹The Home Birth Demonstration Project Tour was undertaken by the Ministry of Health and the Ministry Responsible for Seniors in order to present information about midwifery and the Home Birth Demonstration Project to various hospitals around the province. It took place between October 27 and December 4, 1997, before midwives' remuneration was announced by the government.

³⁰Jeanne Lyons and Elaine Carty, *Reality, Opinion and Uncertainty: Views on Midwifery in BC's Health Care System*, part of the series *Perspectives on Midwifery*. (Vancouver: British Columbia Centre of Excellence for Women's Health, 1999.)

³¹*Edmonton Journal*, May 2, 1998, A6.

³²*Vancouver Sun*, December, 22 1997, A1.

³³Lyons and Carty 1999. There was no difference noted between comments from physicians who practiced in hospitals with Cesarean Section capabilities and those without.

³⁴*Vancouver Sun*, January 26, 1988, B10.

³⁵Lyons and Carty 1999.

³⁶Ibid.

³⁷Lyons and Carty 1999. To emphasize this point, copies of the SOGC's Policy Statement of Midwifery were anonymously placed on chairs at one site on the HBDP tour.

³⁸*The Hamilton Spectator*, May 20 1997, A6.

³⁹Goodwin, James, "Where to be Born Safely. Professional Midwifery and the Case Against Home Birth" (*Journal SOGC* 1997;19:11), p. 1179-88.

⁴⁰Ibid.

⁴¹See "Letter to the Editor" in *Journal SOGC* 1997; 20:11.

⁴²Kornelsen, Jude and Elaine Carty, *Midwives Experiences of Practice Post-Registration*. (Vancouver: B.C. Centre for Excellence for Women's Health – publication forthcoming). This study consisted of interviews with thirty-two midwives across the province between February and May, 1999. They were asked questions about their personal and professional lives since registration.

⁴³Although midwives refer directly to obstetricians for pregnancy-related complications, they may refer to physicians if a medical condition unrelated to pregnancy arises.

⁴⁴Weitz, Rose, and Sullivan, Deborah, "Labor Pains: Modern Midwives and Home Birth" (New Haven: Yale University Press 1988), p. 120.

⁴⁵Ibid., 171.

⁴⁶Lyons and Carty 1999.

⁴⁷*Vancouver Province*, March 6 1998, A7.

⁴⁸In British Columbia, 34.1 per cent of physicians report that they do obstetrical care, compared to 22.1 per cent in Ontario (10.8 per cent in Toronto) and 8.7 per cent in Quebec (2.5 per cent in Montreal). [A.J. Reid,

I. Graba-Gubins and J.C. Carrol. "Canadian Family Physicians Providing Obstetrical Care: Still in the Game." Presented at the North American Primary Care Research Group Meeting, Montreal Quebec November 6th. Part of the Jannus Project of the College of Family Practitioners of Canada, 1998.

⁴⁹Klein, Michael, "The Midwife Dossier: Cooperation or Competition?" (*Canadian Medical Association Journal* Vol. 150 No. 5 1998), p. 658.

⁵⁰There is no training program for nurse-midwifery in Canada at this time and thus no way for nurse-midwives who have trained abroad to register in Canada. Those who do not oppose the home birth requirement, however, may apply to register with the College of Midwives of B.C.

⁵¹Teasly, Regi L. "Nurse and Lay Midwifery in Vermont" (*The American Way of Birth*, Ed., Pamela Eakins, Philadelphia: Temple University Press, 1986), p. 247.

⁵²Katz-Rothman 1991: 73.

⁵³Rothman 1982: 155-156.

⁵⁴Goodwin, James, "Where to Be Born Safely. Professional Midwifery and the Case Against Home Birth" (*Journal SOGC* 1997; 19:11).

⁵⁵Kornelsen, J., Dahinten, S. and Carty, E. "Nurses Perceptions of Midwifery in B.C." (Vancouver: BC

Centre of Excellence for Women's Health – publication forthcoming).

⁵⁶When asked about their knowledge of the requirements for registration, a common theme that emerged among respondents was that the applicant had to have attended a specified number of home births during the 24 months prior to applying to register. Since home birth was only officially sanctioned through the Home Birth Demonstration Project which started in January 1998, there was a perception that registration required participating in an illegal activity. This is not correct. If an applicant meets all of the other requirements for registration, she may be granted "Conditional" status, the condition being future attendance at home births.

⁵⁷Muzio, Lois, "Midwifery Education and Nursing: Curricular Revolution or Civil War?" (*Nursing and Health Care*, September 12:7).

⁵⁸It should be noted that according to midwives, their overall relationships with obstetricians are more supportive and satisfying than their relationships with general practitioners. This may be due, in large part, to their ability to self-select the obstetricians they refer to and the complementary nature of their professional interactions.

⁵⁹Lindecke, L. And Block, D. "Maintaining Professional Integrity in the Midst of Interdisciplinary Collaboration" (*Nursing Outlook* 46, 1998), p. 213-88.

⁶⁰Ibid.

⁶¹Stapleton, Susan R. "Team-Building: Making Collaborative Practice Work," (*Journal of Nurse-Midwifery* Vol. 43, No. 1, January/February 1998), p. 12.

⁶²Ibid.

⁶³Ibid.

⁶⁴Oakley, Anne, "Who Cares for Women? Science versus Love in Midwifery Today" (*Midwives Chronicle* 102, 1218, 1989), p. 215.

⁶⁵Stapleton, Susan R. "Team-Building: Making Collaborative Practice Work" (*Journal of Nurse-Midwifery* Vol. 43, No. 1, January/February 1998), p. 12-18.