Midwifery

Building our contribution to MATERNITY CARE

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I. Preface

In November 2000, key players in the provision of maternity care in Canada, including members of the Society of Obstetricians and Gynaecologists of Canada, the College of Family Physicians of Canada, the Society of Rural Physicians of Canada, and the Canadian Association of Midwives, gathered in London, Ontario to address the future of maternity care. The meeting was precipitated by the recognition among maternity care practitioners that pregnant women and their babies are increasingly being put at risk because of inadequate care due to a maternity care practitioner shortage. This shortage, which has been anticipated by the medical, nursing, and midwifery communities, is the result of an inability to recruit and retain caregivers, capacity deficiencies within the current delivery system, and a lack of interdisciplinary collaboration and efficient use of caregivers' skills.

In bringing together representatives from the professions most closely involved in maternity care provision and articulating current challenges, the London conference was the inaugural event of a process of consultation, problem-solving, and policy generation that is ongoing. It was with the goal of continuing this process that the Department of Midwifery, Children's and Women's Health Centre/Providence Health Care (St. Paul's Hospital) and the British Columbia Centre of Excellence for Women's Health organized the working symposium, "Midwifery: Building our Contribution to Maternity Care," which was held May 1-3, 2002. The symposium brought together midwifery practitioners, researchers, and policy makers from across the country to address professional sustainability and facilitate further contributions to midwifery care in Canada. The specific objectives of the symposium were to:

- Understand midwifery's contributions to care within the context of Canada's maternity care environment;
- Assess, from various perspectives, midwives' abilities to meet the needs of Canadian women;
- Consider new, innovative, and alternate models and plans for practice that would contribute to the growth and sustainability of midwifery;
- Reflect on current practice within the profession in Canada and other jurisdictions; and
- Learn about what other maternity care professionals think midwives can contribute to maternity care in Canada.

During the symposium, presentations and small and large group discussions continued the dialogue about the future of maternity care in Canada that was begun at the London conference. The overall goal of moving the profession forward to meet the challenges of the next decade was thus served.

Although many regions of the country were represented, the gathering was not a comprehensive one. Rather the symposium started a dialogue that may continue

to take place on many levels, from the local to the regional and national, and within many forums, from the professional to the governmental. For this reason the presentations and discussions reflected within these proceedings must not be seen as representing the midwifery position, but instead as encompassing some of the disparate views that are held by practitioners across the country.

We gratefully acknowledge support for the symposium from Children's and Women's Health Centre of British Columbia and, specifically, Dr. Elizabeth Whynot, who has been a tireless supporter of midwives and midwifery. We also thank the British Columbia Centre of Excellence for Women's Health for its continued commitment to a program of midwifery research. Most of all, however, the success of the symposium lies with the participants, whose collective energy lead to enthusiastic discussions about the future of the profession in Canada. We are grateful to them for their contributions.

Jude Kornelsen

Jude Kornelsen, PhD
for the British Columbia Centre of Excellence for Women's Health and the Department of Midwifery of Children's and Women's Health Centre of British Columbia and Providence Health Care (St. Paul's Hospital)

II. Introduction

These proceedings mirror the structure of the symposium, starting with presentations and including summaries of the group discussions (see Agenda, Appendix 2). The proceedings—like the symposium—end with participants' articulations of the key messages that need further reflection.

We have included participants' presentations in the form in which they were presented, including formal papers, but also abstracts, and presentations in Microsoft PowerPoint format. Large group discussions were audiotaped and transcribed in order to make them available in summary form for these proceedings.

Taken together these proceedings reflect the essence of the symposium: a venue for dialogue about the sustainability of the profession of midwifery and the concomitant contributions it can make to maternity care in Canada. Bringing midwives together is a first step in opening up this crucial dialogue. We hope these proceedings will be seen as a second step by generating discussion of the future possibilities for the profession of midwifery in Canada.

III. Midwifery Practice Questionnaire: Preliminary Results

Jude Kornelsen, PhD

Sponsored by
Department of Midwifery
Children's and Women's Health Centre of British Columbia
British Columbia Centre of Excellence for Women's Health

Overview

In March 2002, a questionnaire on midwives' practice conditions was mailed to all midwives in British Columbia registered with the College of Midwives, by the Department of Midwifery, Children's and Women's Health Centre, Providence Health Care and the British Columbia Centre of Excellence for Women's Health. The Department of Midwifery has a clinical mandate to support midwifery practice across the province. Gathering data was seen as a necessary step to fulfill this mandate.

The objective of the questionnaire was to investigate midwives' practice conditions in the four years since regulation. Specific research objectives included:

- To determine the practice conditions that midwives face four years into regulated practice;
- To create a picture of B.C.'s midwifery population from the perspective of growth and sustainability;
- To determine midwives' views on their scope of practice;
- To provide baseline data on midwifery practice for comparative purposes as the profession grows; and
- To replace anecdotal information with data.

Questionnaire Design

The design of the instrument was informed by international literature on professional practice issues, conditions and concerns faced by midwives, results of previous research done in B.C., and consultations with midwives.

Two bodies of literature were consulted: literature from the field of job satisfaction, job stress, and occupational burnout, and literature on professional issues in midwifery.[1]

Questionnaire Development

Twelve registered and currently practicing midwives reviewed initial drafts of the questionnaire. Changes were made based on the comments received. The

questionnaire was then pilot-tested on four midwives, revised, and administered. Ethical approval was obtained from the University of British Columbia's Behavioral Ethics Committee. The questionnaire was mailed to all registered midwives in British Columbia (n = 65) and returned by 35 midwives for a 54% response rate. (Three late responses were received after the analysis had been completed.)

RESULTS

Demographic Information

- Average age of respondents was 45 years.
- Average number of years in practice was 12.9.
- 25 (76%) were married/had a partner; 8 (24%) were single.
- 20 (61%) had children at home.
- 22 respondents (66%) had been conditional registrants at some point; 3 (9%)
- were conditional registrants at the time of the questionnaire.
- Education: 19 (57.6%) were direct-entry midwives; 14 (42%) completed a midwifery degree program.

Respondents' Location

10 (30%)	Identified as rural
15 (45%)	Identified as urban
8 (25%)	Identified as both rural and urban

- Number who had worked in a rural community at any point: 34 (73%)
- Number who had ever worked in an urban community: 30 (90%)

Political Activity

- Number of respondents currently or recently on a CMBC/MABC committee: 22 (66%).
- Number of respondents currently or recently on hospital committees: 29 (87.9%).
- Average number of hours/month devoted to midwifery politics: 33.22 (range: 1 - 98).

Practice Arrangements

- Number of respondents in group practice: 23 (70%).
- Number of respondents in solo practice: 10 (30%).

Number of Midwives the Respondents Share Primary Call With

Number of Midwives call is shared with	Number of Respondents
1	18
2	5
2.5	1
3	1

- 11 (33%) respondents have their office in their home.
- 17 (51%) respondents lease office space.
- 21 (64%) respondents have a receptionist/office manager.
- Average number of weeks of vacation taken in 2001: 2.36 (range: 1-7 weeks)
- Average number of weeks vacation planned for 2002: 8
- 22 respondents (67%) reported they had adequate access to second attendants for home birth; 6 (18%) said they did not.
- When asked if they would like midwives to second-attend hospital births: 32 said they would not (3 with emphasis!); one said she would.
- The two most frequently reported call schedules were one week on/one week off (14 respondents, or 42%) and 24 hours a day/7 days a week (12 respondents or 36%).
- Twenty-two (67%) of respondents practiced full-time and 10 (30.3%) practiced part-time. Of those in part-time practice, 6 were part-time by choice.

Rural Respondents

- Average number of minutes from office to nearest tertiary care facility: 55 (range: 3 minutes to 6 hours).
- Number for whom access is always available: 21 (67.7%).
- Number for whom access is not always available 7 (22.6%).
- Attitudes towards subsidies for rural practice: Number of respondents who felt subsidies should be available for midwives who set up practice in isolated areas: 27 (81.8%).

Inter-professional Relationships

- 31 respondents (94%) had admitting privileges to hospitals (2 did not).
- Most respondents had privileges at 2 hospitals (54%) while 21% had privileges at three, 15% had privileges at one, and 6% had privileges at 5.

Respondent's Experiences of Support Within the Hospital Environment

	Supported	Very Supported	Not Supported
Nurses	15	14	4 "depends"
Other Midwives	10	20	1
Physicians	20	1	5
Obstetricians	17	14	1
Anaesthesiologists	18	2	7
Paediatricians	18	10	2
Hospital Administrators	21	10	1
Dept. of Midwifery	4	17	1

The following chart documents the number of respondents who reported an improvement, deterioration or no change in their relationships with colleagues since 1998 (n=21).

	No change	Improvement	Deterioration
Nurses	7	12	
Physicians	4	12	2
Obstetricians	3	15	
Anaesthesiologists	5	12	2
Paediatricians	5	13	
Community Health Nurses	3	15	
Other midwives	8	10	1

The following chart documents the support respondents reported receiving from nurses.

The majority of respondents receive support from nurses for the following tasks:	
Chart documenting	13
Monitoring epidurals	26
Break relief	13
Help with transport to post-partum ward	15
Administering oxytocin	27
Assisting with PPH	29
Help with clean-up	16
Stay until 3rd stage is complete	23
Assist with suturing	17

- The majority of respondents manage clients in-hospital after epidurals (13), augmentation (13) and induction (12), but not after caesarian section. There was a high number of respondents who "sometimes" took on these tasks and noted that it varied from hospital to hospital, and sometimes within one hospital depending on the nurses on call.

When asked if they would consider being an employee of a hospital, regional health board, physician or community clinic, respondents answered as follows:

	Yes	No	Depends
Hospital	8	11	12
Regional Health Board	9	6	16
Physician	3	20	8
Community Clinic	12	4	15

Conditional Registrants

22 (66%) of respondents were or had been conditional registrants. Of these, 18 (81%) had been able to obtain supervision in their community, 17 (77%) were paid for providing care while meeting their conditions, and 4 (18%) had another source of income while meeting their conditions.

Sustainability of Current Pace of Practice

When asked "How long do you feel you can sustain the current pace of your practice?" the majority of respondents (10) answered "5-10 years", 5 answered "2-5 years", 4 answered "1-2 years", and 7 respondents said "the next six months".

Scope of Practice

Respondents were given a list of possible functions to include in their scope of practice, given appropriate training. The items in the following columns indicate support for inclusion or exclusion.

Functions the majority of respondents want included in scope of practice	Functions the majority of respondents do not want included in scope of practice
✓ N_2O_2 at home (85%) ✓ 1st dose antibiotics at home (76%) ✓ Augmentation of labour (76%) ✓ Fetal scalp sampling (51%) ✓ Insertion of IUCP (61%) ✓ First assist with c/section (64%) ✓ Monitoring epidurals (70%) ✓ PD induction of labour (85%) ✓ Insertion of Prostin gel (94%) ✓ IUD insertion (67%) ✓ Prescribe oral contraceptives (76%) ✓ Prescribe sedatives (91%) ✓ Prescribe narcotics in hospital (97%) ✓ Prescribe antibiotics for UTI's (91%) ✓ Vacuum extraction in hospital (60%) ✓ Well-woman gynecological care outside the childbearing year (70%)	× Amniofusion (60%) × Prescribe narcotics at home (64%) × Insert Norplant (51%) × Vacuum extraction at home (79%)

Model of care

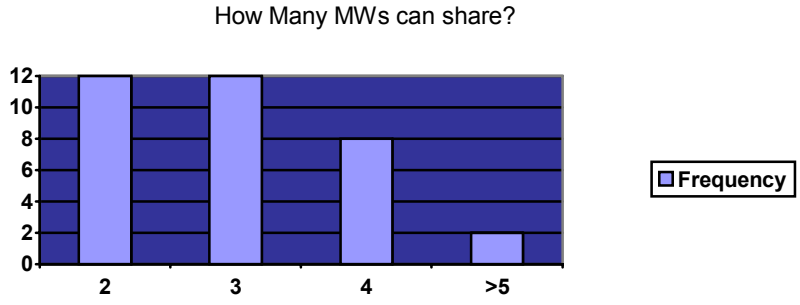
Respondents were asked whether or not they agreed or disagreed with the following statements on continuity:

	Agree/ strongly agree	Disagree/ strongly disagree	Neither agree nor disagree
Continuity of care is essential to midwifery care.	24	4	3
Continuity of care enhances informed choice.	27	3	3
A woman will have better birth outcomes if she knows her midwife well prior to labour.	20	4	8
By providing continuity of care, I increase my client's satisfaction with care received.	27	2	2
Practicing in a continuity-based model increases my level of job satisfaction.	22	7	4

Respondents were asked, "Do you feel it is possible to share client care with someone with a different philosophy of care and still provide continuity to your client?" and answered as follows:

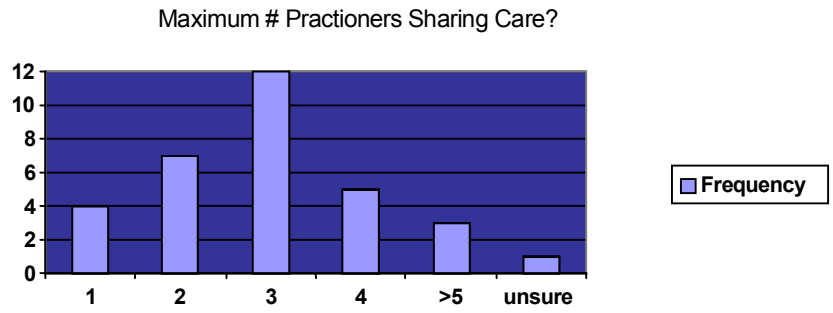
No	18 (54.5%)
Yes	5 (15.2%)
Depends/Don't know	10 (30.3%)

The majority of respondents felt that either two (12), or three (12) midwives could share care and still provide continuity. Six respondents thought that more than three midwives could provide care and two felt more than five could provide care and maintain continuity.

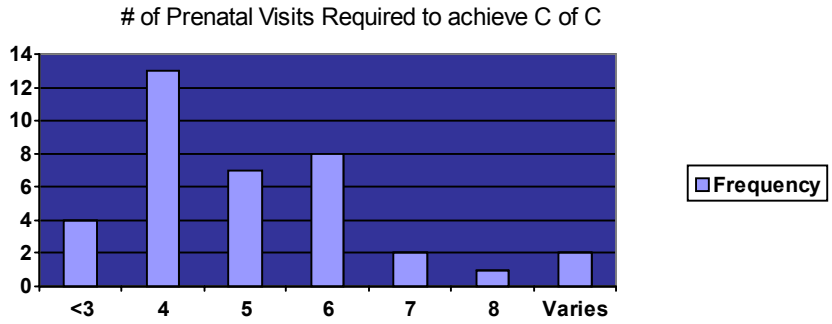


The majority of respondents (12) felt that they would not feel comfortable sharing care with more than two other midwives; seven respondents were not comfortable with sharing care with more than one other midwife and four

respondents felt comfortable only with one-to-one care. Five respondents replied they were comfortable with sharing care with four other midwives and three replied they were comfortable with five or more.



When asked how many prenatal visits need to occur with the attending midwives in a typical course of care in order for the benefits of continuity of care to be achieved, the majority of respondents (13) said four; 4 said less than three, 5 said five, 6 said six, 2 said seven, 1 said eight and 2 said that it varies.



Satisfaction with Current Knowledge

Reported Levels of Satisfaction with Current Knowledge			
	Very Satisfied	Satisfied	Not Satisfied
Knowledge of prenatal care	6	26	0
Knowledge of labour	13	19	0
Knowledge of postnatal care	14	15	3
Knowledge of newborn care	13	21	3
Knowledge of high risk care	5	12	18
Knowledge of new technologies	5	14	14
Knowledge of research methods	3	17	13

Sources of Professional Information

Respondents reported that they accessed the following sources:

	Often	Sometimes	Never
Midwifery journals	16	16	1
Medical journals	15	15	3
Internet	17	12	4
Workshops	14	18	1
Journal club	14	12	5
Popular press	6	13	14

Qualitative Responses

Three open-ended questions were asked:

1. What do you think should be done to encourage practice in rural and remote communities?

2. What do you think should be done to retain midwives in B.C.?

3. How can we increase the number of registered midwives in B.C.?

The majority of respondents (14) felt that increased remuneration was essential to encourage rural practice. This includes consideration of a different payment model (i.e., salaried positions), monetary incentives, subsidies, travel allowances, and a scale whereby professional fees correspond to caseload. Other responses were: the need for greater access to locums (7), increasing access to continuing education (4), help with securing hospital privileges from CMBC (3), developing more positive relationships with GP's/OB's (2), advertising/increasing public awareness (2), and training women from rural communities (2).

There was convergence between what respondents felt was necessary to do in order to attract midwives to rural and remote areas and what needed to be done to retain midwives. As with the former, respondents felt that to retain currently registered and practicing midwives an increase in pay and renegotiation of benefits was essential (17 respondents). Other suggestions included having a more flexible model/working conditions (5 respondents) including allowing for part-time practice (4 respondents), simplifying/lessening the cost of the PLEA (Prior Learning Education Assessment) (4 respondents), having access to more locums (5 respondents), decreasing continuity requirements for registration and decreasing home birth requirements for practice (1).

Aside from incorporating the graduates of B.C.'s new Midwifery Education Program into practice, several suggestions were made on ways to increase the number of practicing midwives. They included changes to the PLEA (shorten it (6), make it

easier to do (2), pay midwives while they are doing it (2)), advertise in other jurisdictions (9), streamline/shorten the registration process (9), recognize training from other jurisdictions (3), encourage perinatal nurses to register (2), make midwives' work more attractive to others (2), and provide refresher programs for foreign-trained midwives (2).

Endnotes

1. Literature consulted includes:

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A. Developing a Plan for Growth and Sustainability in Midwifery Practice

Holliday Tyson, RM, MSc

In the first of her two keynote addresses, Holliday Tyson suggested that at the present rate of practice, midwives in Canada would not be able to meet the demands of a significant percentage of the childbearing population. Their contributions to maternity care will thus be limited. Low numbers of practice midwives also have an impact on other areas of the profession, such as the limited support available for regulatory bodies and professional associations, a less-than-optimal bargaining position for liability insurance coverage, and a lack of capacity for research and teaching. Holliday laid out a plan to increase numbers both in the short- and the long-term.

In this symposium we have been asked to-

- Consider the sustainability of midwifery in Canada;
- Generate recommendations for strengthening viability of the profession; and
- Discuss how midwifery can increase its contribution to maternity care.

I would like to make a contribution of evidence, ideas, and opinion with a focus on these areas. At the outset I want to separate and identify the distinct "sustainables" which concern the midwifery profession. Looking to the future, we are all motivated to achieve sustainable midwifery services in Canadian communities, sustainable careers for individuals in midwifery, and sustainability for the midwifery profession in Canada.

I want to make clear that I care about the current shortage of obstetric care providers in Canada and my presentation content addresses this issue. Equally important, however, is that almost all of my presentation content would be exactly the same even if we were not facing this kind of caregiver supply problem. The evidence which motivates me to share these ideas and possible directions for midwifery's future in Canada is many faceted and has led to a more holistic assessment of midwifery's roles and responsibilities, rather than being just a response to a caregiver supply problem.

Let me give you an overview of my presentation today and tomorrow. Today I'd like to start with a review of some progress highlights that midwifery has achieved in Canada over the past 20 years. Then I hope to persuade you that if we care about midwifery as an essential service and its sustainability into the future, it is imperative to ask some hard questions about midwifery as it exists now in Canada and about plans for the near future.

Today, I'll focus on scale-the number of midwives, capacity for volume and responsiveness, and how this defines the parameters of our contribution to Canada's health care system. Secondly, evidence about the integration of midwifery in Canada and the implications of problematic integration for quality of clinical care.

Tomorrow, I will look at-

1. Recruitment and retention of midwives. I will share with you some information from the new British national framework for "Delivering better working lives together". This is a joint effort by the government Royal College of Midwives and the National Daycare Trust.

2. Challenges for education. How to integrate planning for quality, innovation, and sustainability in the development of the new B.C. school of midwifery.

3. Areas where I think the time is right for midwifery to be taking a leading role in health care policy and clinical practice. It's my contention that midwifery in Canada has been at its best when taking risks, creating new ideas for health care, and connecting with larger societal issues.

What are the limitations of these presentations?

This is British Columbia, so while the discussions are relevant to other provinces, I've tried to focus primarily on issues relevant here. This is not a comprehensive analysis of Canadian midwifery issues for provinces without enabling legislation or funding. And I have not addressed Aboriginal midwifery and midwifery care issues.

Quebec's birth centre model offers a different and distinct approach from that of other provinces with legislated midwifery, so although I make reference to some relevant clinical findings related to midwifery care in Quebec, I haven't attempted to consider their sustainability issues here.

Manitoba is recently regulated and we're going to hear about their model of care and issues during the symposium, so I have not commented directly on sustainability issues for that province.

I have attempted to introduce material which applies broadly to midwifery concerns in Canada, with a primary focus on relevance for B.C.

Let's look at Canada 20 years ago and today.

In 1982 there was no regulated midwifery, but there were practicing midwives outside of the system in most provinces and a small but effective midwifery renaissance and politics, which began in the 1970s. It's difficult to have accurate

figures, but probably a total of 100 midwives were in practice and if you counted people who considered themselves midwives but had been to less than 5 births, about 200.

The 1980's were a decade of defining political work with the vision of midwifery emerging strongly by 1983 as a critique of medicalization and a desire to offer women choice through the legal recognition of midwives. Inquests and other legal and government processes, some supportive and more punitive, gave impetus to the midwifery movement, which involved growing public support and a strong coalition of childbirth activists. By the middle of the 1980s the grounding principles and the model of care were defined. The foundation was "woman-centered care" and the principles were and still are:

- informed choice;
- choice of birthplace;
- time spent with women;
- appropriate use of technology;
- non-hierarchical relations between midwives and women;
- evidence-based care; and
- continuity of care.

So, 15 to 20 years later...

In 2002 midwifery has been legalized and regulated as a publicly funded essential service in Ontario, British Columbia, Quebec, and Manitoba.

In terms of care provided to women and contributions to Canada's maternity care system, here are some of the achievements:

- Midwives have played a central role in bringing choice to women in Canada. Prior to the 1990s, women had little choice about caregiver or the location of their birth. For women who have access to midwives, that has changed a lot and for the better.

- By respecting normal birth and advocating judicious use of interventions, based on evidence, midwives have helped thousands of women experience birth with fewer unnecessary interventions and, by their presence in communities, have sometimes influenced progressive policy changes in hospital for women not attended by midwives as well.

- Midwives have valued time spent with women during pregnancy, labour, and postpartum, and protected this by institutionalizing it in the model of care. The profession wrestles seriously with the concept of the woman as decision maker who deserves support, and with birth as a primarily social, not medical event. In facilitating relationships between the woman and a small known group of caregivers, midwives have struck a chord with something

fundamental in human beings. The desire to connect, to feel safe, cared for, and respected especially when we are vulnerable, is widely shared.

- Canada's obstetric system, like most obstetric systems, had an appalling record of what we now recognize as physical and emotional abuse of women and their babies in rigid hierarchical institutions. Midwifery, together with a number of other societal influences, has played an important role in raising awareness and expectations of improved care and in challenging health care providers to be more responsive and accountable to the people they care for.

- Postpartum care: It is hard to overstate the importance of postpartum care by midwives in Canada against the backdrop of the existing system. Women have often commented that they sought out midwifery care for the labour support and approach to birth, but in retrospect what they valued most was the postpartum care. Midwives not only provide postpartum care, they provide a challenge to our health care system, where postpartum care between discharge from hospital at two days and a perfunctory physician visit at some point in the first month is a black hole—a void of no care.

Why are we talking about sustainability and midwives' contribution to the health care system today?

For some people, it seems premature because they see midwifery as a new profession since legislation for midwives only arrived in the 1990s.

I think the answer is because midwifery as we know it and practice it now was invented in the late 1970s in the context of the obstetrics and the social environments of the time. It was solidified and entrenched in one single model of practice in Canada in the early 1980s. It's now 20 years later. Times have changed in reproductive care and in women's needs and preferences in many ways that are important for us to be in touch with.

Perhaps most critically, despite midwifery's commitment to evidence-based practice, some of the practices made unchangeable under the current model by regulation are not based in evidence, but ideology. For example: quantified definition of continuity of care (i.e., 4 or less); two midwives required at a birth in Ontario; and that 30 to 60 minute appointments are regularly needed for all clients.

The 1980s and today...
It can be instructive to compare experiences and assumptions from the 1980s in midwifery with related ones in 2002.

Remember how women were struggling to leave hospital postpartum within the first 24 hours and now many are fighting to stay in for 60 hours?

Remember the place of ultrasound and Doptones until the last 5 to 10 years? The isolation and disconnection felt by many women seeing a fetal image on a screen, that Sheila Kitzinger's writing reflected? That writing now seems impossibly historical, with the majority of women in midwifery care requesting Doptones so they and their families can hear the fetal heart tones and choosing ultrasound centres which offer take-home ultrasounds in video movie format and ultrasound photos which clients display on their fridge and in a photo book.

Remember when we thought midwives wouldn't be sued because of their relationships with women? We know now that evidence shows midwives are sued in a pattern similar to other obstetric care providers.

Remember how midwives wondered if they should take on someone as a client who smoked or didn't want to breastfeed? Now midwives are beginning to have the experience of wondering if they should take on someone as a client who values pre and postnatal care but wants an elective caesarian section.

Once you get going there are so many examples. Many of you have cared for women giving birth who are the children of clients from the 1980s. I think all of us would agree that the values and principles of caring in midwifery are still sound and desired both by midwives and the women they care for, but also that they are not exclusive to midwifery.

Although midwifery doesn't own them, but shares them with other professions, midwifery stands apart in taking on the challenge of making them concrete and required in substantive demonstrable ways in everyday practice.

At the same time, the midwifery model was designed at a particular point in time to meet women's needs as many women articulated them, largely in response to characteristics of medical care which they rejected, and in sync with social movements, particularly feminism in the late 1970's.

The problem then is that once you have a single model monopoly enacted, the tendency is mostly to entrench practice, to look inward and try to protect and regulate it, rather than respond to changing societal demands. Over time, following this path, midwifery becomes less responsive to the outside world and less relevant, both to the health care system and to the needs of childbearing women of later decades. This is the challenge for midwifery now.

Scale and integration: models from B.C. and Ontario

As we move on to issues of scale and integration, my underlying view of the models in B.C. and Ontario (with small differences between them) is that they were a very good start.

I love many things about these models, but I don't think they are blueprints for 30 years of practice. I think we need to keep inventing as we go along. I also don't want to create a win-lose situation, this model versus that model scenario. Rather I think it's time for midwifery to make the ideological jump to trust that the values we share can be enacted in multiple models, which are responsive to different community needs.

Scale: sustainability and contribution

Let's look at scale as this factor relates to the midwifery profession's sustainability and contribution to the health care system.

One of the key promises of funded, integrated midwifery is access to care for women. In addition, much midwifery literature makes clear that midwives are specialists in normal birth and as such are the most appropriate caregivers for low-risk pregnancy and birth, with obstetricians are better suited to providing care in high-risk situations and where surgery is required.

The Association of Ontario Midwives has a mission statement which says that midwives should be central to the provision of maternity care services in the health care system. What does that mean? What kind of professional population numbers or care provision volume does that mean? Part of midwifery's success in Canada has been due to the practice of applying concrete definitions and goals to values, so the lack of a clearly defined objective within the profession of midwifery related to this mission statement should be of concern.

In England and Europe midwives are the primary attendants at 60 to 70% of all births. Is that what we have in mind? Or do we see something much lower? Say 30 to 40%? Eight years after legislation in Ontario, midwives there, who make up more than half of Canada's midwife population, attend approximately 5% of all births. Nationally the rate is less than 2%. At the current rate of growth it will take more than 25 years of regulated midwifery to approach the 25% mark in Ontario, assuming that midwifery thrives for that period of time.

Some argue that slow growth at the rate in place now is the only possible route, given the shortage of midwifery placements and no guarantee beyond a year ahead of funded places for midwives to work. I disagree with that view. I consider the lack of a comprehensive plan to increase the population of midwives problematic. Fans of slow approaches should remember that almost any plan to increase midwives would take three to five years to produce results.
So, if we examine midwifery's capacity to provide services to women, an obvious barrier to care provision is that both B.C. and Ontario have provided funding which effectively restricts the number of courses of care a midwife can provide to 40 per year, minus the cases which she will transfer. This is a significant barrier. Let's say we are planning maternity care services for a small city with 500 births:

- You could have two obstetricians.
- You could have two to three general practitioners and one obstetrician.
- You could have nine midwives and one obstetrician.

It is very difficult for midwives, no matter how committed they are to their communities, to be responsive to women's need for services when they are limited to looking after their own clients only, to a maximum of 40 per year.

Other reasons the midwifery population needs to be larger

We need a critical mass in order to support regulatory bodies and professional associations. At current rates in Ontario, full-time midwives pay $4,000 per year in basic dues to these two bodies. In order for midwifery to support the system of self-regulation that it sought politically, it needs a confidently growing population. Current population growth and attrition figures indicate that this is not yet being achieved.

The history of professional liability insurance and small groups is not a happy story. A growing population is certainly necessary in order to be desirable as a professional population needing insurance coverage.

In terms of academic development, beginning to develop midwifery research capacity, creating graduate education possibilities in midwifery, the need for a larger Canadian midwifery population is urgent.

What do I think might be helpful in the area of scale-for the number of midwives?

I will be talking tomorrow in detail about recruitment and retention and approaches to education, but for now, I'll say—

- Increase the annual intake of students in the MEP (Midwifery Education Program).
- Consider ways to shorten the education program for appropriate students.
- Prioritize developing PLA (Prior Learning Assessment) programs for foreign educated midwives.
- Offer shortened midwifery education program for nurses with relevant experience.
- Develop and evaluate multiple models of practice, some of which will retain midwives longer in the field.

For midwives to become essential to obstetric care in Canada—

- Eliminate the funding restrictions on the number of courses of care, allow midwives to choose their maximum caseload and evaluate over a three-year period what number midwives choose to attend and outcomes.

- Allow pilot projects of integrated models of care with midwives and physicians which have the capacity to support greater volume and improve integration of midwives into the health care system. Assess all outcomes, with particular focus on client satisfaction.

Integration of midwives and quality and safety of care

I recently presented at a McGill Medical School and School of Management Workshop called "Practicing Beyond Borders". I was asked to bring evidence from Quebec's recent Investigation into Stillbirths at the Birth Centres and Ontario's recent inquest into the death of a baby under midwifery care in Guelph. I'm going to present some of that material now. This evidence from Quebec and Ontario speaks to the most important elements of midwifery in Canada-quality and safety of clinical care-and it indicates that improvement is necessary.

There is a common assumption produced within midwifery that the current legislated model of practice represents the gold standard of maternity and midwifery care. This is an assumption not supported by available evidence and one which needs to be challenged in order for midwifery to mature as a health profession.

In 2000 there was a report released by the Quebec Ministry of Health, produced by a panel of midwives, physicians, and epidemiologists, who examined the rate and individual cases of stillbirths from the Quebec Birth Centers Pilot Project. In 2001 there was an inquest in Guelph, Ontario following the death of a baby under midwifery care.

These events and other coroners' inquests and coroners' case reports have produced some of the most instructive evidence to date of challenges facing midwifery and medicine in a struggle to work effectively together. In the Quebec stillbirth cases, the Guelph inquest case and numerous other coroners' cases, similar systemic problems have been identified in the ways the health care system and midwives currently interact. These problems have marked similarities and are consistently associated with mortality and/or morbidity.

Shared protocols with physicians

As we look at the recommendations from these events, the importance of moving towards shared protocols for midwives is key to improving the quality of care for midwifery clients. The central message of these reviews and inquests is that midwives and doctors need to make new progress in collaboration in order to improve quality of care.

I want to leave you with the thought that integrated practice models with physicians and midwives involve the development of shared protocols that might be a very positive step worth assessing in terms of quality and safety of care.

B. PANEL 1 – Are We Able to Meet Canadian Women's Needs?

This panel addressed the question, "Are we able to meet Canadian women's needs?" from four perspectives. Karyn Kaufman suggested that what is required is a framework to articulate the multiple needs of birthing women, needs that are sometimes discrete and independent of each other. This framework should be predicated on the overarching need for access to care. Two subsequent presenters, Jennifer Murdock and Margaret Haworth-Brockman, suggested ways to increase access to care. Jennifer presented an overview of a collaborative practice model for family physicians and midwives. Margaret provided an overview of the conscious and deliberate steps taken in Manitoba by the Equity and Access Committee of the Midwifery Implementation Council to make midwifery care available to rural and Aboriginal women in that province. The fourth presenter, Ann Liebau, took a step back from the question by suggesting that the profession of midwifery must be able to meet the needs of its members—thereby ensuring the sustainability of the profession—in conjunction with the needs of birthing women. She argues for more flexibility in models of practice, specifically part-time practice.

1. Midwifery's Contribution to Maternity Care: Are We Able to Meet Canadian Women's Needs?

Karyn Kaufman, RM, DrPH

Abstract

There are at least two possible answers to the question of our ability to meet women's needs: "Yes, of course we are" and "No, of course we are not". Both answers are correct.

An analytic framework helps us to understand the multiple kinds of needs that exist, namely:

- Communities/women need maternity care services;
- Women need services that are accessible and affordable;
- Women need (or want) those services from a variety of providers, including midwives;
- Women need care from appropriately skilled providers; and
- Women need safe, satisfying, and effective care from their provider.

When midwifery's contribution is considered in the light of each kind of need, a single answer does not suffice.

Midwives provide care in some communities to small proportions of women. Increasingly, there are areas of the country where maternity care is difficult to secure. Midwifery is as yet unable to address this situation.

The limited number of midwives limits accessibility and, in some provinces, services may not be affordable. Access often depends on geography, but also on early contact and networking. Even for those women who have access and make contact with midwives as their preferred provider, there are insufficient numbers of midwives available.

The inability to meet these kinds of needs speaks directly to midwifery's formative status and the lack of coordinated human resource planning. There are implications also for the organization of midwifery services.

Midwives are increasingly meeting the need to be appropriately skilled providers for the provision of autonomous care. Regulation, monitoring, and mechanisms of public protection are evolving. Questions for exploration include improving our understanding of who benefits most from midwifery care.

Findings to date suggest that midwives meet needs for safe, satisfying, and effective care. Individual personal responses from women are one source of

information. Systematic questions about satisfaction are another source. Clinical outcomes of mothers and newborns are yet another.

The ability of midwives to more fully meet needs depends on growth, retention in practice, organization of services, and participation in coordinated planning.

2. Project Link: Low-Risk Integrated Maternity Services Responding to the Crisis in Care

Jennifer Murdock, RM
Division Head for Midwifery, Department of Family Practice
Toronto East General Hospital

Thank you for inviting me here today to speak to you about how we can collaborate with family physicians to better meet Canadian women's and maternity care needs.

A collaborative model of care between midwives and family physicians to provide low-risk obstetrical care to women is accepted worldwide as an excellent example of high quality woman-centered care. A number of studies have shown that collaborative care models allow for increased access, increased client and practitioner satisfaction, as well as improved health outcomes.

~ What is Project Link? ~

An alternative model of providing maternity care to women and their families by linking the collaborative efforts of midwives and family physicians through the creation of shared-care, low-risk obstetrics.

I am very excited to be here today to speak to you about a project that I have been working on which I believe will enhance collaborative relationships between midwives and family physicians and help to meet women's needs, thereby making a meaningful contribution to maternity care. It is called "Project Link".

Before I begin my discussion about Project Link, I would like to give you some background about me. I am a registered nurse in Ontario and worked as a labour and delivery nurse until I was accepted into the first graduating class for midwifery in Ontario in 1993. In 1996, after graduating, I completed my new registrant's year and in 1997, with three other midwives, I opened a midwifery practice in the southeast end of Toronto. I completed my masters in Health Administration in 2000.

In 1999 I was appointed as the Division Head for Midwifery within the Department of Family Practice at Toronto East General Hospital. While I worked in the capacity of a primary care midwife, doing home and hospital births, my relationships with family practice physicians who did obstetrical care for their clients increased.

Common Goals and Shared Vision
Midwives and family physicians have a similar scope of practice for low-risk obstetrics, a philosophically common approach to family and women-centered care, and a desire to provide ample and easy access to clients.

It became apparent to me early in my career that although we had different professions, most of us had a shared vision and a common goal related to healthy maternal and newborn practice. That is, both our scope of practice and philosophy of client care were congruent.

As I continued practicing midwifery, it became clear to me that family physicians and midwives also shared similar barriers to their practice.

Barriers to Practice	
Midwives	**Family Physicians**
imposed "cap" on service and low numbers of midwives	decreasing number of MD's doing low-risk obstetrics
limited pharmacopoeia and laboratory ordering ability	inadequacies in training
difficulties in human resource planning due to existing model	limited support to sustain practice

Approximately 85% of childbearing women are classified as low risk. Currently midwives only provide 2 to 3% of this care in Ontario and, according to some projections, this percentage is not likely to increase for a number of years.

Family physicians in Ontario continue to provide only a small percentage of this care. This is most true of urban core family physicians who do intrapartum care for their clients.

Although the profession of midwifery is growing in Ontario, the numbers are well under 1,000. Each year the number of graduates only exceeds by a few the number of midwives either leaving the profession or taking a leave of absence. Midwives' limited pharmacopoeia and available laboratory ordering capacity, combined with their limited scope of practice in Ontario, curtails their ability to give seamless care to their clients. In addition to this, midwives have a cap on the number of clients they can accept, which also severely limits access for women. Most midwifery practices have waiting lists.

The model of midwifery care in Ontario further compromises the ability to create sustainable human resource planning due to the requirement for two midwives to

attend each hospital birth, instead of utilizing the already available expertise of nurses in the role of second attendant. As an aside, this particular stipulation has also been, in my opinion, a real barrier to hospital integration for midwives in Ontario.

Family physicians are also confronted with a number of barriers that make maternity care difficult to undertake and sustain. These include but are not limited to:

- Perceived and actual inadequacies in training and the inherent difficulties in finding appropriate and accessible continuing education in this clinical area; and
- The conflicts between professional and personal life and the rigors and unpredictability of continuously being on call for an obstetric practice.

Project Link is aimed at addressing some of these barriers to family practice and midwifery obstetrics through the development of inter-professional collaboration across the country in provinces where midwifery is legislated. Project Link is designed to link the collaborative efforts of low-risk obstetrical practitioners, primarily family physicians and midwives, by creating site specific, high quality, low-risk obstetrical clinical and educational programs.

Unique Skills and Expertise	
Midwives are…	**Family Physicians …**
experts in prenatal, intrapartum and postpartum care for mother and baby	have a larger medical knowledge base
excellent in providing informed choice	are able to provide care to both healthy and unwell clients
known for the appropriate use of technology	do "cradle to grave" care for their clients

Project Link creates true shared and collaborative models of care in each site by maximizing the expertise of individual practitioners and not having one profession substitute for the other. Clinics involved with Project Link will offer the full range of antenatal, intrapartum and postpartum care to its clientele while providing an accessible and evidence-based curriculum for trainees and practitioners.

Philosophy of Project Link	
Continuity of Care	5 practitioners, all known to the woman
	follow-through indefinitely
Informed Choice	appropriate time with clients to allow for information sharing and subsequent decision-making
Education and Research	emphasis on evidence-based practice, policies, and education
	promotion of research for low-risk obstetrical and newborn care

Project Link will incorporate a program philosophy which asserts the main tenets of midwifery care (continuity of care, evidence-based practice, and informed choice) while ensuring that the appropriate amount of time is spent with women and a high level of educational and research opportunities for trainees and practitioners is available.

Expected Outcomes of Project Link
increased access through a sustainable, shared care model
increased client satisfaction
decreased re-admission to hospital
improved maternal and newborn health outcomes
increased practitioner satisfaction

Most concerns regarding access and health outcomes for women and their newborns and professional satisfaction and integration will be addressed through this alternative model of practice. Ultimately it is anticipated that, due to the increased access to care, there will be a decrease in unnecessary hospital emergency visits and hospital readmissions and length of stays in maternal and newborn units.

Project Link can be initiated in any community where family physicians and midwives are available. Sites must have a critical number of midwives and family physicians working in the same facility.

The Team
5 practitioners on each team
3 midwives and/or family physicians
2 midwives and/or family physicians with a registered nurse as second attendant at hospital births
home births to be done with 2 midwives as usual

In order to truly have a shared care model, a combination of family physicians and midwives would be teamed up to no more than a maximum of five practitioners on each team. Each team would share the care for all the women on their team

and would do a 24-hour call, one in five (one day out of five or one day every five days). Staff nurses will act as the second attendant at all hospital births. Women choosing a home birth will be cared for by a traditional midwifery team as per the existing model.

Components of Project Link	
Evaluation	multi-centered (implemented at all participating sites)
Clinical and Education Programs	referral base
	curriculum
	workshops
Research	research assistant availability
	grant proposal preparation
Management, Administration, and Budget	support on-line
	billings and bookkeeping

Individual centres can implement all of or any portion of Project Link with the evaluation component being bare minimum.

In addition to the evaluation, Project Link offers standardized clinical programming, educational programming, assistance with research, management, budgeting, and adminstrative support for organizations.

The comprehensive evaluation will be implemented across all participating Project Link sites. Having a number of sites across various regions using the same evaluation criteria will enhance the quality of the evidence, allowing government policy makers and professional colleges to obtain the necessary information regarding health outcomes and efficiencies in this model of care.

Change is difficult and challenging to most people. Therefore, to ensure any successful model in practice we require a clear vision of the future and the ability to focus our energy to make the dream a reality. A strong infrastructure, policy forum, organization, and funding method is crucial.

The Low-risk Obstetrical Clinic will…
Link the efforts of midwives and family physicians to provide high-quality, low-risk maternity care to women and their families and education to trainees and practitioners in a collaborative model. This will be achieved by using the guidelines for Family Centred Maternity Care as developed by Health Canada.

It is my goal that Project Link, through excellent clinical and educational programming and research and management, will help to improve maternal and newborn health outcomes, allocation of resources for maternity health care services, decrease re-admissions to emergency units, increase client satisfaction,

and increase the satisfaction among those practitioners who are charged with the very important task of providing low-risk obstetrical care to women and families in our community—namely, midwives and family physicians.

3. Midwifery in Manitoba: Access, Supply, and Demand

Margaret Haworth-Brockman
Former Registrar, College of Midwives of Manitoba

This summary draws on highlights from Margaret Haworth-Brockman's presentation, "Delivering an Alternative: An Overview of the Regulation of Midwifery in Manitoba". Haworth-Brockman described the history of midwifery in Manitoba, with particular attention to the question of equality of access. She described the conditions that contribute to the present-day shortage of midwives.

History

The development and implementation of regulated midwifery in Manitoba was an enormous undertaking. Its history begins in the early 1980s and even before that, when women first began to reclaim their births and found other women who could help them do so. My own involvement began in the mid-1980s, first as a mother seeking a midwife's care and then as Chair of the Equity and Access Committee of the Midwifery Implementation Council. I worked in that capacity for over five years, as well as on other committees, until the College of Midwives of Manitoba opened for "business", when I became the first Registrar.

When we look at the question of access, we can see that, historically, women's choices for maternity care in rural and remote communities of Manitoba have been limited. Many Manitoba women must travel considerable distances to Winnipeg or Thompson because there is no obstetrical care available in their community. Women from northern and remote communities are transported to Winnipeg for childbirth. Moving from one centre to another always leads to a certain fragmentation of care. For Aboriginal women from northern reserves it can mean being flown to Winnipeg as much as two to four weeks before the expected due date, to a city where both the medical staff and the language may be unfamiliar.

The Midwifery Implementation Council was determined from the outset to ensure that this newly regulated profession should be available to all Manitoba women, that it would not become yet another resource only available to urban middle-class women.

The Equity and Access Committee was asked to consult with women across the province and document their concerns, suggestions, and comments for the development of regulated midwifery. Over two winters, evening meetings were held in 15 rural communities, reaching more than 200 women in all. Participants were very clear that they did *not* want geographical restrictions placed on Manitoba midwives when the profession became regulated.

The Equity and Access Committee also hosted numerous consultations with Aboriginal women in the province. In general the Council found cautious acceptance of the idea of regulated midwifery among these women. The Aboriginal women we met with agreed that midwives who are able to bring current, medical knowledge to a practice that also relies on more traditional, holistic, and culturally appropriate care, would be acceptable.

Following the consultations, the Council proposed that there be ensured, continued participation of Aboriginal women in the development and regulation of midwifery. Therefore, the *Midwifery and Consequential Amendments Act* requires a Standing Committee on Issues Related to Midwifery Care for Aboriginal Women (known as Kagike Danikobidan). The Committee was first convened, following passage of the bill, in June 1997.

It is not possible to cover all aspects of the many pieces that contributed to the eventual Proclamation of the Midwifery Act in 2000 in anything less than a book. (I wish to thank my colleague, Yvonne Peters, who contributed a great deal to this paper.) The *Midwifery and Consequential Amendments Act* identified midwives as autonomous health care providers. Coincidentally, the Manitoba Government confirmed the mechanisms to make midwifery care available as a funded service for women, including the means for payment to midwives and for collaboration with other health care providers.

Manitoba Standards for Care

Before regulation in Manitoba, the few midwives who provided care and attended births at home did not have admitting privileges, could not order or interpret diagnostic tests, and had only infrequent working relationships with physicians. This is in contrast to the many more midwives in B.C., Ontario and Quebec, who were in practice before regulation in those provinces, some of whom had ongoing working relationships with local physicians.

Since 2000 the Regulations and [the Midwifery] Act allow midwives to provide care in all settings. Decision on place of birth rests with the mother. Midwives must provide care in all settings and there are sunset clauses for midwives who are establishing their competency in one setting or another.

The Standard for Consultation and Transfer of Care includes protocols to maximize care by midwives, as appropriate to their scope of practice.

The Standard for Out of Hospital Birth criteria takes into consideration the geography and distance of communities in Manitoba. In the absence of conclusive evidence about what is acceptable for distance, the College does not assign arbitrary figures to distance, time to physician help, etc. Instead the onus is on the midwife and the woman to reassess the circumstances of the pregnancy and the

proposed place of birth. The midwife does have set guidelines for ensuring appropriate back-up, access to emergency assistance within reasonable limits.

Integration with Other Health Care Providers

Working with provincial and some local representatives, the Midwifery Implementation Council developed templates for how midwives and public health nurses, emergency measures personnel, and hospital staff could clearly define their roles and responsibilities for care of mothers and babies.

With thanks to our counterparts in B.C. and Ontario, in Manitoba we were able to bypass some of the friction expected when physicians and midwives began to work in collaboration. Some months before regulation was fully in place, we were able to secure a physician billing code for consultation with a midwife.

Assessment and Upgrading

Manitoba Health provided funding for 50 midwives (in groups of 10) to go through the Assessment and Upgrading, which was Manitoba's qualification and registration process. Briefly, we used a competency model for the process and over the years we developed an English-for-Midwives language course which provided familiarity with terminology as well as appropriate study skills and support. Proclamation of the *Act* was delayed until a number of midwives had completed the process and were able to register under the new regulation. There are 28 registered, practising midwives, seven of whom were trained in non-English-speaking countries.

Before the *Midwifery Act* was proclaimed it became clear that providing midwives to northern and rural Manitoba would be problematic. Therefore the Council actively sought, recruited, and held placements for midwives who said they were prepared to work outside the cities of Winnipeg and Brandon.

Education Programs

Following the establishment of the Assessment and Upgrading process, the Council's Education Committee devoted considerable time to developing a curriculum outline for a competency-based full education program. This was done, in large part, in conjunction with and with support from the Faculty of Nursing at the University of Manitoba. Briefly, candidates can be assessed for their knowledge and competency at any stage of the program, access is simplified by placing the early modules in the community colleges, and the program is designed to include a large distance-education component.

Currently the proposal for the education program sits on a shelf, unsupported, because no department of the Manitoba government will agree to fund the new program through the University or its affiliates. Without the developed curriculum,

a Refresher program, designed especially for foreign-trained midwives, is also undeveloped.

It is possible for midwives to train as apprentices in Manitoba. However, final assessment of some competencies depends on unreliable funding. Also, as is the case in the rest of Canada, midwives are so few in number that taking on apprentices makes for a very heavy workload.

The College of Midwives has recently supported the development of a PLEA (Prior Learning Education Assessment) process for Manitoba applicants. This too is awaiting necessary funding.

Access to Midwives Today

Currently, many Manitoba women do not have access to a midwife. With no education program in place Manitoba Health is relying on strategies for recruiting midwives from outside the province and that has not been too successful. This is particularly disappointing and frustrating for members of the public who led the fight to have a funded, regulated midwifery service. There are a number of factors that make it difficult to provide full access at this time.

1. Currently, the provision of midwifery services by a Regional Health Authority (RHA) is voluntary. (Since June 2000 Manitoba Health has designated a specific midwifery budget to cover the costs of employing midwives in the 12 RHAs in the province. In the 2000/2001 fiscal year, funding was provided for 26 fulltime midwifery positions. Of these, 16 are in Winnipeg and 10 are located in the rural and northern RHAs.) However, while Manitoba Health is encouraging all RHAs to provide midwifery services, it is not a mandatory service at this time. At the outset Manitoba Health believed it would be more politic to introduce midwifery care where it was wanted and where the effectiveness and value of providing midwifery services could be demonstrated. It is unlikely that midwifery care will become a required RHA service until there is an adequate supply of registered midwives and RHAs have had more experience with midwives. However, Manitoba Health may eventually declare midwifery to be a core service which must be provided by all RHAs.

2. Generally speaking, employed midwives can only provide service to residents living in their employing RHA. In certain circumstances, a RHA will accept an out-of-region client. However, as caseloads grow, it will be difficult to continue with such arrangements. As a result, most women living in RHAs which do not employ midwives are without service.

   Even where an RHA provides midwifery services, access can still be limited. RHAs do not yet have the number of midwives required to provide region-wide service; thus they have specified that midwifery services will only be

provided in a certain part of their region. Women living outside this specified part of the region can still get midwifery services, but they must travel to receive care, including for an out-of-hospital birth.

3. One of the most significant factors affecting access to midwifery care in Manitoba is the lack of supply of midwives. To provide midwifery care in all 12 RHAs we would require well over 100 midwives. As I mentioned, there are only 28 midwives registered with the College of Midwives of Manitoba.

Supply and Demand

As in other provinces, the demand for midwifery services is fast outstripping the supply of midwives.This is particularly true in Winnipeg where women are being turned away because of overflowing caseloads. Caseloads in rural Manitoba are not quite so heavy, but we believe that it is only a matter of time before they too reach their maximum.

There are only a few registered midwives who are not employed or practising in Manitoba. Training programs for new midwives and recruitment from outside the province are necessary to ensure significant expansion of midwifery services. This is especially true for providing culturally-appropriate care to Aboriginal women outside Winnipeg. The work of the Council, and the continued work of Kagike Danikobidan, generated a lot of interest in some communities and now there are insufficient midwives and no appropriate, funded means of training new midwives.

Recruitment and Retention in the Rural and Northern Regions

Not surprisingly, most midwives have opted to work in a city, mostly in Winnipeg. Where this is not possible, the next option is to work in a rural region that is close to an urban area. As a result it has been very difficult to recruit midwives into the north.

The RHA of Burntwood, which includes the city of Thompson and several Aboriginal communities in a vast geographical area, has funding for four fulltime midwifery positions. To date, they have only been able to fill one position.

The Prairie Women's Health Centre of Excellence will be undertaking research in the coming years which will look at recruitment and training models from other countries. The research will be used to develop policy about northern and rural health care to women, including midwifery care.

Conclusion

For two years now we have seen the fruition of the five and half years of preparation and work done by the Council and many others. In many ways we have demonstrated that it is possible to build feminist, and women-centred policy,

although it is clear we cannot consider the work done until midwifery is truly accessible to all Manitoba women. Despite the good attempts to make sure that midwifery in Manitoba would not be just another Winnipeg-based service, women are now without care in many parts of the province. Universal difficulties of recruitment and retention persist.

Research and evaluation and narrative projects will help document the success of the process, far beyond what can be covered in this short paper, and provide insight into what didn't work well. It is essential to keep the momentum of interest and good will, both in the community and in government. The challenge for Manitoba and the rest of the country is to ensure there are adequate budgets and support for new midwives to receive appropriate training and experience which is relevant to the communities they will serve.

4. Is It Possible for a Midwife to Practice Part-time?

Ann Leibau, RM, BA

Is it Possible for a Midwife to Practice Part-Time?

Slide 1

Is it Possible for a Midwife to Practice Part-Time?

- Can we accommodate part-time practitioners?
  - Midwives with young growing families.
  - Midwives in Semi-Retirement.
  - Midwives pursuing higher education / teaching / research.
  - Rural communities with smaller client base.

Slide 2

Can We Attract and Retain Young Midwives to the Profession?

- Providing flexibility for raising a family.
  - The majority of midwives entering the profession are entering their childbearing years.
- Providing adequate compensation for work.

Slide 3

What Works:

- Able to "keep my hand in" & practice profession I love
- Flexibility in scheduling clinic and home visits around family's needs
- Bring baby along sometimes – clients love it!
- Liberation from feeling indispensable
- Good family / community support essential

Slide 4

Challenges:

- Difficult to keep part-time
  - Difficult to limit caseload
  - Women's needs expand to fill all available time
  - Full-time demands for meetings

Slide 5

Challenges:

- Being on-call:
  - Being away from baby for long undetermined periods
  - Arranging on-call childcare
  - Client's family's needs more important than my own
  - Returning calls and pages while distracted/disrupted by children
  - Hard to sleep the next day

Slide 6

This Is What I See When I Walk Out the Door.

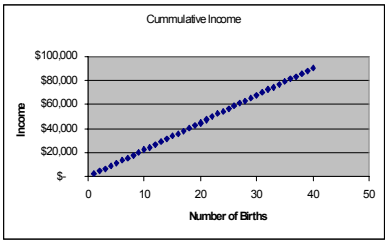
Slide 7

Challenges:

- Financially, it is volunteer work!

Slide 8

How Much Do You Make Working Part Time?



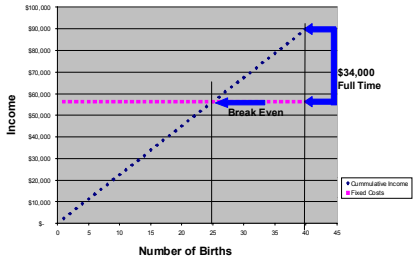
Slide 9

How Much Do You Make Working Part Time?

Fixed Costs	
Liability Insurance	$4,000
MABC Dues	$1,500
CMBC Dues	$1,200
Office Overhead	$24,000
Pager / Cell Phone	$840
Transportation Ins	$1,400
Transportation	$4,800
Nanny	$16,800
Continuing Education	$1,000
Equipment & Supplies	$600
Total Fixed Costs	**$56,140**

Slide 10

Income vs. # Births



Slide 11

This Is What I See When I Come Home.

Slide 12

5. Questions & Comments Session

Question: Should the number of births midwives can attend per year be capped?

Participant question for Holliday Tyson: Before we make an assumption that either by ramping up the number of midwives or ramping up the number of births that will customarily be done by most midwives, are we assessing, and has your data and your investigation assessed, the impact on those existing women in care?

Holliday: I think the point I want to make is that we don't have any clear evidence that suggests the optimal quality and safety of care is achieved by having "X" number of births and "X" number of hours. My point is to raise the question "If you get rid of any kind of cap, so let's say 40 per midwife and not 200 for 5 midwives, let's just say here are the principles of care and here is your scope of practice and we are going to pay you per course of care and just go to it." We have been investigating for over three years to see what people are actually doing—of course meeting needs is more than about maths. However, it *is* partly about maths and a lot of people express real frustration that they feel they could attend a lot more births and they are not able to, so I think it's a step towards addressing some of that. I don't think midwives are ever going to be Mother Theresa, we are not going to save everybody in the health care system that doesn't have a care provider, but we can certainly do better than we are doing now and there are no grounds to continue any kind of capping of numbers.

Question: What are the implications of increasing the number of spaces allocated in midwifery education programs?

Participant question for Holliday: I wonder if you have given any thought about how the existing pool of midwives would lobby and also respond to a statement about the entrant class size, that would change the number of graduates and increase it substantially?

Halliday: Sometimes my frustration is with people saying, "We really can't rush into increasing numbers because we may find something has changed in a few years." I think people must understand that by taking some time in the next year or so to make a change, the very bare minimum for a PLEA program is a few years before we will have people up and running. For an educational program, depending on how you construct it and whether it's a shortened course or the existing course, it will still be three to five years [before we see any results] and, as you are pointing out, it's more likely to be five to seven years.

Issue: Challenges to inter-collaborative relationships

Participant: A couple of years ago a colleague and I played with some numbers when we started to hear about this "crisis" idea and we worked out how midwives could actually do overnight shifts at local hospitals and catch all the normal births. We thought we would be such a great help to our obstetrics colleagues because they wouldn't have to get up except if there was a complex case. We worked out how many more midwives we would need in the practice so that each midwife could do one or two months of this shift system and we could literally provide all the low-risk care for the overnight 12-hour shifts, 7 days a week. We ran this by some friendly obstetricians in our urban area and they said frankly they needed to catch the low-risk babies in order to get paid enough to justify being on call.

More recently we approached the Head of Nursing about what she thought about midwives using the nurses as a second attendant at the hospital births because it was obviously what our colleagues were doing in B.C. She said, "Forget it, I've got a nursing shortage, and we are not going to take on your work as well."

This was in a very positive environment where we all work to similar protocols within the hospital, and I would just warn you that sometimes what we think of as great solutions are not remotely needed. Yet I was slightly frustrated, Jennifer, when I heard that your scheme, which is very exciting, needs a substantial number of GPs and midwives to do it. Again I'll harp on my hobbyhorse that there are vast parts of the country that don't have that luxury and I think that's where we need to start trying to find solutions.

Issue: Alternative payment plans

Participant question to Margaret Haworth-Brockman: I just have a question about Manitoba because I'm dying to know. I believe your midwives are salaried and work on an employee model. I wonder if you can give us a little information on the salary levels, how midwives are paid, and whether they get to choose who they work with, when they take their time off, and what sort of control they have within that employee model.

Margaret: We didn't do a course of care payment model for a number of reasons, which I can't go into right now. We were specifically directing care to women who were otherwise marginalized by maternity care. We felt that maybe a midwife would have to spend a lot of extra time with such a client. We also had concerns about what would happen if someone doesn't stay with a midwife for a full course of care for one reason or another. Also because we knew midwives would be very involved in all the administrative aspects of implementation, the committees, the college, the association, mental health, and all of that. So providing salaries to the midwives we felt would address a lot of those issues. It was contentious, not everyone is happy and it's been difficult. The midwives are still employed by a

regional health authority so the money comes from a separate pool, but they are now employees of the regional health authority, which has other difficulties.

The level of salary was worked out about five years ago in a human resource strategy prior to proclamation of the [Midwifery] Act, and at that time, Manitoba Health looked at various things, some of which were levels of payment for nurse practitioners, also the differences in payment in other provinces between midwives and family physicians doing very similar work. At that time, there was a four-stage payment model that was developed, for various reasons again, time is too short, but all midwives at the time of proclamation started at the same salary level, which I think was just over $61,000, but that was just salary. Manitoba then funded regional health authorities additionally for equipment costs, overheads, mileage, and all those kinds of things. The salary increment comes to the next level after 12 months of employment, not after certain hours of work, and that memorandum of understanding between the Midwives Association and Manitoba Health expires on June 8, 2002 and we will see what happens after that.

There is a top-up as well for midwives who work north of the 53rd parallel.

Issue: the perceived nursing shortage

Jennifer Murdock: I just wanted to respond very quickly to Judy's comment about nursing and the perceived nursing shortage. In our hospital we have just opened a brand new unit, which is enormous even though we have these wonderful LDRP's (labour delivery room postpartum), and more of them than before, it seems that our nursing crisis is really huge. I really appreciate that it can get the hackles up of a number of people, specifically nurses, who have to manipulate around the schedule, but the discussions that started to come out about nursing shortages are really the beginning of the discussion, and what became very clear as we started getting down to the reasons, was looking at the systems that were across the entire maternal-newborn health service, not just about nurse to patient ratio, but really about what is the appropriate delegation or allocation of nursing for certain populations within the family birthing centres. So, if we still believe that numbers of childbearing women are still low-risk, then in fact what is the need for a $35/hour nurse dealing with acute care situations, to take care of that low-risk woman four to five hours after delivery? And really what we are looking at now is saying, Okay, if the acuity is in an arc like this and the major amount of nursing care is central to labour, delivery and early postpartum, then in fact who is taking care of the details of this, i.e., early labour and low-risk postpartum after the acute stage? What we have come to discover is that, in fact, all of those nurses who have been allocated equally across the spectrum of well-woman care in the hospital could probably be flipped out of the early labour stuff and the late postpartum stuff, into the more acute care areas and can in fact see efficiencies in human resource planning and still be able to take care of and help out the concept of having a second attendant as nurse. I would also like to point out that the budget, which pays for midwifery or family physician or any other primary care provider, is quite a bit different from the

global budget that pays for hospital care. This tends to be a bit of a red herring when we say if we have a nurse working with a midwife it is going to cost more money, in fact it is not. Probably what costs the money is inefficiencies within the organization and how they support our community-based primary care practitioners.

C. Midwifery's Contributions to the Maternity Care Crisis: A Family Physician's and Obstetrician's Observations

Insights into the role midwives can play—both alone and in conjunction with other maternity care providers—in maternal-infant care in Canada, were offered by Dr. Michael Klein (a family physicians) and Dr. Jan Christilaw (an obstetrician). Dr. Klein emphasized the current support for interdisciplinary collaboration from the College of Family Physicians of Canada, but suggested that in order for midwives and physicians to remain in the maternity care game they must strive to keep childbirth "normal" lest it become the domain of surgical specialists. Dr. Klein suggested there is the potential for the debate on caesarian section on demand to overshadow the impulse for vaginal birth. He pointed to the small percentage of births currently attended by midwives in Canada and suggested that in order to secure a long-term role in maternity care, a larger contribution must be made. The small numbers, however, belie the leadership role midwifery is taking in educational and training initiatives in B.C.

In her presentation, Dr. Christilaw pointed to the demographic changes in obstetrics in Canada and the progressive, contextualized view of the determinants of women's health that obstetricians have adopted. Our present tenuous maternity care environment threatens our stellar rates of infant and maternal mortality due to funding cuts and human resource challenges. Dr. Christilaw suggests ways to address these challenges.

1. A Family Physician's Observations

Dr. Michael C. Klein
Chair, Maternity and Newborn Care Committee
College of Family Physicians of Canada

Introduction

While other organizations have been addressing some of the issues that came out of the London Conference on the future of maternity care, midwives should take great credit for being among the first, if not the first, to convene a conference specifically to address the evolving crisis. We all know that "crises" is not a favourite term, but we also all know that we are in the midst of an evolving serious problem and it is heartening to see the leadership by midwives on this important issue.

I don't actually represent Family Practice though I am a family practitioner and I am Chair of the Maternity and Newborn Care Committee of the College of Family Physicians of Canada. I would point out that this committee is an interdisciplinary committee made up of nurses, midwives, family physicians, obstetricians, paediatricians and others who, while under the auspices of the College of Family Physicians of Canada (CFPC), take a very broad view of their role in supporting all who are working in the maternity care field. The focus is on the needs of mothers and babies and only secondarily the needs of practicing professionals.

The Maternity and Newborn Care Committee was recently requested to consider whether it was necessary to have a position on "midwifery". This request came from the Executive of the CFPC. It should be understood that this is a very broad-based national organization, and the progressive attitudes of Ontario, Quebec, and British Columbia are not necessarily mirrored throughout the country-so for some members of the College of Family Physicians, this was an issue.

It may be of interest to midwives that the committee decided that it was not appropriate for one professional organization to take a position on another professional organisation. What we did do was to take what we considered to be a "high road" position and passed the following resolution to be delivered to the Executive of the college. "Be it resolved that the CFPC supports multi-disciplinary maternity and newborn care in which the various professions and individual providers (including physicians, nurses and midwives) uphold the principles of mutual respect, collaboration, self-regulation, standards-based practice and continuous professional development." This resolution was unanimously carried.

History

While it is beyond the scope of this conference to describe in detail the historical

context, it is perhaps astonishing that this group of midwives is focusing on the maternity care crisis in an era that is not so far removed from a famous, some would say infamous, conference that took place in Chicago in 1921. This conference was the annual meeting of the Society of Obstetricians and Gynaecologists of the United States and its then president, Joseph B. DeeLee, delivered his talk on the prophylactic forceps operation. Within that prophylactic forceps operation, of course, was found the exhortation to include routine episiotomy along with outlet forceps as normative for birth.

DeLee's talk actually established the discipline or specialty of obstetrics and gynecology and quite consciously wrested it from midwifery and general practice. It defined the specialty as a surgical discipline. There is a very important link between the current debate on caesarian section on demand and that 1921 conference. While we today consider our role in helping to resolve the maternity care crisis, in 1921 we see the origins of obstetrics and gynecology as a surgical discipline principally and, in fact, the movement of maternity care into the surgical domain. It is important to consider that if childbirth were once again reconfigured as a surgical event, then those with the highest developed technical or surgical skills would be the logical "managers" of this event. The role for family practitioners and midwives could eventually be relegated to an historical footnote. Our role therefore in helping to solve the maternity care crisis is also to keep childbirth normal.

If childbirth becomes increasingly a surgical event, then community maternity care without surgical support on site will be untenable and rural and remote maternity care would be abolished so that women would then be delivered in large factories by strangers.

Governments Can be Helpful or Harmful

In Quebec the Ministry of Health has in fact created a dysfunctional system that encouraged and continues to encourage the separation between midwives and medical practitioners with not good results for mothers and babies. The medical profession, of course, contributed, but so did the midwifery profession and the Ministry of Health and even lobby groups that wanted separation from mainstream medicine. The net effect has perhaps created a permanent separation between midwifery and medicine and it has continued to interfere with consultation and transfer-putting mothers and babies at risk. The research was reported in the *Canadian Journal of Public Health*. The results of the study are in fact more than a bit problematic. In my view it was not really a study about midwifery, it was a study about a dysfunctional system of care leading to outcomes that are not surprising-just what you would expect in a dysfunctional system.

It is manifestly unwise to be providing isolated care so removed from colleagueship as to be dangerous. So we are pleased that relationships in this province (B.C.) remain reasonably good despite funding debates, but if the B.C.

government expects cooperation from physicians, physicians should certainly be at the table when decisions are made about the model of care, as well as at the table for discussion of issues that have become so obvious in the current debate on regionalization/centralization and the closing of maternity units.

The Situation in B.C. and Where Does Midwifery Fit?

- In B.C., 64% of births (about 27,500) are attended by family physicians. This is down from 80% over the past 10 years. Midwifery births last year were at somewhat less than 2,400 or about 6% of births. Perhaps 40% of these were intended at home and resulted in a 20% transfer rate, approximately combining antepartum and intrapartum transfer. This transfer rate is appropriate.
- Obstetricians are responsible for 30% of births or about 13,000. However obstetricians are also involved in an estimated 20% of family practice and midwifery births in their consultant role, so that they also engaged in about another 6,000 births, not to mention their support role by phone and other means to help out family physicians and midwives.
- The problem for midwives is that even if they attend double the number of births 10 years from now as a result of new training programs at UBC and the arrival of new registrants from out-of-province, the total number of births attended by midwives will only be about 12% of the total-and this is optimistic. Midwife burnout, aging, and retirement are influencing the midwives just as they are the physicians.
- In consequence, if midwives want to have an important and powerful impact on the health of mothers and babies in the province, they will need to be engaged in the totality of the discussion on the maternity care system and not merely the 6 to 12% of births attended by midwives.
- The geographical and practice patterns of the province would suggest that midwives would continue to concentrate in the main population centres in the province—as they need the same backup that family physicians need and because the demand is not yet apparent in smaller communities, though it is there in the background. It is all a question of volume and the right volume to sustain a group of midwives so that they can have a life and avoid burnout. There are of course a few intrepid midwives working alone or in pairs in communities of 100 to 300 births, but this is rare and sustainability issues demand creative solutions.
- So to have a real and sustained impact on maternity care, we all need to get beyond the next woman who comes in the door of the office. Midwives working in consort with others need to change the system itself. Internationally the greatest contribution to the health of women has occurred when midwives take on difficult populations of special need. Examples might be the rural populations of Appalachia in the United States, including the well-known Tennessee project.

The Role of the Division of Maternity and Newborn Care

In our division, obstetricians, family physicians, midwives, nurses, and doulas are all working together and midwives are providing leadership, really putting themselves out and making a huge difference in the reconfiguration of birth itself. Midwives are involved in:

- Curricular change at the undergraduate level for medical students, nursing students and, in the future, midwifery students, including transdisciplinary education, role modeling of the normalcy of birth, the development of new care models and in evaluation, as well;
- One of their greatest contributions now in the division has been to assist with the Adopt-a-Medical-Student Program and the direct mentoring, what the medical students call "shadowing", where our midwives have made themselves available, with great support from their patients, so that first-year medical students can be exposed to normal maternity care practice very early, before their obstetrical clerkship in the third year. Out of such programs has also come the doula training program for first-year medical students, which has been facilitated by the medical students themselves with the cooperation of Kathie Linstrom at Douglas College. Family physicians have also been heavily involved in this, but it is fair to say that midwives have taken a lead and for the first time are coming out of their offices and engaging directly in the system, in the educational enterprise, in a way that will have a profound effect that goes well beyond individual women clients. This is an example of how the impact of midwifery care can extend beyond the 6 to 12% of women cared for by midwives. It is a first step but a very important step in actually changing the system for all women.

What Else Can Midwives Do?

- Catalyze the development of new models of care that are flexible and adaptable to the many conditions of British Columbia. In some communities the arrival of a midwife can stabilize the community's maternity care scene. Many family physicians are aging and under strain and giving up maternity care. When a group of family doctors supporting each other is down to one or two, each one is thinking of quitting maternity care. The arrival of a midwife, and given a new and creative method of financially supporting their work, can lead to the continuation of maternity care service that would otherwise be lost.
- In other communities the arrival of a midwife or midwives can lead *inadvertently* to those who where hoping to quit to actually quit, but without the backup of physicians, maternity care would be lost.
- In still other communities the effect of the arrival of midwives can be neutral.
- Ideally, on a community-by-community basis, midwives, family doctors, doulas, and specialists (obstetricians if present, general surgeons and other specialists if present) in the community itself will open a discussion about the

particular needs of the community. This happened in Nelson with the leadership of midwives, but it occurred very late in the process and we don't know the outcome. Nevertheless midwives have played a key role in that community and have been respected and appreciated by family physicians and the obstetrician of Nelson. Out of such interaction a community sustainability plan has developed. The plan takes into consideration on- call surgical backup, transfer needs, and lastly and very importantly, the various financial models that would be needed to sustain it. If it begins with financial battles it will go nowhere. It needs to start with *the needs of women and babies* and then the financial models to support it follow logically.

- Then the regional authority and if necessary the Ministry of Health is approached by a consortium representing the various disciplines in the community. The approach is not about the needs of any professional group but the needs of women and families.
- The linkages to the rest of the health care system of the community and region are spelled out. While maternity care is a lynch pin for the community itself, the relationship between having a viable and hearty, vigorous maternity system and the emergency room and the primary care system needs to be detailed. Those mainly concerned with short-term financial issues need to be educated to the quite dangerous consequences to the community of maternity care.
- This whole issue is spelled out in the enclosed article that will come out in the June issue of the *Canadian Family Physician*. This article was handed out at the conference and will be included as an Appendix to proceedings. The article is written by myself, the President of the Society of Obstetricians and Gynaecologists of Canada, Stewart Johnson, a family physician for rural B.C., and Elaine Carty.

Midwives as Indispensable Members of the Health Care Team

It is clear that if midwives remain closeted either at home or behind closed doors in maternity care facilities they will have a limited impact. In an era where physiotherapy, massage therapy, and chiropractic care have been delisted, it doesn't take much imagination to recognize that midwives could be next. Therefore, even from the point of view of self-interest, not to mention the needs of women and newborns, midwives need to make themselves indispensable. Those who are now working within the Division of Maternity and Newborn Care have understood this. They are involved in undergraduate education, postgraduate education, and reshaping birth. They are joining hospital committees; they are focusing on demonstrating that birth is a healthy phenomenon. And most importantly, they are talking to women in their practices about how important it is to educate the next generation of doctors, nurses, and midwives so that the women will have caring people to assist them in their birth and the birth of their grandchildren.

Serving a small niche market of women who want midwifery care at home or in hospital is important, but it will do little to advance the care of the majority of women in the province and the country. The difference that midwifery care can bring to the overall care of women goes well beyond the interesting debates about episiotomy or cord clamping timing or the use of Vitamin K, or even in a certain sense about choice itself—though choice of course is very important. Vaginal childbirth itself is under attack.

To make themselves indispensable to the health care system, midwives need to be visible everywhere. Yes, I know it takes time and you don't have time and family physicians are going through exactly the same thing. At the University of B.C. we, family physicians, are taking a major piece of the undergraduate curriculum and we don't have the time either.

Midwives working with the rest of the team need to develop new models, including birth centres where family doctors and midwives and specialists backing them up can demonstrate that it can be fun and effective. The Health Transition Fund offers an opportunity to develop such models.

Watch Your Language

Using terms like "the medical model" or "patriarchy" versus the midwifery model is not helpful. These terms are admittedly shorthand for things that we all in fact understand. The people in this room understand it, but once we leave this room and speak to a wider community, it is more off-putting than helpful as it creates tension and defensiveness. I think it would be much more helpful, even though the characterizations are often true, to stick to the facts. Terms like "the medical model" most importantly don't win friends. What I mean by talking about the facts is to speak directly to the practices that are not evidence-based. Talk about optimal practice approaches that lead to optimal outcomes and define the outcomes that are desirable. For example—

- Enter the debate about caesarian section on demand. Question the evidence.
- Question the evidence about pelvic floor functioning problems as a result of normal childbirth.
- Remind people about the complications of surgery itself.
- Go well beyond the discussion about complex forceps and the potential damage to the pelvic floor. It is wonderful that Vicky van Wagner is debating this issue at the upcoming conference in Toronto in November 2002.
- Get into the debate on the nature of informed consent and the nature of choice.
- Question the routine use of epidurals and their consequences in raising the caesarian section rate.
- Talk about the routine use of episiotomy in the presence of forceps. The overall debate on episiotomy seems now to be largely settled, but many physicians still do routine episiotomies when forceps or vacuum are applied.

- Get into the debate about early admissions to hospital and what we can do to prevent them in order to make it less likely that the well-known obstetrical cascade takes place.
- Support programs, including research programs, that look at the effect of early labour support at home by nurses.
- Collaborate in doula research.

These are all examples where many allies can comfortably join the discussion and it avoids what is essentially name-calling when you talk about the medical model. We all know that some physicians can practice a very supportive caring practice that represents the best of midwifery practice and we know also that some midwives can practice a style that is not very dissimilar from interventionist, so-called medical practice.

Some Questions for the Floor

In this section of this paper I am going to describe what I think took place between myself and the audience when I asked a series of questions, first about vaginal birth and the pelvic floor and later about home birth. I posed the following questions to the audience:

1. How many of you think that vaginal birth damages the pelvic floor in a significant proportion of women?
2. How many of you think that it does not?
3. How many of you think that the literature regarding pelvic floor functioning-comparing vaginal birth with caesarian section-is flawed or at least vastly overstated?
4. How many of you think that those who counsel women about the advisability or even acceptability of elective caesarian section without communicating the risk factors for mothers or babies are in a conflict of interest position?
5. How many of you think that it is therefore unethical for those in such a position to give counseling?

The responses from the floor were interesting. For questions one and two there was a great deal of discussion and argumentation. People were offended by the first two questions, which they thought they were vague.

When we got to questions three, four, and five, the audience clearly felt that the science behind the so-called caesarian section on demand promotion by organized obstetrics and gynecology is absent. There was strong agreement about this in the audience. And this is true. We in fact have a situation where there is a distortion in the literature on pelvic floor functioning. The description of the risks of operative birth should cover both short- and long-term morbidity such as infection, newborn risks, placenta previa, and fertility issues, increased hospital admission rates, and even excess maternal mortality.

We obviously need to talk to women about how they are being taught that their bodies are defective and that they are incapable of managing childbirth without drugs and surgery. We need to join collaborative research on normal pregnancy.

In the next set of questions I discussed home birth and informed consent in general, and based on the home birth demonstration project results published in mid-February in the Canadi*an Medical Association Journal* (2002), asked the following questions:

1. How many of you think that home birth is safe?
2. How many of you think that home birth is unsafe?
3. How many of you think that it is not clear that home birth is safe or unsafe?

Again there was animated discussion from the audience. Virtually everybody in the audience said that home birth is safe. Nobody said that home birth is unsafe, and a few hands went up to indicate that they were not clear on the issue.

As a researcher in the home birth demonstration project and someone who has followed the literature very carefully, and as one of the authors of the B.C. Home Birth Demonstration Project, I can tell you that my interpretation of the data is as follows:

- Home birth is not what the media said it was. The media focussed on the fact that home birth was safe. They did this because the fact that home birth is unsafe is not news. We have been talking about unsafe home births for years in the era of unregulated midwifery. What was news was that home birth could be interpreted as safe.
- The home birth demonstration project is not what the anti-home birth folks took from the study either.
- It is also not what the home birth advocates took from the study.

The home birth study is wonderfully ambiguous. There seem to be major advantages for women in terms of reduced intervention rates of all sorts in the home birth group and somewhat less but similar trends in the midwife hospital group compared to the physician group. This study is not a randomized, controlled trial. There are, however, some outcomes that are potentially problematic. It appears that babies born in the presence of meconium may be disadvantaged if they are attended at home. These babies come from ostensibly normal pregnancies and labours and the situations are not predictable. Ultimately these babies in this small sample did well short-term but the study was too small, and was always known to be too small, at somewhat more than 800 births, to be able to address infrequently occurring outcomes.

If the trends found in this study were to continue, home birth would be considered to be unsafe. Therefore it is very important for midwives not to overstate the importance of the home birth demonstration project vis-à-vis

safety. What we concluded was that home birth appeared to be *safe enough* to continue and what is necessary is long-term study.

I mention the home birth demonstration study in the context of what midwives can do to help with the "maternity care crisis" because overstating the results, and claiming safety and being immodest about what the results show, works against midwives in the debate on the future of maternity care. This is principally because it creates enemies out of people who can be allies.

I think that people missed the point about what home birth is about. Home birth is about choice. Its relationship to organized midwifery is about the reality that women will continue to have babies at home with or without regulated midwifery. If it were offered under organized midwifery, it would be *safer* than it would otherwise be under unregulated midwifery. And if it would not be offered under regulated midwifery if would be in the hands of unregulated midwifery, and we could expect the same kinds of outcomes that lead to the various coroners' cases that led to the organization of regulated midwifery in the first place.

In other words we would wind up turning the clock back, leading to results that none of us would like to promote. So overstating the results will hurt midwifery and gives a gift to your detractors. It allows them to say "I love midwives, I just hate half of what they do". Then they can dismiss you. They need to be educated that midwifery is about making childbirth and home birth as safe as possible. Tactically, if you don't overstate the home birth story, you demolish a major distraction for those who are less than friendly to organized midwifery.

Why have I juxtaposed the two questions on pelvic floor in vaginal birth with home birth? I have done this because I wanted to point out how basic biases exist within all professional groups and midwifery is not exempt. It was clear that the audience did not believe the research data on pelvic floor dysfunction as a result of normal childbirth and it is perfectly true that the literature supports evidence of some dysfunction, though that literature is regularly misinterpreted by the zealots who would promote caesarian section on demand. So, midwives reject that literature.

On the other hand, midwives in the audience accepted the literature that home birth was safe, and I submit to you that is because of the obvious bias of the midwifery community towards home birth. *You can't have it both ways.* If you are going to be intellectually honest you need to demand evidence of high quality for the positions that you take. You need to do it across the board and not just for those issues that fit with your own biases.

I hope you recognize that this criticism is coming from a friend who wants to see midwifery remain effective in the ongoing debate on all issues as they affect the health of babies and women. I am advocating for consistency. I am not talking about anything else.

I have to admit that as a family physician I feel that this whole debate about home birth is about apples and oranges. If we look at the home birth study in B.C., we were studying highly-motivated women who chose home birth and a midwife and well-motivated women who chose hospital birth with midwife, and making comparisons against an unselected group of women who were geographically in the same locations who went to an unselected group of doctors. As part of the modesty of the results debate, I would point out to you that we really don't know what the results would be like if we looked at a group of doctors practicing a style of practice that was supportive, intimate, non-interventionist, confident, and women-centered. Such doctors do exist and wouldn't it be interesting if the results for them were extremely similar as the results for midwife care, at least on the hospital side? That has not been studied yet. But that is subject for another discussion and another research project.

Conclusion

We are all in the same boat. We need all the help that we can get. It is about sustainable models. We need to support midwifery, but first of all we need to support women and change the system. It begins at the undergraduate level and that is where B.C. midwives are making a huge contribution. To sum up:

- We need real role models that our trainees can and want to emulate.
- Let's speak respectfully about our non-midwife colleagues that attend birth so that we can build bridges.
- Let's practice evidence-based medicine and its appropriate application.
- Let's insert ourselves into the life of all the institutions in which we work, meaning journal clubs, quality improvement exercises, patient education, research into normal pregnancy and birth, supporting nurses, doulas, and midwives.
- And let's advocate for women, babies, and families in the communities where they live.

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2. Perspectives on the National Maternity Care Crisis: The Search for Solutions

Dr. Jan Christilaw
President, Society of Obstetrician-Gynaecologists of Canada

In her presentation Dr. Christilaw pointed to the trend of women dominating the profession of obstetrics in Canada and related demographic changes. She also pointed to the progressive, contextualized view of the determinants of women's health that obstetricians have adopted. She stated that it is imperative for interdisciplinary care providers to work together. Such relationships can be fostered through shared educational models and the quick resolution of territorial and financial issues. Dr. Christilaw also pointed to the global context of maternity care, noting we must think of maternal mortality as a social justice issue. She highlighted the importance of supporting and fostering Aboriginal midwifery in Canada.

Dr. Christilaw's presentation is summarized below.

The Changing Face of Maternity Care in Canada

- The medical model
- Historical forces
- The women's health movement
- The rise of midwifery
- An opportunity for a new model

The Evolving Face of Obstetrics

Demographics in obstetrics in Canada are changing: 80% of incoming residents are female and 50% of practicing obstetricians are female. Women want more balanced lives; they don't want to sacrifice childbearing for their careers. The 2000 Task Force on Women's Health re-set goal posts for obstetrician/ gynecologists.

Women's Health

Obstetricians in Canada have adopted a determinants of health perspective, embracing the view that, "Women's health involves women's emotional, social, cultural, spiritual and physical well-being and is determined by the social, political and economic context of women's lives, as well as biology. In defining women's health, we recognize the validity of women's life experiences and women's own beliefs about, and experience, of health."

Issues Identified by the Task Force on Women's Health (2000)

Women's Health Issues
- Income and social status
- Sexuality
- Education
- Culture
- Violence

Health Care Delivery Issues
- Access to health services
- Health care reform
- Role of obstetrician-gynecologists

Society of Obstetrician-Gynaecologists of Canada (SOGC) Organizational Issues
- Organizational Development: The challenge for all levels of SOGC is to review strategically and act on the implications of the determinants of women's health.

The Status of Obstetrics in Canada

According to the United Nations maternal mortality figures, Canada ranks number one for the lowest maternal mortality at 4 in 100,000. The United Nations Educational, Scientific, and Cultural Organization's (UNESCO) figures for 2001 state that Canada also ranks first in perinatal mortality, tied with Denmark.

Threats to Maternity Care in Canada

- Funding
- Human Resources
- Nurses
- Midwives
- Family doctors
- Obstetricians

Sustainability of Human Resources in Maternity Care

- Recruitment problems
- Lifestyle
- Medico-legal challenges
- Competing career options
- Sustainability of those in practice
- Burnout
- Aging of providers with career shifting

Human Resources: Obstetricians

There are 1,400 obstetrician-gynecologists in Canada. Of these, approximately 875 do maternity care. 30% are over 55 years old. At the same time residency programs are not full. SOGC has been predicting a crisis in obstetrical care for a decade. And the numbers will continue to fall unless the trend is reversed.

Another trend is towards practice in large groups in large centres.

2002 Canadian Resident Matching Services (CaRMS):

Why do Residents Choose Obstetrics?

- The number one reason residents cite is a positive role model or mentor. There is also a perceived "usefulness". Also desirable is the mix of skill set: surgical, obstetrical, counseling, and office practice.

Why Not Obstetrics?

- lifestyle
- medico-legal
- CaRMS match
- practice issues
- reimbursement issues

Possible Solutions to the Crisis in Obstetrical Care

- new practice models
- promotion of the specialty
- address issues at the heart of the matter

How Silos Form

- historical and political rifts
- lack of trust because of lack of communication
- education, starting from day one, reinforces it.
- different skills sets assigned different values
- territorial issues
- philosophical differences
- media/public perceptions

How Silos Fall

- collaborative educational models
- resolve territorial and financial issues (e.g., alternate payment plans).
- opportunities for dialogue and the setting of common goals

Maternity/Midwifery Needs of Aboriginal Canadian Women

This is an area of great and unique need. The Aboriginal Health Committee of SOGC includes a subcommittee of midwives. Also, a working symposium is planned at the Annual Clinical Meeting in Winnipeg in June 2002. Aboriginal midwifery must be supported and fostered.

Addressing Changing Expectations

- the question of caesarian section on demand
- Is more choice good or bad?
- the role of midwifery in stabilizing the slippery slope

How Big Can This Picture Get?

We need to accept our role as citizens of the world. This means accepting our responsibility to work for the welfare of all women, Canadian and other wise. Canadians are taking a leadership role in the global struggle to lower maternal mortality.

The International ALARM (Advanced Labour and Risk Management) course is now in 22 countries. We have partner projects such as the one in Uganda and consultancies as in Kosovo. We need to have more collaboration with midwives.

Every minute 380 women become pregnant and 190 women face an unplanned or unwanted pregnancy. Every minute 110 women experience pregnancy-related complications, 40 women have an unsafe abortion, and one woman dies.

Maternal mortality is social injustice. Maternal mortality is rooted in women's powerlessness and unequal access to employment finances, education, basic health care, and other resources.

What is the way forward? To see a decision node as an opportunity. To develop collaborative models in education, practice, and logistics. To restore the wonder—not just of birth but of birthing. To build on each other's strengths rather than exploit the weaknesses.

Can we change obstetrical models and still keep our place as the best in the world? Of course we can.

3. Questions & Comments Session

Issue: Home Birth Demonstration Project (HBDP)

Participant: I think we just have to be careful. As you said, there were only 854 (in the study population). It looks as if home birth for low-risk women with registered midwives is as safe as having that same birth in the hospital with these provisos and that we need to continue to study the numbers.

Michael Klein: Yes, I think we have almost got it right, I would agree with 90% of what you said, within the confines of the 800 odd births that took place during the HBDP. We know on the basis of statistical power calculations that we don't have enough numbers to deal with the question of unexpectedly flat babies or babies with excess ventilation, and so we then nevertheless followed those values in the study. What we found was that there was a slight, apparent concentration in the home birth group. I don't know whether you give women the study, or give them a summary of the study, but I think in the end it's a balanced discussion on informed consent and if everybody does more or less what you suggested, that's fine. I also think in your public discussions with the College of Physicians and Surgeons, and all the rednecks we have to deal with, you have to bend over backwards to be modest about the results and if you do that, you basically cut their ability to get distracted on some issues, so that now you can talk about collaboration. Whatever you may feel, if you present it in an understated way, you are going to be fine.

D. Working Together for Solutions: Perspectives on the National Maternity Care Crisis

Dr. Bob Woollard
Head, Department of Family Practice
University of British Columbia

Let us neither exalt our importance nor abrogate our responsibilities. We are all here today under one roof because we care about mothers and babies and because we might have something to offer.

Mothers will deliver without us but some will need us. So let us be humble in the face of that need and in the eyes of each other to work together so that the future continues to deliver exemplary care to all women wherever they choose or must have their babies.

I prefer not to call this a crisis because that-like interventional obstetrics-tends to call forth an immediate response, using existing resources and processes with a demand for rapid resolution even if the outcome is less than optimal. Like a woman in labour who is showing some signs of distress, it is best to consider very carefully both the nature and the urgency of any intervention. After all, like the usual labouring woman, the current pattern of obstetrics care *at the present moment and in the usual circumstances* is producing healthy babies (and moms). Our aggregate fetal/maternal morbidity rates are (as they should be in a wealthy country) among the best in the world. Clearly, among certain populations (Aboriginal, especially Inuit, and inner city), morbidity rates are at unacceptable levels, to our enduring shame if we do not solve this thorny problem as we seek to address the current "crisis". And equally clearly the trends in the retention and renewal of the various caregiving professions that assist women in healthy deliveries-like an abnormal fetal heart response-will be ignored at the peril of the patient's health.

So let us look briefly at some of the signs of distress, but first let's look at some normal variants:

- Variance in specialty involvement;
- Variance in intervention rates;
- Variance in locale of delivery.

All complex areas of variance, but if the *only* measure is fetal/maternal mortality (not resource utilization, not equity of access, not family costs/choices, and not the total experience of birth), then by global standards we are doing okay.

BUT—

- Fewer graduating medical students are choosing obstetrics.
- Fewer family practice trainees are planning to include obstetrics in their practices.
- Distressingly few spaces are available for the education of midwives.
- Ever larger numbers of an already aging cohort of family doctors are leaving obstetrical practice.
- Recent surveys in B.C. indicate that a disturbingly high percentage of the already small numbers of midwives are "burning out" and thinking of career changes.
- Regionalization/centralization threatens the distribution of obstetrical services to those most vulnerable.

So this looks like a rather worrisome monitoring strip. But those in the active practice of obstetrics realize that an obsessive focus on the numbers, beat to beat variations, etc., has limited value in gaining an assessment of the entire situation and even less in tailoring the response.

To push the analogy of birth perhaps beyond the breaking point, we need to consider the team required to respond to a challenging situation-and this must embrace all the immediate care groups but extend beyond to include (as in the best of maternity care) the patient (in this case the families and community of women who need our services) and the institutional supports for our services-in this case the government.

It's important to avoid any of us acting precipitously, but with all deliberate speed.

E. Luncheon Talk – Building our Contribution to Maternity Care
Midwifery Education – Supporting our Students

Elaine Carty, MSN, CNW

In her talk on the roles and responsibilities of midwifery educational programs, Professor Carty noted the importance of educating aspiring midwives about their social responsibility for promoting maternal and family health. She offered a set of principles to guide educational programs to meet these ideals. She also emphasized the importance of the role the larger community of midwives plays in contributing to student-midwives' educational experiences. In an era of caesarian section on demand, increasing midwives' numbers through educational programs is essential to preserving the normalcy of birth.

Midwifery Education – Supporting our Students

Elaine Carty, MSN, CNW
Professor, School of Nursing, University of British Columbia
Director, Division of Midwifery, Department of Family Practice,
Faculty of Medicine, University of British Columbia

> Two women
> were standing in shadow
> one with her back turned.
> Their talk was a gesture, an outstretched hand.
>
> They talked to each other,
> And words like "summer",
> "birth", "great-grandmother"
> kept pleading with me,
> urging me to follow.
>
> from Della Pollock, *Telling Bodies, Performing Birth*[1]

What is it about stories of birth that draw us in? They are women's stories, stories built out of scraps of memory, stories of tenderness, of pain, of strength, of sadness, of disappointment, of love. They embody the politics at the heart of the debates over reproductive technologies, place of birth, pain relief in labour, and type of delivery. The trend, as seen in some parts of the western world, towards epidural anesthesia for every labour, for caesarian delivery as the optimal birth choice, is a result of a society focussed on risk, technology, cost-effectiveness, time-management, and control-and of a health care system that embodies these characteristics. Health care systems around the world need midwives to be with women, to assist through birth, to believe in normal birth. We must be caregivers giving care in a way that women can receive it, so they can come through the experience with a knowledge of the uniqueness and power of their bodies. We are called on to assist women, to nurture, and to be, in Sheila Kitzinger's words, an "anchor when there is fear and pain; to be a skilled friend who is in tune with the rhythms of birth, the mountain tops and the chasms, the striving and the triumph".

If we lose normal vaginal birth as the way most babies are born, birth stories will disappear. To borrow a post September 11th phrase: *The world will never be the same again.*

But maternity care providers and particularly midwives are scarce. The need for educational programs is crucial to the survival of the profession and, consequently, to the survival of normal birth. One task of the educational program will be to increase the numbers of practitioners who can contribute to

changing the climate around birth. But there are other tasks as well. The students will be educated not only to assist women with birth but also to focus on their social responsibility for promoting maternal and family health in their communities and with government. And, in the broadest sense, I hope the program will contribute to a society where birth is not feared.

The educational program must be structured in such a way that new graduates gain some experience in thinking about and working at all levels of society. How will we do that?

We will need to articulate our values about the educational endeavour. The Boyer Commission on educating undergraduates, particularly in a research-intensive university, presented the notion of the university as an ecosystem.[2] A vital environment can be forged through the interaction of faculty, clinicians, students, and ideas. Students must be allowed to flourish, enjoy diverse experiences, and become or continue as independent and self-reliant learners. They must experience a high-quality learning environment with a genuine sense of community. Bringing the two notions together, a learning community makes connections among the teachers, students, subject matter, educational purposes and goals, the university as a whole, and the larger world.

We are fortunate at the University of British Columbia (UBC) to be in a research-intensive environment. The spirit of inquiry is what underlies the development of new knowledge. Our students will have an opportunity to learn through inquiry because all faculty members are involved with the research process. They will learn in an environment where knowledge is generated as well as transmitted.

I want to thank our colleagues in the Ontario program for supporting us and providing us with the materials of their curriculum, including situation-based cases that will encourage the students to learn through discovery.

The Boyer Commission also emphasized three other important characteristics for educational programs, which we will work towards in this program.[3]

1. An appreciation of arts, humanities, social sciences, sciences, and the opportunity to experience them at any intensity and depth the student can accommodate, should be encouraged. Faculty in other disciplines who will be sharing their own fields of study and research will teach a number of the courses in the UBC program (e.g., biology, pharmacology, history, philosophy, microbiology, women's studies).

2. Another recommendation of the Boyer Commission is an appreciation of interdisciplinary work. Midwifery, family practice, nursing, and obstetrics and gynecology are coming together to structure opportunities for our students to work together at points along the curriculum. Eventually we hope that we can have students coming and working synergistically not only in the educational

realm but also in practice and research. Students will also have access to many courses, such as international health and Aboriginal health through the College of Health Disciplines.

3. The final recommendation of the Commission was to stress the importance of providing training in the skills necessary for oral and written communication at a level that will serve the student both within the university and in postgraduate, professional, and personal life.

All of this needs to take place in the context of careful and comprehensive preparation for whatever may lie beyond graduation.

What this careful and comprehensive preparation is aiming for is competence. A recent review of the literature on competence published in the *Journal of the American Medical Association* defined competence as: "The habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served."[4]

An awesome task indeed. And all of you will be involved.

I realize that in addition to all the clinical and committee demands on your time, many of you are already involved in the teaching enterprise, working with students in Ontario and conditional registrants in B.C. On top of all of this we will soon be calling on everyone in B.C. to examine their own talents and values and, I hope, to consider their willingness and desire to work with student and to be an effective mentor for students.

We all have experienced working with a good teacher. I hear students all of the time telling stories, not unlike birth stories, about their experiences with their teachers. And these are birth stories of sorts, the experiences of the labour of going to school, the tension at the time of the synthesis paper and clerkship, and the reality of the postpartum period in the first few months of practice.

As the Director of the School, I feel a heavy obligation to our potential students, an obligation to provide an experience that will result in a positive learning/birth story for the four years of their endeavour. How can we, the school and the clinical faculty, with whom they will be working on a day-to-day basis, provide them with a developmental experience, even though tough, that they will cherish forever?

I will come back to Della Pollock and a quote from her book, which comes after a discussion of the importance of trust and respect in the caring relationship during birth.

I just opened to receiving
what was there.
I will never be the same.
I will *never* be the *same*.
Because the experience of being loved was so profound
that I couldn't deny it. And that's something very
difficult for me.
It's not very hard to love
but it's very hard to be loved.
So, I don't,
I don't think
there's any
closing that door...
again.[5]

Well-taught students, trusted and respected students, say they will never be the same again. They, too, talk about never closing the door, the learning door. It's very exciting that we can all work towards the education of new midwives who have the important and critical task of contributing to the maternity care needs of this country at this particular time in our history.

Endnotes

1. Pollock D. Telling bodies, performing birth. New York: Columbia University Press; 1999.
2. The Boyer Commission on Educating Undergraduates in the Research University. Reinventing Undergraduate Education: A Blueprint for America's Research Universities. New York: StoneyBrook University; 1998.
3. Boyer Commission, 1998.
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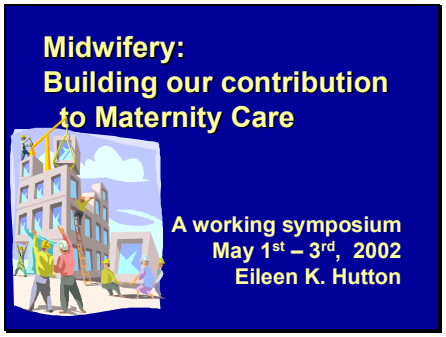
5. Epstein RM, Hundert EM. Defining and assessing professional competence. J Amer Med Assoc 2002 Jan 9; 287(2).
6. Pollock, 1998.

F. PANEL 2 - Building Contributions

Panelists presented ways in which midwives contribute to maternity care through research (Eileen Hutton) and through the range of practice possibilities afforded by the current model of care (Luba Lyons Richardson). Eileen Hutton emphasized the importance of research in contributing to evidence-based practice and as an essential part of the autonomous practice of midwifery. She suggests that currently in Canada we have focussed on issues of clinical practice and midwifery education to the detriment of clinical research. She discussed challenges faced by midwifery researchers and strategies and solutions to meet these challenges. Luba Lyons Richardson suggested a variety of on-call models for midwives that increase off-call time to alleviate burnout. She noted the potential for registered nurses in the hospital setting to provide support to midwives and spoke of possibilities for shared care arrangements between midwives and physicians.

1. Research and Practice: Implications for our Future

Eileen Hutton, RM, MNSc



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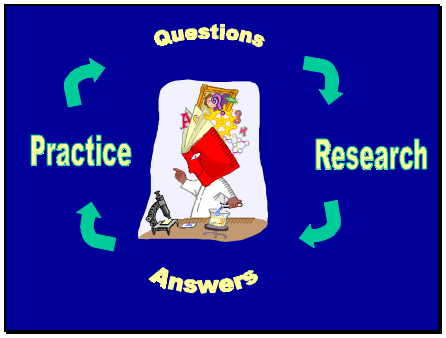

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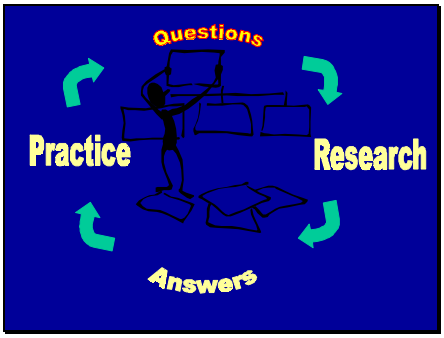

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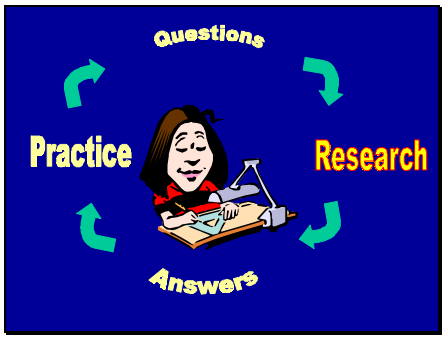

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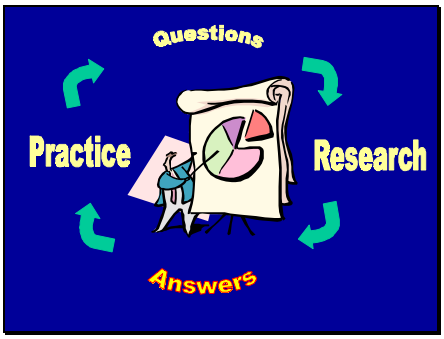

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The Colleges of Midwives

…Require that midwives provide evidence based practice…

Slide 9

Where does research for evidence base practice derive from?

- Other professions including:
  - medicine (obstetrics, paediatrics, anaesthesia)
  - Nursing
- Midwifery from other jurisdictions:
  - UK, Australia, USA

Slide 10

Do Canadian midwives need Canadian research?

- Much obstetrical research from other professions and from other jurisdictions is readily generalisable to Canadian women cared for by midwives

HOWEVER:

- Some important questions may only be of interest to midwives
- Undertaking research is one of the important elements of autonomous practice

Slide 11

Attributes of an Autonomous Profession

Practice – practitioners must be fully accountable and governed by a self- regulating College

Education – of new practitioners must be provided by members of the profession

Research – must be undertaken to inform a distinct body of professional knowledge

Slide 12

Status of midwifery research:

- Implementation of midwifery in provinces across the country have focused on issues of clinical practice and on midwifery education
- This has been to the detriment of clinical research

Slide 13

Challenges to enabling the Midwifery Research in Canada

Slide 14

Challenges to midwife researchers

- Requirement to maintain active practice for those in academic positions limits time availability for meaningful clinical research
- If maintaining a part-time clinical load, a midwife in Ontario who takes a sabbatical will need to return to full time practice following the leave in order to maintain active practice status

Slide 15

Challenges to midwife researchers

- There is limited availability of education and mentoring opportunities for researchers
  - Very few midwives possess the skills to effectively undertake clinical research
  - No graduate programmes in midwifery

Slide 16

Challenges to midwife researchers

- Few opportunities for mentoring beginning researchers
  - Few experienced midwife researchers
  - Limited collaborative networks established

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Challenges to midwife researchers

- Midwives must compete with other more experienced researchers for funding
  - Personal funding
  - Project grants
- CIHR does not recognise midwifery credentials for personal funding
- Academic positions have not prioritised designated research time
  - Difficulty retaining or attracting midwife researchers

Slide 18

Challenges to midwife researchers

- Midwifery client base is limited in size
  - Resulting in a limited client base to enroll in trials
  - Need to access women from other care provider groups

Slide 19

Implications for our Future

Slide 20

Strategies & Solutions

- Encourage Regulatory Colleges to acknowledge the value of research expertise
- Establish graduate programmes affiliated with clinical epidemiology or health science programmes

Slide 21

Strategies & Solutions

- Establish relationships with research centres which focus on clinical research pertaining to health of women and newborns
- Build networks with interdisciplinary research groups
- Collaborate with more experienced researchers

Slide 22

Implementing research based practice:

College guidelines should be updated regularly to reflect current research findings, for example:

- Breech presentation in labour
- contraindications for home birth including VBAC
- Changes to the pharmacopoeia to reflect current practice for GBS, induction agents, misoprostol for PPH

Slide 23

Implementing research based practice:

- Midwives may benefit from assistance with:
  - accessing research relevant to practice in a timely manner,
  - Reading and understanding research findings
  - Leadership from Associations in developing practice guidelines or protocols

Slide 24

Conclusion

Regulatory bodies, and faculties of midwifery must support midwives as researchers to prevent midwife researchers leaving the profession.

Slide 25

Conclusion

Regulatory Colleges need to:

- re-assess active practice requirements for midwives undertaking clinical research
- review and update policies and guidelines to reflect current research findings

Slide 26

Conclusion

Midwifery researchers need to consider ways to establish effective mentoring and collaboration with other researchers in maternal child health

Slide 27

Conclusion

Practicing midwives should review their practice to ensure that their care is informed by research, and that the research findings are provided to parents with the goal of enabling fully informed choice, and improving health for mothers and their babies.

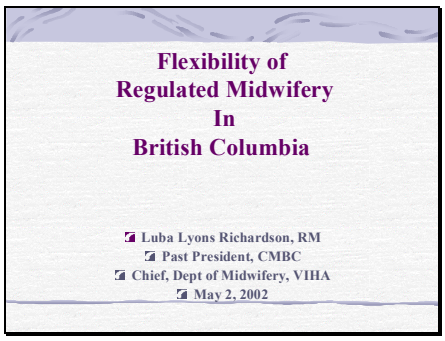
Slide 28

Slide 29

Slide 30

2. Flexibility in British Columbia's Midwifery Regulations

Luba Lyons Richardson, RM, RN
Past President, College of Midwives of B.C.



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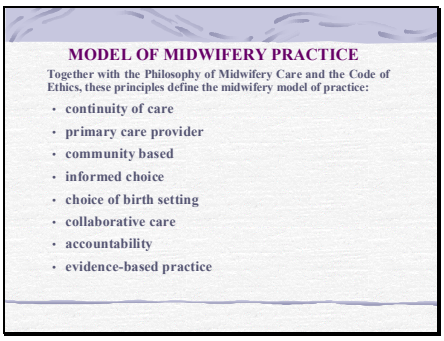

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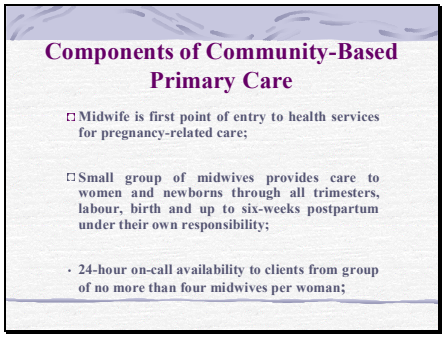

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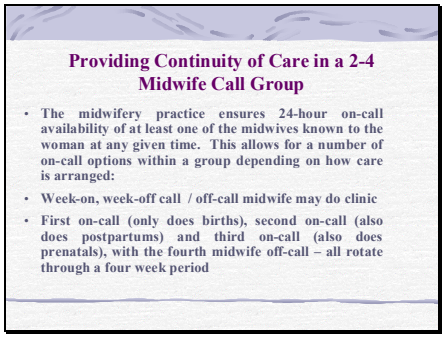

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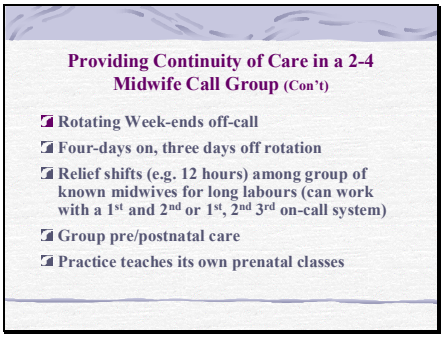

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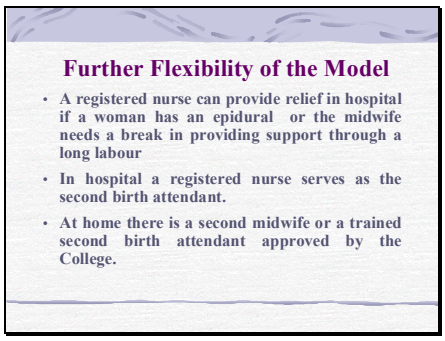

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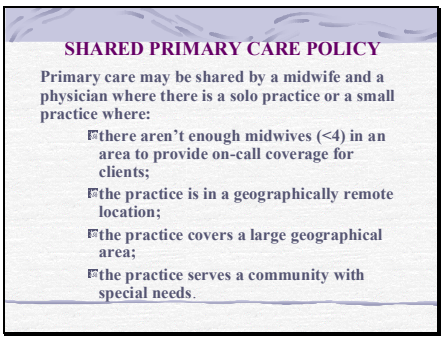

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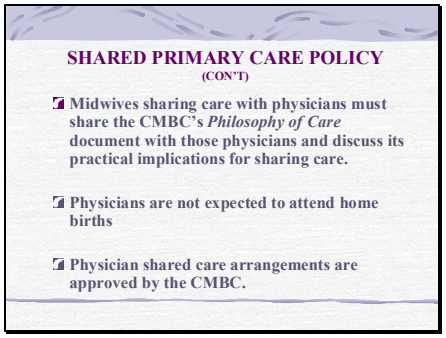

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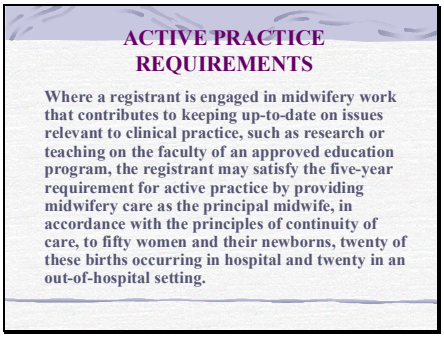

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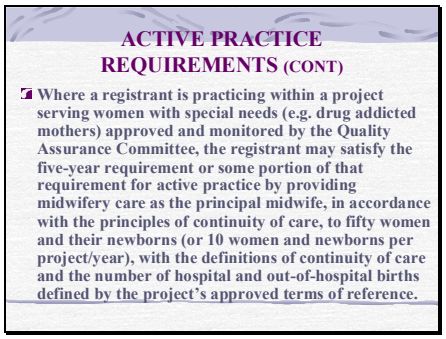

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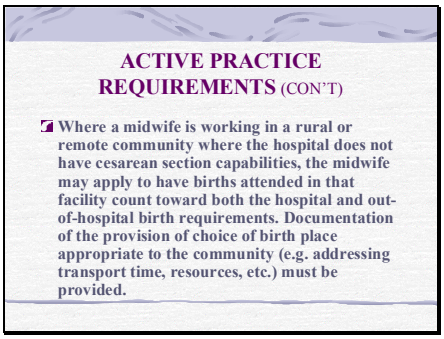

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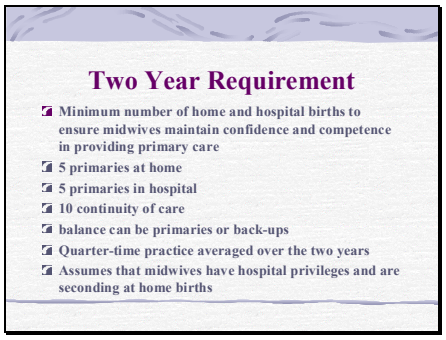

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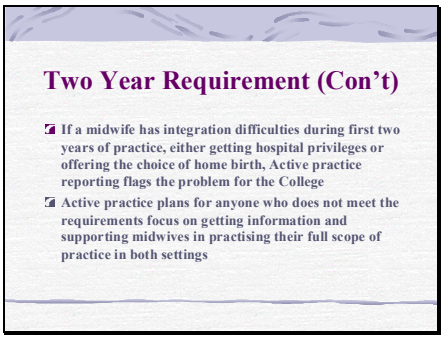

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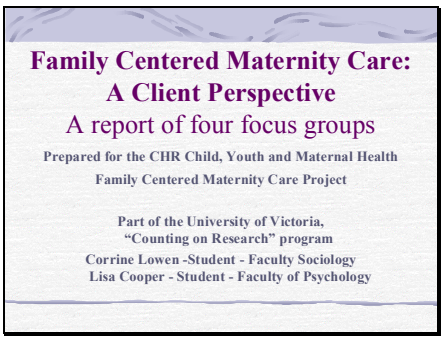

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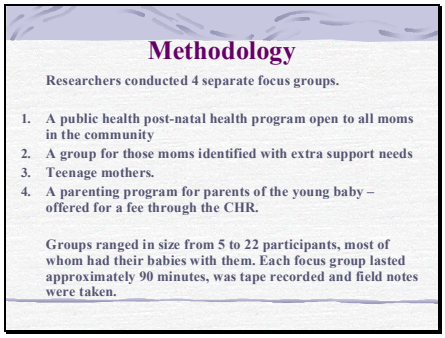

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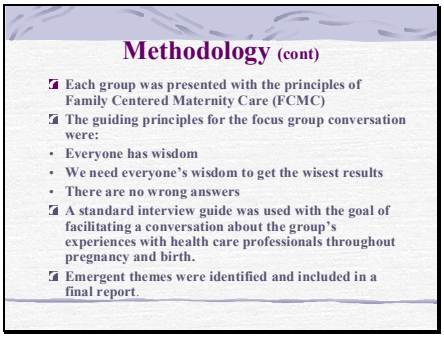

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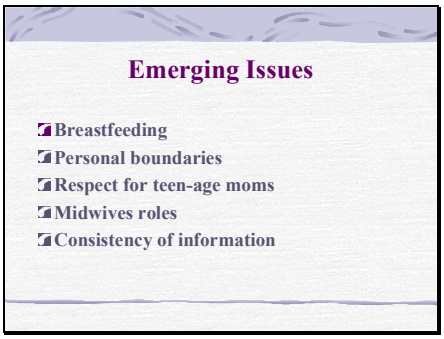

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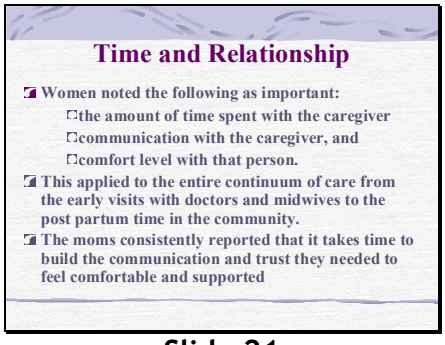

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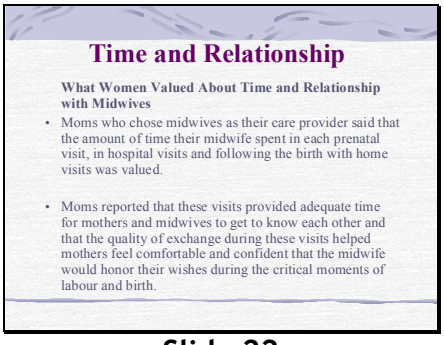

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Time and Relationship (Con't)

- One mom said she saw her midwife once a month for almost one hour each time. The visits increased in frequency as the pregnancy progressed. After delivery midwives visited moms in hospital and in one case twice a day.
- Moms said they gained confidence and valuable information in the longer prenatal visits.

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Choice and Control

- Positive experiences by moms included comments of being honored, included in decisions and having a sense of control. Moms with midwives reported very positively on this aspect.
- Mothers and labour coaches felt actively included in midwifery care, and reported that midwives honored a mother's body.
- One mother told how the midwife helped the family to reestablish a feeling of control while she was feeling vulnerable in the hospital setting.
- With midwives, moms said they felt in control of the care of their new infant, and consistently supported throughout the entire process by someone they could depend on to be there, and with whom they had established a rapport.

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Midwives Roles

- Discussions about the women's experiences with a midwife are described above, but the women mentioned a couple of issues, which may be important to note.
- Some mothers in each group said they would have been interested in having a midwife but did not realize that they could, or that they would still be under a doctor's care, or what the costs might be.
- They felt information about midwifery care and access to it should be more widely available.

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Conclusion

- The authors do not claim to be experts or to present a complete discussion of the parents' experiences of perinatal or midwifery care. They have attempted to access a broad demographic and provide a qualitative analysis of that demographic. They present their focus group findings as a touchstone, a collection of accounts of the lived reality of mothers and their families.

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Conclusion (Con't)

- The authors state that; "For instance, while the accounts of midwifery would not be statistically significant in a quantitative study, the qualitative accounts of these experiences tell us that their positive aspects would be statistically significant if more women had the opportunity to have this experience."

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HOME BIRTH DEMONSTRATION PROJECT

CLIENT EXPERIENCE
- SEPTEMBER 2000

LABOUR AGENTRY SCALE RESULTS:

MEAN SCORE:

Study subjects:		Published Norms:	
Home:	192.6 +/- 11.0	Home:	169.5 +/- 20.3
Hospital:	182.3 +/- 16.0	Hospital:	150.2 +/- 23.6

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HOME BIRTH DEMONSTRATION PROJECT
Summary Comments From Clients

- Responses to the open ended question inviting comments were overwhelmingly positive.
- General themes pertained to the experience being happy, satisfying, and positive, with high quality of care and one that the clients would recommend to others.
- The major elements of this satisfying experience related to the midwives' knowledge, competence, and professionalism, a feeling of empowerment and being emotionally supported and respected, having plenty of time with the midwives and being in a familiar environment at home.

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HOME BIRTH DEMONSTRATION PROJECT
Client Comments - (Con't)

- Clients contrasted their experience with prior hospital births, and if they gave birth in hospital with the current pregnancy, described their midwife as a mediator and advocate.
- They spoke to their gratitude for having home birth as an option and outlined barriers to access including not enough midwives, the need for more geographic locations where midwives were available and for more midwives to have hospital privileges.

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3. Questions & Comments Session

Issue: Midwifery, family physicians, and normal birth

Comment: The study of normal pregnancy is obviously a completely multidisciplinary, trans-disciplinary exciting place. But in Canada this should be a collaborative effort between doctors and midwives because that is what we do. Our obstetrical colleagues do something different most of the time. How do we bring these solitudes together around that one issue—the study of normal pregnancy? I think if we do that we will be much stronger because we did go through more or less, successfully, although we are still not quite there yet, the evolution that you have outlined so well.

Eileen Hutton: I think it's still a very good point and an important one too, and part of what I wanted people to take away is that there are some questions that will be unique to midwifery. For example, the home birth project that you have been working on is probably, at least at this point, primarily relevant to midwives, but the bulk of research that we do is really focussed on low-risk, well women and the issues that we face.

I have to recount just briefly the experience I have had with the project that I undertook as my PhD. research. I am looking at a trial of early external cephalic version (ECV) and beginning ECV at 34 to 36 weeks compared to 37 to 38 weeks. I undertook the project because I really have an interest in this and I really believe that it works, but the research, and Cochrane reviews, have basically said "don't do it". Because they have done the meta analysis and the systematic reviews and it's just like it's dead in the water. But I thought it was just not working for us here to do it at 37 weeks, and my experience tells me that early ECV works better. So when I started out to do that project, and I thought okay, it's the midwives who are going to have to do this because no doctor is going to want to touch this. However, that was a wrong conclusion to have reached! I started in on the project, I have presented this across the country, across the world frankly, and the interest has come. Midwives are interested, but not many midwives do ECV. At the end of the day it is the OBs and family doctors, and even many family doctors are not doing ECV.

When I read those reviews I was very excited, got it funded first round which is pretty amazing. We needed to work on the protocol, we tuned it in a little bit better, but the support I have had for that research has been tremendous within the medical community and for me it was a real "Eureka!" moment—it's about what care do we need to provide not about who is providing it. I think this is what you are saying, not to focus on what do midwives do with this or that, but what kind of care really enhances women's experience of that.

Issue: Alternative models of practice and flexibility in the current model

Question: How do you deal with the statistic of 10% of midwives practising in B.C. who may only be able to sustain their practice at that pace for another 6 months, and I think the issue of call should not be downplayed. I think also some questions for me are what does the College of Midwifery of B.C. think about when midwives feel they are not able to continue to do call? Do they have to start a whole new profession, is there any place for midwives to provide postpartum care, antenatal care, contribute to their profession? I think we are in danger of losing a lot of very talented people.

Response: Well, I am sure there are a lot of people who would like to have input into those questions. We do have an aging profession, so people are looking at issues within regulated midwifery. We are already looking at slowing down and retiring because that just happens to be the age a lot of us are. We ran this one around in our heads too and we actually came up with a way for four or five midwives to practice together, where one midwife would virtually do no call, but would do pre- and postnatals and be supported by her practice partners for a period of time, to just do that part of care. There are ways for it to be done, but I think we need a lot of people creatively looking at how it can be done. I certainly don't have all the answers. I would say to you that midwives in their experience have a lot to share with health care, public health policy, and I don't think we should diminish our ability to make contributions if we don't want to do call any more, or we want to contribute in some other way. People have to decide what they want to do in their lives and if we were funded well, we could even slow down in an appropriate way and it could be cost-effective for us. I think, unfortunately, the funding stands in the way of that. I wouldn't minimize call, but I think people may not be using some of the flexible options or different ways of working that might be able to minimize the stress of that.

Issue: Lack of evidence for minimum number of births for active practice requirements

Comment: I would like to say that there is absolutely no evidence for the first number they came up with, that you now have to have evidence for the change. Vis-à-vis the question of numbers and conditions, I find you are the *most over-regulated* profession I think probably exists on the face of the earth.

Response: So are you talking about active practice numbers? Okay. Well, the Quality Assurance Committee is beginning to look at a different way of practice. We are beginning to look at continuing education and maybe actually letting go of numbers. It has been talked about at the most recent meeting, so we are beginning to look at that.

I think when we began practice, people felt that we were taking new practitioners whether they were experienced or not into a newly regulated system, and there is

some evidence to show that when people begin practice, if they do volume, they solidify their skills. It was therefore felt by the Quality Assurance Committee at that time that there needed to be numbers to keep people current at the beginning of practice. It is now being talked about again because there isn't any evidence to support that in the long-term.

Issue: Relationship between the midwifery model of care and college's mandate

Question: How does having a model of practice regulated by the college fit with their mandate to ensure public safety? Just for an example, if I am safe to provide care and deliver a baby of someone I have seen throughout the pregnancy and will see for six weeks postpartum, how am I less safe to deliver the baby of a woman I meet somewhere? If the job of the college is to protect the public and ensure I am a safe practitioner, how am I less safe to do a gynecological exam of a woman at six months relative to a woman at three months, relative to a woman at six weeks? What aspects of the model protect the public?

Respondent 1: The model was developed for numerous and various reasons and one of them was public safety. But, clearly, as everybody went through the history, it was to give women something different from the conventional model. Probably everybody in this room who was involved in the regulation of midwifery in their province knew that to do that in the conventional model, you had to protect a continuity of care model or it would be very quickly changed and watered down. Because we had a commitment to providing that for women, it was enshrined in the model. I think the model we have has actually been very poorly studied and evaluated, so let's study it [properly]. It's there, it's really different, it offers an option to women they have never had before, and before we go and change it, let's evaluate it and look at doing it in other ways and evaluate that before we throw the baby out with the bathwater.

Respondent 2: I am anxious to answer that question. I want first to ask what is the model that we are talking about because the words "the model" could describe a multitude of things. So in this context we are talking about the model that the college protects and its relation to public safety. What is the evidence around the connection between protecting the model and public safety? I would say that first of all we need to decide what kind of evidence we are looking for and we also probably need to undertake to gather that evidence. But based on it being a fairly new profession, what I am assuming is that the basis was, in fact, evidence coming from a grass roots perspective of what women were asking for, and that really midwifery care was developed as a partnership between professionals of a variety of different kinds. Midwives and others, as well as the public. So in terms of the evidence, and I agree that we need to gather evidence around what we consider to be the model, I would propose that maybe what we can think about as the model are the principles. Perhaps that's what Holliday was talking about earlier. I don't know whether she would feel the same way, but to

my mind, the principles would be informed choice. This is something I have not heard talked about very much thus far. Continuity of care or the concept of continuity of care provider, that a woman knows who is providing her care, and certainly those are two principles, the continuity of care aspect. I think there is evidence to show that fewer mistakes happen when the careprovider knows the client and is familiar with the client, the chart, the history. I think that evidence does exist around continuity of care, I think there is a connection to public safety. Around informed choice and public safety, I think again there is evidence building to show that informed choice in terms of the health of the individual, the community, health promotion, and determinants of health, it is important that people have control over their lives. So in terms of the connection between the college, those standards, and their reflection on what our model is, I could easily make the connection between it needing to be protected. For the purposes of public safety.

I have a question around informed choice and power sharing related to the fact that the conventional model of providing maternity and newborn care, as has been pointed out, has not been based on a power-sharing dynamic, has not been based necessarily on the dynamic of women having power and control and having informed choice. So what are the implications of a very small, yet powerful profession emerging and wanting to join in partnership with a conventional model that I believe has a lot to learn from what midwives and their clients brought to regulated health in Canada.

Eileen Hutton: I would have to say that had you asked me that question 10 years ago, I would have said that the impact of midwifery would be quite great, and we did in fact have some published studies in Toronto, for example. There was a family physician who published data looking at the impact of midwifery on the family practice involvement with intrapartum care in Toronto. I think what I have seen is a huge shift in the way that physicians and nurses provide care to women from when I started out in maternity care almost 30 years ago. I really think the impact we can have today is small because there has been such a shift in the way that care is provided and informed choice, whether you call it informed choice or provision of information. I think if you look at the documents that have been made available or the patient information materials that are available, I think we need to recognize there has been a shift. So yes, we could have an impact and I think we did have an impact, but I am sure if you measure it today you would see a huge shift.

Respondent 2: May I suggest that we consider in our work working towards a policy on promoting informed choice and community-centred care, in terms of the power and decision making of the women, as a policy for all health care and health care planners much like they have in New Zealand. Because in that way I would feel more comfortable about the security of ensuring that the power lies with the women.

Issue: Models of care. Experiences of a rural Ontario midwife
(The long commentary that follows was given by a midwife in the audience who is in a rural group practice in Ontario.)

Rural midwife: I practice in rural Ontario in a very large practice that is quite old, it has been in the community for 15 years. I just wanted to share some of things that we have done to work within the model in Ontario, which we enjoy working in and it is actually starting to work very well for us. I have to let you know that not only have I been practising 15 years, in that time I have had three children and also one burnout. It's important to know that. It is also important to know that my practice, which has nine practitioners in it, serves a large urban community that focuses one group of those midwives, and then the other side is completely rural which I will call the "western side". That rural area is served by four midwives right now and there are five in the urban centre.

We find it essential to be this large to attempt to do things like regionalize our administration, hand out jobs that actually are very important in the function of the practice. We had to develop a very large number of protocols. We had to share those with our community in order to make it a functional group practice serving such a large catchment area. All of us are working full-time right now, except for someone who is sharing a job after doing maternity leave and doing political work. We are in the process of trying to secure two more midwives or even three if possible, and we think that will actually fill in the complement to serve the rural area. So I want to tell you a little bit about the west because we are most challenged there.

In order to provide care to women who don't have access for either cultural reasons or isolation due to their profession as farmers living in our community, we have had to go to the government after fine-tooth combing our contract, looking at our regulations and saying, "Look, I think this is what these women need, and I think it's the only way we can deliver it to them." That is by taking a large group of midwives (four to five), have the women meet them all, work in seven-day call periods (we are on call for seven days doing postpartums and births), then you are off call doing a clinic for the following week.

We were prompted to make changes in our practice as a result of a college requirement, which is to ask women if they got continuity, did they in fact have informed choice? The pressures and issues for those women were much more related to how to get their care. They wanted shorter appointments, they wanted always to be guaranteed that their clinic would never be cancelled. They were fine—if we had students, whether they were nursing students, physicians, midwives, they wanted to share in that—they were pleased to participate in that whole process of teaching.

To work full-time and to actually feel you are getting enough time to not burnout; my lesson had to be learned after the burnout or just prior to it happening. We

had to change the way we were working, and I think the time off that we are able to take by working in a large group practice, and that can draw from yet another practice who we are intimately involved with when we really are working our most full-out.

It's pretty successful. The large group allows us risk screening and case management that I don't think we would normally have when you work in such a large rural community. Whether someone plans a home birth in their location is exceptionally important because in winter we are totally isolated with 40 minutes to 1.5 hours of transport time. We share that because we share liability with all the midwives in our practice. We also share that with the women because they are trying to make a choice around place of birth.

How do we know all the women? I can even get called over to that eastern side where there is big hospital if there is a lot going on. Well, we have decided to go technologically forward and for some of us that are older that's a bit harder, but we are all carrying PDAs [personal digital assistant, handheld computers] that carry our clinical databases with us. It allows us to know women even though we might not have personally met them. Now of course the relationship they have built with care providers during their prenatal care we can never replicate but I can, I believe, do a delivery by walking in and offering that woman my service.

With that said, I do want to talk about the collaboration in my community between the obstetricians and general practitioners. I actually get the opportunity to deliver some of their normal babies because they are busy doing the high-risk things. They consulted with me for many years, they worked with me outside regulation and I owe them. That's the way we do it. They ask me if I can deliver a baby this month or next month, and I don't want pay for it, I just want them to reciprocate and understand our limitations.

I think they are using midwifery to fill a gap sometimes that we can't possibly fill. I enjoy dealing with normal women, I don't want an extended scope. I enjoy my limited scope in my community and I am happy to leave the complicated and not normal to my fellow colleagues, my obstetricians, and family physicians.

My biggest concern in my community is transport, whether it's from two of the hospitals in which I deliver where there is no surgical help. I then have to transport to another hospital, or if I transfer from my level two's to tertiary care which is three-and-a-half hours away, that's by land. I'm lucky if I can pull a helicopter. So for me right now in our practice our focus is becoming how we can improve our transports: how to get our women into the hospital or how to get to another hospital faster, or to get the right on a dodge to another community where they can actually get good care. Our rate of babies being born in hospitals where the women have never met anyone, as they try and get to London, is going up and there are 28- and 34-week babies, and it's pretty sad, so many services in Ontario are being affected by the concerns we are discussing today.

Participant: It's very encouraging to see that there is an ability to work creatively, but you have stretched the technical limits of the college requirements and my reason for asking my theoretical question is not because I want to go out and do well-woman care only, but I want us to think beyond the box and to think about what to do in those communities, how do we deal with it, and effectively provide care to the women who need it.

Rural midwife: I think we need to undo some of the binding that we have done. I would fully agree that we have the most over-regulated profession. We have this real concern that if we don't put it down and define it carefully that somehow midwifery will go off the rails or midwives will go off the tracks. I feel that we need to have more confidence in midwives figuring out how we can work in the system and then just to go ahead and do it.

Issue: Flexibility in the model of care

Luba Lyons Richardson: I just want to say that part of the reason I wanted to do the talk on flexibility is because I keep seeing that people haven't read what flexibility is there. You can deliver those babies for the obstetrician. We offered in my community recently when the GPs were going to stop doing OB call for the day because they weren't being funded, and we offered to set up an on call rota and take those patients on for a short period of time, until they solved the problem. Because the college asked for a minimum number of care with continuity, that's why you can work in larger call groups, that's why you can catch a baby with somebody you haven't met before. The flexibility is probably bigger than people realize and I am not saying we shouldn't look at other options, but I still keep hearing you can catch the baby. You only have to do 10 a year with continuity. There are other ways to do the rest of the babies you catch.

Respondent 1: The only problem is there isn't a funding model for somebody who is going to catch that baby and that is a separate issue and something that we have to deal with.

Respondent 2: And the funders won't look at it because it doesn't fit with the model.

Issue: Billing and birth numbers

Luba Lyons Richardson: Let me tell you, and I didn't want to tell you this morning when Wendy Katherine brought it up, that midwives are billing for more than 40 births and I know many midwife/colleagues are billing for more. If you give the service, okay don't tell them, but it's happening. If you give the service to 42 women and 43, which I have done, I have billed for it and no one has said "Boo" about it! It's time to take that limitation away, anyway.

Wendy Katherine: I wasn't wanting to interrupt, but I wanted to respond to something Eileen said about whether or not it's appropriate—or maybe your words were stronger than that—that the ministry was opposed, or somehow preventing flexibility in the model by virtue of not accepting proposals on innovation. One of the things I said was that the ministry can't respond in a meaningful way to proposals that haven't been surveyed at the community and stakeholder level, multidisiplinarily. And one of the points, the crux we find ourselves in midwifery in B.C., and I am ashamed to say I hear it as several years behind in Ontario, whereas we should be ahead in the areas of data collection we are very unfortunately behind B.C. I see that with many of the presentations that have been done on the clinical outcomes for midwifery in B.C., where none has been done on a comprehensive basis in Ontario. Nor has there been costing or effectiveness data on the service provision or the model over the seven and-a-half-year time frame since midwifery has been funded. That limits the ministry's ability to respond in a micro way to the incorporation of the model. If there are resources that say there is a appetite for change, it sounds like great things are happening, that people want to perhaps consider doing births with other midwives or not, working with other caregivers and some of this stuff does have an impact on funding. I think we are at a relatively naive point in the evolution of midwifery in this country and I share that responsibility to be able to effect further change than we have, without data to back it up.

Issue: Clarification on maximum number of births permitted

Participant: What I am hearing here is making me very confused. The policies and regulations are there from the college, but if you approach it this way, around the back door, you could do this, and if you go underneath this way, you could do this. But why isn't it crystal clear to everyone in the room? So we are not all figuring out ways to deek around the college guidelines around a model of practice? I still go back to saying why do we have a model of practice that's being regulated by a college?

Luba: I think what ensures that is that if you practice in a group of four or five, in order to meet your active practice requirements, 10 of your births that year have to have continuity of care. So within your group of 4 or 5 you need to make sure that you actually saw some of those women, meeting the definition of continuity.

***Participant:* Why?**

Luba: Because that's what midwifery is. That's what makes it different from the conventional model. That is what everyone wanted midwifery to be. If people don't want it to be like that any more, then I challenge you to come up with some projects that will try something different and do it within the confines of evaluating it so that we don't throw the baby out with the bathwater.

Issue: The importance of women as primary decision-makers

Participant: I think we are missing something here, and it's not that continuity isn't important, but there is an essence in it that we are really missing which is that the woman is the primary decision-maker. That is what we mustn't lose. That's the fear that underlies what this discussion is about when I hear midwives aligning themselves with the conventional model that comes from the discussion that we have been having about maybe doing some work with the SOGC on guidelines, because we will lose something that is very special. I think what we need to focus on is how, if the woman is the primary decision-maker, because the woman is the one who brought us here today and she is the one we really value. So if she is the primary decision-maker, how can we empower her to be the primary decision-maker in many diverse ways within the way we practice midwifery? I think it's essential that we allow diversity in our profession. So definitely leave the midwives who only want to do the normal, but we also need the midwives who are prepared to open their practices and do something like Project Link. We also need midwife-consultants who can nurture our new profession as we come along. It is so very, very important that we don't just get stuck in the semantics. That is what our challenge is as we carry on, to think about our fear of losing what we have, what we value so much, and really of letting women down, which prevents us from moving forward, and how we can keep the woman as the primary decision maker, which I think is more the principle and more the essence of everything else that we do.

Issue: Interdisciplinarity and models of practice

Barbara Kemeny: I am pleased we are talking about diversity because we midwives pride ourselves in being so open to diversity and so flexible no matter where we are in providing intrapartum care no matter what the setting is. But when it comes to the model, I somehow feel that this flexibility is a little bit depressed, so I would like to invite everybody to uphold the spirit of our diversity when we discuss the model of midwifery care. I would like to make a couple of points, one of them is something you brought up, Zoe, about upholding informed choice. What I heard was a worry about if we go into interdisciplinary settings, whether or not other careproviders would be upholding that same principle and/or philosophy.

I have, in my midwifery past, worked with many different health care providers and I have worked in a lot of disciplinary routines. I have grown up in a country where we actually work very closely with physicians. The midwives in Germany were actually in a very powerful position because the law stipulated that you have to call a midwife to a birth—in other words a doctor had to call a midwife to a birth, but a midwife didn't have to call a doctor. Just to spell out the facts for you. I grew up in a system where I feel very comfortable working with other careproviders, and I can also look at a particular situation and adapt practices and attitudes to an environment, to a situation, to a community, and to a practice. If we midwives embrace the kind of change that we seem to want, we have to embrace the other health careproviders, i.e. the physicians, whether that is family physicians,

obstetricians, and nurses. We have alienated them in Ontario to a large extent. Some have forgiven us for it, some we have to work hard on, and this is one opportunity where we can do that.

I am a midwife, no matter where I am, and the principles of midwifery that distinguish me include informed choice. No matter what the model is, it will be included and I want our stakeholders to believe as professionals that we can do that, no matter where we are situated, and no matter whom we work with. Also, give us the opportunity to be teachers and leaders, to be role models for the ones that have to come along a little bit. Also I'm very happy with, for example, the SOGC, who in terms of informed choice actually upholds this principle and they tell their membership this is a way of practice. We are talking about evidence-based practice. We are so much closer to a similar way of practice and the philosophies we can implement.

Then, in terms of the model, we are talking about metaphors. I am in the process of buying a new car and so I am test-driving all these different cars. I can tell you the reason why I need a new car which is because my old car is no longer meeting the needs I have (i.e. liability)—it's too big, my kids are driving their own cars etc., etc. So I am driving all these new models and I do my research and I come away with particular priorities which are important to me. It has to be safe, reliable, fuel-efficient, and start in the winter! As I am doing that, it's just what I am trying to do right now. The midwifery model was often referred to as a Cadillac, so if you only drive Cadillacs and are asked if you are happy with your car, then of course you will say "yes"! But if we have no comparison to another car, then how can we judge the other cars?

Issue: Evidence-based practice and body knowledge

Elaine: I am really worried sometimes that all the information women are getting is making them afraid. I want to be humble about this notion of evidence. I mean I remember having those debates around episiotomy, when I was taught in midwifery school to do an episiotomy and women were saying "why are you doing that?" and I was saying "why are we doing that?" and was told "Because, look at this anatomy and if you do it this way, this is going to save the perineal floor". And it really does bring up an anger in me that we had to have a randomized, controlled trial to refute what we already knew. There are so many of those things that we do already know. There is plenty of body knowledge and I am afraid women are going to lose their body knowledge by us presenting them with so much information, that they have to make choices around evidence that I think we ought to be really humble about. So I guess, if I tell everybody in this room who have been my students that if you can come out of your education realizing you know nothing, then that's the best way.

I guess the question that is evolving out of this for me is, as we have always said, hospitals don't really implement family-centred care—of course they don't—and are we really implementing women-centred care if we only do it one way?

Issue: The need for alternative modes of practice to meet the diversity of women's needs

Participant: I take it from the silence this is a rhetorical question. I think the best thing about this discussion is the thought processes that it is generating, and as someone who has been a fanatical believer in the model. I just want to say that my gut sense for the last little while is to begin to look at this profession of midwifery and how we do it more as a tapestry than as the one-size fits all. And partly it's because I have been spending time looking in rural communities and looking at other places. I think so many of the points that have been brought up have been incredible, and I also don't want to throw the baby out with the bathwater. I think what midwifery has brought to maternity care in Canada has been incredible and it has pushed a lot of the development that Eileen has talked about and that we have seen over the last 15 to 20 years. But, I would really like for us to remember that we came here with women, we got here in partnership, and so many professions once they become recognized have become self-serving. So what I would say is, as we explore what is needed, and I think hearing from the obstetricians and the family physicians and all of the women, trying to elicit from the women who aren't speaking yet, (and there are many women in Canada who are silent and don't have the power of choice), that we are looking at what some of the options are, what are some experiments, what are some other ways that midwives might work, and taking that case to our regulatory bodies, based on need, and trying to remember that the need that is generated has to be a need from the community, more than a need just from us. I am not denying our need. I think midwives need to figure out how to work in ways that we can sustain. But I would like us to actually take a case to our professional associations, to our regulatory bodies and say, "how can we do that?" Ending up with a tapestry rather than a one-size fits all. What works in Alert Bay is not necessarily going to be right for Richmond or even some other rural community. A lot of it depends on some really quirky things like personalities.

I also want to remind you that in England they had the system of hospital-based midwives who did shift system. And there developed an incredible enmity with the community of midwives who felt that the hospital midwives were technocrats, the hospital midwives thought the community midwives just drank tea all the time and were totally incompetent. We have to be incredibly careful not to develop that "siloing" of attitudes about each other.

Issue: The role of midwives as agents of change

Michael Klein: I'd like to make a comment about something that has happened in our own setting as it relates to the comments made earlier about concerns about what happens when midwifery become co-opted by the conventional system, about what might be lost. I work at B.C.W, where there are 7,000 births and our caesarian section rate in the last three-quarters approached 30%. Until very, very recently, midwives functioned very well behind closed doors. They did a fine job for the patients that they were looking after, and nobody doubts that. But if we come back

to the larger issue of the women of Vancouver and indeed B.C., the question really was, were they going to change the way this monolithic inertia-driven organization is going to reshape birth for women served by the hospital? The answer might be "no". The answer might be that the hospital would eat them, a real possibility. But what you heard a little bit about earlier was the Adopt the Medical Student program and all the other things that the midwives are doing. They are taking students in their offices and soon, we hope to have nursing students paired with medical students going out in the Adopt the Medical Student program, and midwifery students paired with nursing or medical students so that they can get rid of all the mythology about the different roles that people play. I'd like to think, and maybe it's dreaming in technicolour, that the midwives might actually be able to change the environment of birth in a sick organization that is very, very large. Maybe this will burn them out, but the existing organization is so much in need of a midwifery perspective that I think there is an obligation to try to change that system. The midwives have something to offer if they just stay behind their doors looking after women very well, [but] it's not good enough, because you know what will happen? Women will choose midwifery practice and the patients that want will go in that direction and then the other people will go into the other system, but the net effect on the women of B.C. will be nil and I would like to see something better than that.

Issue: Changes to the midwifery model of care in British Columbia (numbers to maintain competence, changes to the PLEA process and credentialing registrants from other jurisdictions)

Jane Kilthei, College of Midwives of B.C.: The first thing I want to say is just how excited I am about events like this and conversations and I am really optimistic about midwives and change. That I am sitting in the back of the room and saying to myself we are just a little over four years into having midwifery as part of the health care system in B.C. and look at what is happening. Look at how passionate and interested and ready to jump in at the deep end midwives are when given the suggestion of "well, we could do this, or we could do that" and I think there is a whole lot to work with there. We have known for a long time that numbers don't make competence and that was kind of like, well, we'll put something in place and then we'll deal with the next place. What we are really looking for is development money right now to develop a comprehensive quality assurance program so that we can get rid of those numbers. We don't want those numbers. Anything we are putting in place to make flexibility happen in those number policies right now is a temporary measure, to allow for some of the experimentation that people are eager to get at before we have the QA program in place.

I also wanted to update you a bit in terms of growth of the profession. We have been running some numbers. We have grown 160% since we started in January 1998 and we have just had our deadline for our PLEA process this year. We are committed to doing that in B.C. every year at least until we start to get graduates coming out of the program at UBC and this year we have 20 people in our process, 12 of them are brand new. and we have 8 continuing from last year. And there are

still 10 days left in terms of the exemption stream portfolio, so people who would qualify for exemption from exams we haven't even got their applications yet, so that process is alive and well. There is also a major evaluation of it in process and we are starting to get a sense of where that is going and I anticipate the recommendations that are going to come out of that process are going to assist us in major streamlining of the process before 2003. The people doing the evaluation for us are really optimistic, so I thought you'd like to hear that.

We are also hopeful that English for Midwives, which is not your basic ESL program, but a specific course with midwifery content which we are hoping to get off the ground for people who couldn't come into registration because of language issues will start, we hope, this year and over the next two years we will have a modularized refresher program. We are working with Kwantlen College on this and it will be a place to bring people back into practice as well as to bring foreign-educated midwives in. There is good growth potential here and we are not waiting five or ten years for that to happen.

I wanted to publicly thank the Midwifery Education Program in Ontario for letting us experiment with you in terms of a process for approving education programs from outside of B.C. for direct registration, not having to go through any additional evaluation or assessment processes. That was really useful to us and we are already in the process of evaluating two other programs from the USA. We are also in dialogue with New Zealand around approving their programs not one-by-one, but because they have standards for education as a countrywide process.

Participant: Hi there. I am a brand new registered midwife and I have been in practice for four months. Thus far in my four months, I have had two GPs fire clients because they have chosen midwifery care, I have had nurses be extremely unsupportive. So I have had some really challenging experiences in integrating into the hospital. I see myself as very diplomatic, very collaborative, very much in the spirit of working with a number of other health care providers, and I always have been. However it has been extremely challenging consulting with the OBs. So when I start hearing about thoughts around joint guidelines, as a new midwife I have been very glad to hear comments raised from Zoe, from Elaine, from a number of people who have brought forth ideas about what might be lost from the process of integrating with these other health care providers. It is precisely this model of care that inspires so many new young women to want to become midwives. Consistently, one of the very first questions new clients want to know about me is my call system, how available am I going to be, what can they expect with respect to how often they are going to see me. Clearly from my brief experience that continues to be a real priority in women's minds.

Secondly, I just wanted to say it seems that we can maintain much of the values and the models and the basics of what midwives provide. But still meet some of these needs around changing the systems in which women work and provide midwifery care. I don't see these things as mutually exclusive. Having trained in the USA all I

ever heard about from my colleagues and preceptors and a number of nurse/midwives and licensed midwives, how impressed they were by the Canadian College's regulation of our model of practice and how much that supported the sustaining and protecting of that model.

Participant: I'm going to be very brief and I am directing my comment to Jane. I want to speak to a couple of numbers that we have been crunching. In 1998 there were 47 RMs in our province. In that year, there was one person who stopped practicing. In 2002, we have 65 practicing midwives, the total non-practicing since 1998 is 17, so although you have had an increase from 47 to 82, you are actually looking at a very small number, and overall a 21% attrition rate. From our point of view that is very concerning because our mandate is to grow and support a sustained profession. It's obvious that the model works for women and we are not at all interested in dismantling the model, but we are committed to making it work better for RMs.

Jane: I want to respond to the numbers because I think we need to sit down together and talk about what they really are, because what you've got in that attrition number are people on short-term and maternity leaves. One of the problems we have in our province with the liability insurance being paid out of the midwives' pockets is that midwives go in and out of non-practising status to save money over a three-month period. So the numbers we have from the College of Midwives is an attrition that is somewhere between 9 and 12% over the long-term, looking at people who we believe to be on long-term leaves or having retirement.

Issue: Challenges faced by Ministries of Health

Wendy Katherine (Ministry of Health, Ontario): I'll just be very quick. I guess over the course of the day people have touched on different issues. I just want to say that from inside the government a lot of us are challenged, not because they are complicated or expensive, but because inside the ministry it still looks quite unconverted. The discussion around the cost-efficiency of midwifery, its applicability to contemporary maternity care, and its ability to meet health system needs and/or to be the solution for the crisis in low- risk obstetrics, is mixed. There are people in there who are very converted and very positive advocates for this initiative in all its myriad types of visions and there are others who are quite far back in history and in their experience of working with midwives in a modern day model of any kind. So it's a challenge at times to be in a position of making a saleable case for something that may not appear to help things. So I just want to say to people that those who are in a policy situation in a ministry and who have to write funding briefs or some such, depend on things like information from the local level and the anticipated impact of a change and a proposal's ability to meet the needs. I think we could prioritize in colleges and professional associations to work on midwives' abilities to write proposals and develop and collect the information that's going to help ministry people support funding changes.

We also need to economize and capitalize on existing trends in health care systems or in the professional association agenda so that when things like legislation open, you can pile in as many possible changes you need that are well thought-out at the political advocacy level so it only needs to be done once. The scariest thing I have heard anybody say in the course of the last two days has been "Oh well, we'll just change the model". Whereas, in fact, already in the very short history of midwifery in Canada we have an entrenched procedure for doing that. The last time we did that it took two-and-a-half years and so there is some real economy to be shared for all of us in our energy and our ability to keep up with what we want to be doing, to avoid multiplying and replicating the work over and over again.

I would urge people to share their discussion and bring issues to the attention of their professional associations so they can really scope it out with the college and bring it to the government in an already complete way. That would make ministries' lives much, much easier.

Lee Saxell: I just want to remind people that we are not talking about changing the model, we are talking about expanding opportunities. We are not talking about a drastic change so what we have in place is no longer available. We are talking about more options.

Elaine: I don't know how to wrap this up except it fits very well with my philosophy— saying that we are left not knowing a lot and asking a whole lot of questions which is, in my view, the ideal way to have our brains continue to work as we sleep tonight and to hear a few more comments tomorrow and hopefully leave here with some strategies that might be comfortable to everyone. I am hopeful that is what the panel tomorrow afternoon will do. Maybe people could think about one or two things that you think are realistic, accomplishable strategies that we could leave here with.

G. The Midwife's Expanded Role in Interdisciplinary Education

Diane J. Angelini, EdD, CNM, FACNM, FAAN
Clinical Associate Professor
Department of Obstetrics and Gynecology
Brown University

Director, Nurse Midwifery
Women and Infants' Hospital
Providence, Rhode Island USA

Dr. Angelini's presentation focused on the importance of interdisciplinary education to maternity care, benefits, barriers, and strategies for successfully implementing such models and the significant contribution to interdisciplinary education midwives can make. She pointed to Brown University as an example of a successful interdisciplinary educational program and noted the positive effects such programs have on inter-professional relationships.

Definition: Inter-professional Education

"An educational approach in which two or more disciplines collaborate in the learning process with the goal of fostering inter-professional interactions that enhance the practice of each discipline."[1]

"Shared Learning" =	Concept being advocated
"Multi-professional Education" =	Learning together
"Inter-professional Education" =	Learning together to promote collaborative practice

The Promise of Interdisciplinary Education[2]

- healthcare marketplace changing
- demand for non-MD practitioners
- need for interaction between MD and non-MD professions
- web-based curricula more widespread
- hiring of faculty across disciplinary lines
- health sciences campuses in best position to implement change

Background: Interdisciplinary Efforts[3]

- scan the environment for opportunities
- set realistic goals
- build commitment to those goals, then negotiate the means

- avoid useless battles; look for non-competitive areas, practice sites and
- patient population
- measure and celebrate success
- small steps and moderate successes

Two Major Factors that Work Against Interdisciplinary Activities[4]

- professional orientation
- workplace structure

Interdisciplinary Learning: Evidence Base[5]

Outcome effects of 30 studies reviewed (of undergraduate health profession programs) found benefit from interdisciplinary education with outcome efforts primarily related to:

A. Knowledge
B. Skills
C. Attitudes
D. Beliefs

Research[6]

Evaluative in focus, less emphasis on outcomes.[5]

Largest Effects: Students' knowledge, attitudes, skills and beliefs, understanding of professional roles and workings of a "team".

Smallest Effects: Transfer of learning into students' experimental practice.

Community Partnership Experience: East Tennessee State University (ETSU) 1992-1999[7]

- Kellogg Foundation: $47.5 million, 7 community partnerships funded
- Regional academic institution: 12,000 students overall
- Goal: to develop primary care providers who could function in an interdisciplinary health care system and who would be sensitive to rural community needs and under served.
- Nursing, medical, public health and allied health students

Experience

Moved away from discipline, specific training to interdisciplinary collaboration.

1st Project - 1991-1996

Integration of medical, nursing and other students; 25% of nursing and medical students enrolled in interdisciplinary/community based core courses.[8]

2nd phase of project
Addressed same issues but at the graduate level—family practice residents, master's level family nurse practitioner students and graduate public/allied health students—community-based/interdisciplinary experiences.[9]

ETSU: Graduate Phase[10]

Collaborative Practice

- Used an exemplar provider team in the region
- Developed a regional health professions training network of multidisciplinary practice sites
- Assigned a resident and FNP together to same practice site
- Supported collaborative practice environment

ETSU: Lessons Learned[11]

- Commitment and knowledgeable leadership at the highest level "build team skills"
- Communication—manage conflict, resolution. value, differences
- Community involvement

Interdisciplinary Education in Medical Schools
(1982: McPherson / Sachs Survey)

- survey to determine if interdisciplinary concepts were being taught in US/Canadian medical schools
- < 30% of 105 responding schools had a component of interdisciplinary teamwork

Physician Opinions about Midwifery in Canada[12]

- self-administered questionnaire
- random sample 844 MDs
- 71% response rate
- Conclusion: knowledge of midwifery practice gained through collaboration in the workplace and interdisciplinary education could help MDs to better understand the significant contributions that midwives can make to the health care system.

Pew Health Professions Report[13]

- 1998 co-commission

- stresses need for interdisciplinary competence among health professions

Barriers

- regulatory changes
- lack of rewards
- funding/administrative support
- faculty lack of knowledge of other disciplines

US Public Health Service: Primary Care

- policy fellowship
- instituted to help address interdisciplinary education and collaboration
- 3-week educational experience
- held in June
- US midwives participating

Midwifery Models, Interdisciplinary Teaching: CNM Participation in Medical Education in the US[14]

- More than half of US medical schools formally using CNMs as educators.
- 57% of CNMs participating in the education of family medicine residents.
- 59% in education of OB/GYN residents (hard to know if this is formal vs. informal teaching).
- 80% of CNM respondents felt "ok" with educating student physicians; did not feel this was inconsistent with philosophy of midwifery practice
- Sedler et al., Angelini et al., Harman et al., Markoff studies involving CNMs in OB medical education

Brown University Department of OB/GYN[15]

Historical Development:

- beginning academic service model formed basis for interdisciplinary approach
- 9,000 births/year; 3500 collaborative resident delivery service
- 1990 - first CNM recruited
- coverage for patient care situations in labour and delivery
- need to expand and upgrade clinical education for medical students prompted the incorporation of midwives into the Department of OB/GYN

Background

- currently 5.7 FTEs (including Director)
- 12 years CNM model in existence
- selected criteria for CNM recruitment
- medical faculty appointments at Brown University

- non-competitive model in LDR
- both OB/GYN residents and midwifery faculty share intrapartum caseload Monday - Friday
- sharing a common caseload (competition between midwives and resident/medical student learners
- 1991 - CNMs - separate section within Dept. of OB/GYN
- Clinical/Academic appointments
- Support of the Department Chair
- CNM faculty work closely with Director of Medical Education

CNM Responsibilities with Medical Students

- Enhanced educational experiences of medical students during core clerkship rotation
- Medical students - 2 weeks on labour/delivery
- Formal lectures
  - Intro to labour and delivery
  - Fetal assessment/monitoring
  - Pelvic teaching
  - Abortion care
- Clinical teaching on labour and delivery
  - labour management
  - deliveries with midwifery faculty
  - clinical review of surgical technique, suturing skills and hand maneuvers for delivery
- Evaluation
  - Osseous: objective, structured clinical examinations - 2 skill stations
  - total of 12 Osseous in student evaluation
  - shift to "skills emphasis" in student curriculum

CNN Responsibilities with BO Residents

- A more structured teaching approach during 1st rotation on labor and delivery.
- Week-long new resident orientation - CMS do full day "skill stations":
  - abdominal/vaginal assessment
  - fetal electrode/IUPCs/Amnioinfusion
  - local anesthesia/suturing
  - fetal assessment lecture
  - principles of ultrasound
  - hand maneuvers/shoulder dystocia
  - management 3rd stage labour
- Core Curriculum Lectures:
  - fetal Assessment
  - Labour/Dysfunctional Labour
  - 2nd Stage Labour
  - Abortion Care

  - 3rd Stage Labour
- Advanced skills - PGY2
  - Repair (lacerations)
  - Pudendal block
  - Shoulder dystocia
  - Alternative birthing positions
  - Clinical pelvimetry
- Clinical decision making in labour and/OB triage
- Clinical checkouts 1st year residents (rite of passage)
  - 30 births check-off: hand maneuvers
  - Suturing
  - Vaginal exams
  - Limited OB ultrasound: AFI/ BPP/ Biometry
- Preceptors for OB/GYN Interns - 1996
  - Early identification of problems
  - Positive reinforcement of clinical skills early on
- CNM Director - Member of Resident Evaluation Committee

Other CNM Responsibilities

- Maternal Fetal Medicine
  - GDM Clinic
  - In house "team" responsibilities
- Research

Evaluation

- Excellence in Teaching Pins x 10 years—positive evaluations from medical students/residents
- Focus group findings - 1998
  - Teaching highly valued
  - Midwifery approach valued
  - Transitional support valued
- New midwifery faculty model that private MD attending staff have had to adjust to
- 1998 Resident survey
  - 22 item survey - valid / reliable questionnaire given to CNMs and residents - 100%/97% return rate - retrospective data only
  - Residents/CNMs agreed on most items
  - Largest variance - "Research to Improve Patient Care"
  - Evidence-based approach critical to CNM role in collaborative setting

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H. PANEL 3 - Reflections on Midwifery Practice in British Columbia

Three senior midwives with extensive practice experience in British Columbia reflected on the current context of their practice and issues that, if unresolved, will impede the sustainability of their contributions to the profession of midwifery. First, Maggie Ramsey provided an overview of her experiences of providing care in a rural community without caesarian section capability or physician backup. She noted the high level of collaboration between the medical staff in her community and in her relationship with midwives and the Department of Midwifery in the referral community. She described the innovative collaborative care arrangements. Although her community is one in which most births occur locally and midwifery care is the norm, she cautioned that rural and remote communities would face challenges to providing care unless we take steps to strengthen rural maternity care in B.C. To this end, she offered five recommendations.

Linda Knox described the challenges that a thriving midwifery partnership faces in an urban environment. If unresolved, the lack of off-call time and the often-overwhelming combination of practice and professional/political commitments may lead to practitioner burnout.

Carol Hird also spoke of the challenges of integrated midwifery practice. Within the context of the trade-off between client continuity of care and practitioner well-being, she emphasized the importance of recognizing the lifestyle and health needs of midwives.

1. Rural Practice

Maggie Ramsey, RM, RN

Thank you for the opportunity to address this symposium. It feels a bit like going from the sublime to the ridiculous following Dianne Angelini! In terms of scale, we are very tiny, but we do have some common challenges and experiences and I am hopeful that I can shed some light in a small way on the topic of the maternity care provider crises. My talk today is informed by my experience of over 20 years of practicing midwifery, primarily in the Gulf Islands of B.C. and to a lesser extent in the far north of Quebec, extensive discussions with my rural midwifery colleagues on the growing body of research, much of it based in Canada, about rural maternity care. This panel is entitled "Reflections on Midwifery practice in B.C.", so I am going to first reflect upon the practice of midwifery in my community and then answer the question, "How can we help resolve the maternity care provider crises?"

The first part of my talk I call "From Outflow to Down the Toilet to Reversing the Tide". My community is in the B.C. Gulf Islands and I live and practice on Salt Spring Island. For those of you who have never visited, when you take the ferry from Vancouver to Victoria, these are the little islands that you pass through.

There are about 10,000 permanent residents on Salt Spring and many fewer on the smaller islands. While someone earlier mentioned that Salt Spring is a "yuppie retreat", that's not entirely correct. There is a significant, low socioeconomic demographic, affordable housing is a serious issue, and we have a higher than (provincial) average number of teenage pregnancies. There is a wide disparity, with many residents being wealthy retirees and a large number of young people living below the poverty line. The community is rapidly changing with the majority of residents having lived there for five or less years. This all brings challenges and stresses to our community as we adapt to these changes.

Salt Spring has a small 50-bed hospital, 35 of those beds are extended care, and the rest are acute care with one designated for maternity. During the day, if you hit the ferries just right and everything runs like clockwork, it's about 90 minutes from our small hospital to Vancouver General Hospital (VGH). If you miss the ferry, travel time can vary up to three hours from hospital to hospital. At night the ferries don't run and transport off-island is by water taxi or, in serious emergencies, by helicopter. Availability of helicopter transport is dependent on the weather and through triage with the rest of the province. While weather isn't the factor that it is for my more northern colleagues, it plays a role. Practitioners need to keep a constant awareness of the ever-changing ferry schedule, the weather, and the time of day when providing care.

There are currently two midwives providing all the maternity care to the island, originally in a shared care practice and now in two private practices. We provide holiday and on call coverage for each other locally, and we have an on call midwife of the month in the Capital Health Region (CHR) Midwifery Department who can take our transfers to VGH if we are not able to accompany the client.

Prior to midwifery regulation, Salt Spring Island was a high outflow community. If you are not familiar with the term, this refers to a community where most of the women leave the community to give birth somewhere else.

Midwives have always attended a small number of home births, with the majority of births attended by family physicians at the local hospital. As the older, more experienced practitioners retired, younger physicians with little experience outside of tertiary care centres replaced them and the outflow of births increased as did the number of intrapartum medevacs.

With midwifery regulation in place, there remained one physician providing maternity care and myself with a full midwifery practice. We hoped to stem the outflow of births and provide good collaborative care for local women. We established a shared care policy and had this approved by the College of Midwives of B.C. (CMBC) in order to provide backup and share call.

This worked really well until the new chief of staff at the hospital decided to ask the B.C. Medical Association (BCMA) if they thought this was a good idea-not surprisingly they didn't. They were okay with the physician providing backup for me but not with me providing backup for her.

This is the "Down the Toilet" bit. The BCMA met with the local physicians and very shortly afterwards I received a letter informing me that I would need to stop practicing midwifery in my community due to the lack of available backup. Well, those of you who know me know that I don't give up without a good fight!

I received great support from Jane at the College of Midwives and from the head of our Midwifery Department, Luba Lyons. Eventually the tide reversed and now midwives do 99% of all the births in our community. I think that's pretty good.

We have even become in a small way an "outflow" community and women from the other islands are coming to Salt Spring to give birth. Traditionally, women from the smaller islands came to Salt Spring for their births. With the high rate of intrapartum transfers, this has changed. Women were saying, "It's one thing to take a boat in labour but if I have to take a boat to Salt Spring and then get shipped out again in the middle of labour, forget it. I'll just go straight to town."

As our reputation has grown, these women are starting to come back and we have had women from Lasqueti, Gabriola, Mayne, Pender, and Saturna Islands. Women

from Galiano Island, once a hotspot for do-it-yourself births and births attended by unregistered caregivers, are now starting to come to us.

We do a lot of collaborative care. For women who wish to deliver off-island, either by choice or due to risk, we collaborate with our midwife colleagues in Victoria. We provide most of the antenatal care; they go over to VGH for the delivery and come back to us for postpartum care. Similarly, we collaborate with obstetricians for our higher risk clients. Our local women receive the usual RM care with one midwife providing care for her own clients and the other midwife covering for time off and holidays. We work with two Registered Nurses who are CMBC approved second attendants and they provide backup for all our home births.

For the women on the smaller islands, the collaboration varies depending on their local resources. Some islands have physicians and others have the nurse first call system. A number of the doctors are from the UK or South Africa and there hasn't been a moment of hesitation from them about collaborating with us.

Usually the women will see their doctor for the early part of care, come to us later in pregnancy for the birth and early postpartum and return to their local caregiver for the rest of their care. Some families have their own boats, but most come over on the school boat with the high school kids for their visits and make a day of it shopping and visiting friends and then head home with the kids at the end of the day. Our office is within easy walking distance from the dock, so it works out well for them.

For the births, the women have a choice of birthing at a friend's home or at the local hospital. Some women come over ahead of time for their births, maybe staying with friends or family, and others do what we call "drive-by birthing"—over in labour by the water taxi, have their babies and head home. We're okay with this if they are experienced moms and they have a doctor on their home island. We like the primips to stay until we are sure that breast-feeding is all sorted out.

As Lee mentioned, we are the only midwifery practice in a community without c-section capability. And while we could focus in terms of absences-we don't have any physicians who do maternity, no OBs, no Peds and no epidural service-what I would like to do is focus on what we *do* have. What we have is tremendous support from our community and tremendous support from our colleagues in nursing, medicine, and the local hospital from the administrator on down. We have also benefited from being a part of the CHR Department of Midwifery, which helps to ensure that our small voice doesn't get lost and our department head has gone to bat for us on a number of issues. We have really appreciated this support.

I like to be involved in the education of students and with continuing education. When I worked in Northern Quebec we had students from McGill's rural medicine program and it was great to get the students before they had done their

obstetrics rotation and introduce them to midwifery care as their first exposure to birth. Salt Spring is a site for the University of B.C. rural medicine rotation and we try to get the students to spend a day in the clinic with us and to attend births at the hospital. We have even got a couple of the medical students to home births and they really enjoyed that. I like to promote the idea of rural practice in general and model a safe rural maternity service.

The evidence shows that students exposed to positive experiences during their education are more likely to consider rural practice when they graduate. Salt Spring is a desirable rural community to live and work in so it's a pretty easy sell!

Over the years I've had a number of conditional RMs through the practice, as well as a student midwife from Ryerson and a couple of student nurses.

I'm a Neonatal Resuscitation Program instructor and have trained local ambulance crew members and the staff nurses. We do the orientation for new hospital nurses to maternity and do emergency childbirth skills workshops for the staff nurses. I recently did an emergency birth workshop for the outer island nurses who provide first call and they hope to come over and do some clinical work with us. It's great to work with the different students and health care professionals and it really helps with team building.

So let's review the results. As I mentioned, we do 99% of local births. The 1% we don[1]t attend are planned unattended births and, even more rare, unplanned physician attended births!

Of the women we see, 10% choose to deliver at VGH either for reasons of risk or choice, such as access to epidural. The women who deliver locally are pretty much evenly divided into home and hospital births. 10% of these women will transfer during or after birth. Most of the maternal transfers are non-progressive primiparous deliveries and the occasional premature delivery. 84% of these transports were by private vehicle or ambulance and ferry, suggesting that they were non-urgent transfers.

As I mentioned, we have no local c-section capability, so we have a pretty low c-section rate! Currently it is hovering between 7 to 10%. This includes all of the women in our care whether they delivered locally or were transferred. We have no local access to epidurals and therefore have an even lower rate of epidural use. As a labouring woman, when you have to get out of bed, get on a ferry and drive to town to get an epidural, you think twice about it! As midwives, we maintain and build the skills to help women get through a normal labour.

As the tide has turned in my community to local births with midwifery care as the norm, my belief in the benefits of women birthing in their own community has strengthened. I feel that our profession has a lot to offer and would like to make

five recommendations that I believe will help address the current challenges of providing maternity care to the women of B.C.

Recommendations

1. We need to acknowledge the existing evidence that supports the safety of rural maternity care, with and without c-section capability. And work to maintain and enhance existing rural maternity services.

   From the Report on the Findings of the Consensus Conference on Obstetrical Services in Rural and remote Communities (2000): Evidence suggests that the presence of a local rural obstetrics service, even if limited in scope, offers better outcomes for mothers and newborns than no service.[1]

   From the Society of Obstetrics and Gynaecology of Canada Joint Position Paper on Rural Maternity Care (1998): "The available evidence suggests that rural hospitals with limited services and in many cases without local caesarian section capability, do offer acceptably safe maternity care. Furthermore, and perhaps more importantly, populations served by rural hospitals which do not offer maternity care seem to have worse perinatal outcomes."[2]

   From the conclusion of an outcomes study of maternity care in a rural hospital without on-site caesarian capability (2002): "The presence of a rural maternity unit without surgical facilities can safely allow a high proportion of women to give birth closer to their communities. This study demonstrated a low level of perinatal risk."[3]

   The evidence is there that providing care to women in rural communities is safe. We need to acknowledge this and feel proud that we are offering a safe and effective service to the women in our care. We need to feel it in our bones. I'm getting tired of people telling me how brave I am. I'm not brave; I live in a wonderful community doing what I love. I think it takes bravery to work in a tertiary care centre where everyone seems to me to be scared to death of birth!

2. Acknowledge, recognize, and adapt to local conditions existing policy statements regarding the safe delivery of rural maternity care.

   From the B.C. Reproductive Care Program (BCRCP) Rural Consensus Statement: "Nulliparity is not a reason to exclude a woman from delivery if her community lacks c-section capability."[4]

   Nullips planning on delivering at Campbell River Hospital are required to travel to Comox Hospital when there is no anaesthetic or OB coverage in CR, Duncan women are diverted to VGH or Nanaimo, and Saanich diverts toVGH when there are gaps in anaesthetic and OB coverage.

From the BCRCP Rural Consensus Statement: "Augmentation with oxytocin and /or induction of labour may be offered in communities that lack c-section capability."[5]

Low-risk Gulf Island clients have to travel to VGH for what is essentially an outpatient service (i.e., prostin induction at 41+3 weeks) and then must deliver there.

From the BCRCP Rural Consensus Statement: "Regional anaesthesia may be offered to women in the absence of local c-section capability".[6]

Salt Spring Island RMs have support for this option from our GP anaesthetists, but have been blocked from implementation.

Why are we restricting women's options when good evidence and consensus exists to support these options as safe and appropriate? We need provincial standards of care rather than local pockets of resistance.

3. Acknowledge and promote the existing skills, competencies, and scope of RMs, expand the scope of practice to reflect rural realities, and increase the delivery of safe and effective care.

   CMBC guidelines allow RMs to manage VBAC deliveries for women with one prior LCSC. Several rural RMs report that VBAC deliveries are managed by Obs in their hospital.

   B.C. RMs are currently being surveyed regarding their scope of care; results are not yet available. Many rural RMs report a desire for an expanded scope (e.g., vacuum deliveries).

   Midwives working in isolation need access to a full range of options to provide care in an emergency.

4. Encourage inter-professional collaboration, and reduce barriers that limit RMs access to specialist consultation.

   Midwives in rural communities report "over-involvement of OBs" and report that "all consults become a transfer of care". A consistent complaint was the rural RMs' difficulties accessing epidural services for their low-risk clients. They report "not being allowed" to speak to the anaesthetist or being required to consult with an OB prior to their client being able to receive an epidural. Midwives at Lady Minto Hospital may administer demerol or fentanyl to their clients under pre-written orders approved by the CHR Chief of Obstetrics; in other rural hospitals the OB or doctor on call gets a call in the middle of the night for analgesic orders.

Midwives report MDs on call for maternity care refusing to speak to them and requiring that they access care for their clients through the doctor on call in the ER who may or may not have obstetrics experience.

This is unacceptable. Turf wars have no place in an integrated health care system. We need team work not competition.

5. Involve rural care practitioners in the education and continuing education of students and colleagues and reduce barriers to provision of continuing education (CE).

All participants in the recent rural midwives' teleconference reported outreach CE as a priority and travel to CE offerings as problematic due to lack of local locum coverage. They would like CE that is relevant to rural practice.

All participants in this teleconference reported an interest in providing preceptor sites for the UBC Midwifery Education Program.

In summary, rural maternity care is a safe option for women. Midwives need to be better integrated into their local health care teams with an expanded scope that is appropriate to the realities of their practice site. We have consensus amongst the stakeholders about how this care can be offered most optimally. Now we need to break down the artificial barriers and get on with the job. Midwives working in rural areas have good skills and experience that they are ready and willing to pass on to the next generation of practitioners.

Thank you for your time.

Endnotes

1. B.C. Reproductive Care Program. Report on the Findings of the Consensus Conference on Obstetrical Services in Rural and Remote Communities, Vancouver, B.C., Feb 24-26, 2000. Canadian J of RM 2000;5(4):211-7.
2. Joint Working Group of the Society of Rural Physicians of Canada, the Maternity Care Committee Physicians of Canada, Society of Obstetrics and Gynaecology of Canada. SOGC Joint Position Paper on Rural Maternity Care, No. 72. April 1998. Online at http://sogc.medical.org/SOGCnet/index_e.shtml
3. Leeman L, Leeman R. Do all hospitals need cesarian delivery capability? An outcomes study of maternity care in a rural hospital without on-site cesarean capability. J Fam Prac 2002 Feb;51(2):2.
4. Iglesias S, Grzybowski S, Klein M, Gayne G-P, Lalonde A. Rural Obstetrics: Joint Position Paper on Rural Maternity Care. Can J Rural Med 1998;3(2):75-80.
5. Iglesias et al., 1998.
6. Iglesias et al., 1998.

2. Practicing in a Shared Care Model

Linda Knox, RM, MA (Candidate)

I want to start by saying that over the past couple of days I have been sobered and filled with renewed hope for the future of our profession and its role in maternity care in Canada. My passion for midwifery has been really challenged over the past couple of years and I am feeling it re-kindled as a result of this dialogue. It's so exciting! I am excited by the opportunities and possibilities that are being raised through the different presentations and by the thoughtful comments and careful questions that I am hearing. We have always been a hugely diverse group and we may approach issues from pretty diverse places, but I am hearing a commonality that says we mostly are looking for the same things and the same solutions and that we are on the same page. I am encouraged that this can guide us into creating positive, flexible, and sustainable solutions.

Since midwifery was regulated here in 1998 I have worked in a partnership of two, providing care to approximately 80 women a year. Our partnership is situated in the group practice of six midwives. I was originally asked to talk about what I think the strengths and weaknesses of this model are for the women and their families and for the midwives providing care. But over the past couple of days, I think we have talked a lot about the strengths of this type of model and all that it embodies, and Luba did a great job yesterday of reiterating the strengths. One of the advantages of presenting on the last day of a think tank like this is being able to adapt and be responsive to what has gone before. It can also be a bit of a challenge and I think this has changed every 10 minutes for me as I have listened to people ahead of me.

I think, therefore, it would not be a wise use of time to discuss the benefits, but I would like to spend some time examining the weaknesses.

I found the discussions yesterday afternoon stimulating, to say the least, and I appreciated the information regarding some of the flexibilities of regulation, but I felt that when some of the challenges and weakness were talked about, they were kind of quickly minimized or simply bundled under the label of "burnout". So I want to talk about and explore the weaknesses, and please don't mistake my intent. I don't want to negatively focus on what's not working or in any way diminish the benefits, but rather try to identify and validate our struggles and challenges.

Several people have commented during these proceedings that we must be thoughtful as we consider change. In order to be thoughtful we should be able to consider all the angles and use our findings to inform our approaches to change.

I want to push through what in the past was thought to be a kind of conspiracy of silence. I mean get a bunch of midwives together in a room sometimes and it is

just like instantly everybody is going on about how burdened, tired and exhausted they are, how sick they have been, and it's just such a struggle. And other times it feels like it's not okay to talk about it because it appears we are putting on a negative image. We have talked about the fact that we need to try and change that so that we aren't putting that image out into the wider community and certainly not to those new midwives coming into practice.

I can only speak from the experiences in our practice and I trust that they will be fairly representative of the many stories I hear from other practices as well. As a jumping off point I will draw a brief sketch of what our care looks like.

When women come into care with us, they see my partner and me on a schedule of alternating visits so that by the end of the pregnancy they will have developed a relationship with each of us. They will be cared for by whichever one of us is on call when they go into labour. We switch call weekly, doing one week of call and one week of clinic. The on call midwife attends labours and births, does postpartum hospital and home visits, antepartum home visits when necessary, and takes any urgent calls from clients. The midwife in clinic does two-and-day-half days of clinic visits and, hopefully somewhere in there, gets a four-day stretch off before going back on call. Needless to say that happens rarely! Lee and I tend to debrief at the end of most clinic days and after every birth, which keeps us pretty closely involved in the care of our clients. It is a very intimate way to practice and embodies all the benefits and strengths we have debated and affirmed.

I have to say that when I started out in regulated practice I thought this was just the hottest system! I have a partner, I have support all the time, I have regularly scheduled down time, what could be better? And I had a partner who was kind of interchangeable. Our clients often, still at the end of care, call us by each other's names and that's great because they obviously feel that comfortable with us. In theory this should be an ideal model of care for both clients and midwives, but in reality it seems probable that one population of women, the clients, are having their needs met and possibly exceeded at the cost of another population of women, the midwives, who are struggling with quality of life issues. The truth is I do have a great partner but the other truth is I rarely if ever feel like I'm off call, unless I scurry out of town.

The model of two-on-one is just too similar to one-on-one because it doesn't matter how carefully you structure your caseload and how carefully you spread out your due dates, you are going to have double-ups and you are going to have those marathon back-to-back births, and yes, in our practice, we still have those long primip labours. Then there are the postpartums to be done at the end of the day. We often are on second call for each other. We have a busy urban practice and it's really not okay often to turn my pager off and just feel like I'm off for the weekend. As we have heard today, exhaustion is a huge issue in safe care, and in the first three years of practice we just soldiered on, we kept ploughing ahead, because that's what was expected. We have done it for so many years, so we just

kept putting one foot in front of the other and went from client to client and birth to birth and kind of cat-napped wherever we could, and we thought that was okay. Now we really get it that it's not. So we have had an even stronger commitment in this last year to never let our partner be up for longer than 24 hours. That just means I am always there to relieve Lee or Lee to relieve me.

That's why, Luba, when you asked the question yesterday, "where is your partner and why hasn't she come in to relieve you?" it's a simple and obvious solution. You do that for each other, but the cost is huge, it's just huge. My partner is supposed to be off call, she has done her week on call. She needs to have down time, renewal, and family time before she goes back on call. This is hugely problematic and we have done some things in our community to try and deal with that. As I mentioned, our practice is situated within a group of six midwives so that, in theory, when I get really tired and have been up for too long I should be able to call one of the other midwives in my practice who is on call. But that's difficult too, because now my client is being looked after by a stranger and our whole thing about continuity of care becomes difficult and oftentimes the other midwife is running from birth to birth. Then I feel I am burdening them with an extra client when they could be catching up on sleep before they get paged out again.

There is also a financial impact. We hate to say that and we hate to think it, but the truth is that if I am calling other people to look after my client caseload, I have to pay them to do that. It's hard enough to run a clinic and carry overheads and pay all the things that we have to pay to stay in business without having to give away our income as well. If these things are difficult for us, as senior practitioners, I just keep shaking my head when I think about the new midwives coming into practice and those midwives who want to try to practice part-time and are finding it so difficult to find models that will support them to do that.

Then there is the whole component of guilt that sneaks in there as well, that pressure to be there no matter what. So it's like, if you are not able to be with your client, you do feel guilty. We do that to ourselves. And we are understanding that more and more, we have had not to be there for clients and we're actually quite surprised at how well they take it. They are maybe not missing us as much as we think they might be.

The big one, of course, is burdening your call partner or another midwife and then there is the whole issue of what happens if you are sick. How many of you have gone to bed ill when you are on call, just praying that your pager doesn't go off? It's like "please not tonight-just give me one night in bed and I know I'll be better, don't call tonight"! That is a tough one because there aren't any spare midwives who are out there to do locum call. Wouldn't it be great-dial up the pool like they do for substitute teachers! "It's the Midwifery Group, we need two"!! I'm really looking forward to that day. Lee and I have discovered this year that it's way harder to accept the help than to offer the help. If you were a fly on the wall listening to us it would sound something like this:

"So listen, I have decided to stay on call for another couple of days until you're feeling better."

"Oh no, no, it's all right, I don't want you to have to do that, I'll be fine."

"Actually you're not fine, and I have already decided that I'm staying on."

"No, really, really, I'm fine, I'll be okay if I have to get up and go tonight, I really will."

"Actually you won't, you just told me you have a fever and you're still throwing up."

"Yes, but that's okay. I'll just take some more Gravol and Tylenol and I'll be fine."

"No, I'm fine and you're not, and I'm staying on, stop it already."

We actually get mad at each other to convince each other that they have to let us help them. It's funny but it's also pathetic. It's taken a few years, but we are learning. So what this really means is that your partner is never truly off call. And so I think that some of the things we have talked about in looking at different models-certainly having more midwives will address this big problem. Being able to expand the number of midwives involved in care so that you can actually have rotations that take all of that into consideration.

Then the other big one is coverage for holidays, for educational leave. What about that? Time off is next to God in our practice. The importance of time off. This work is far too intense to keep doing it for long stretches of time without down time, and try finding locums to hire for that. Every once in a while you get lucky and you find someone and it might work pretty well, but a lot of the time it's just impossible, there is no one out there. And I see Maggie looking at me who works in isolation as so many of you do, and I really do take my hat off to you. But it's a really big problem because you are not resting or renewing and I think that's difficult.

We in our practice have actually been lucky to be able to hire locums. Last year Lee and I both wanted to take chunks of time off, educational leave. Lee is working on her PhD. and I'm trying to work on a Masters program. So we actually booked a locum for a period of time and we felt so lucky. But the problem is that most of the more experienced midwives who have been in practice for a long time and really established in their own practices, so what it meant was that we brought into our very large and very busy urban practice, a fairly new midwife and it was really tough. We kind of had to still be there some of time to help her out. It was so overwhelming for her and we actually in the end had to send her home early because she was exhausted!

This year, hopefully, I can take a month off in July and Lee can take a month in August. But what that means is before your holidays and probably after as well, you are working twice as hard, so you are really burned out when you go away and you lose the advantages of your time off pretty quickly when you come back and have to work solo for a long period of time. It also, again, has financial implications because it means that the person who is taking time off isn't being paid for that time. You can't build a full caseload to meet your overheads and pay everybody with just one person working.

Those are the big issues and they are huge. And one of the things that really concerns me-and again I would throw into the mix that what a lot of midwives talked about, if they only had their practice to juggle and balance it would be almost manageable. But when you throw in all the other multitude of tasks that need to be done to keep the profession moving, again there is that little "guilt" component that jumps up and bites you in the butt because the work has to be done and it shouldn't be done on the shoulders of a few. It needs to be spread over everyone. My fear here is that for the practice work and the political work, we have been doing it for so long that we have normalized it. Hey it's what midwives do. I believe it really impacts on our negotiations with the funders. They've been watching us do this for 10 to 15 years and we just keep plugging along. We don't say "no". We are so committed and passionate about our profession that we just keep going. So now we have normalized it. I think its quite amusing: the other day, a bunch of midwives in Vancouver who all see the same careproviders, the same family doctors, same homeopaths, and we go in for care, and they just kind of look at us and go "Dah, look at your life!" And for us, we don't even see that, we just think what we do is normal.

Our families look at us like we're crazy. I have an older daughter who now has a child of her own and she actually gets impatient with me every now and again. I get a little scolding sometimes! So as we move into some of the changes we are looking at, we need to have some non-negotiable guiding principles, one of them being that as we keep women in the centre of decision-making in care, we also have to honour ourselves the same way and keep our health and lifestyle and the balance that we are lacking central to our decision making as we move ahead. This is one of the reasons I am so excited by all of this. I think I'm hearing lots of ways that we can do that and creatively create models that will support us as well.

3. Burning On: Lifestyle Challenges of a Practicing Midwife

Carol Hird, RM, RN, MA

The focus of this paper has been very difficult to find. The subject is vital to my colleagues and myself. It is complex and intensely personal. I decided to keep the content both research-based and personal.

I have had a full life with midwifery. So, this is not a litany of woes but rather a reflection on how the considerable lifestyle challenges of midwifery practice need evaluation and evolution.

Evolution is change. All of us will agree that the last five years have involved *change*. I consider how lifestyle challenges affect our personal well-being and, ultimately, our collective ability to sustain our practices. I will mention some of the literature regarding stress lifestyle and wellness.

We had a dream, not quite the impossible dream, but by Canadian standards the improbable kind. The dream was to establish midwifery care that was respected not ridiculed, accessible to women and their families, midwifery care that was autonomous and women-centred. Eighteen years later, through enormous work in British Columbia and internationally, our dream was realized. Shared or single midwifery practices were established, midwives were funded, and women had greater access to funded midwifery.

When in 1993 the B.C. government announced its intention to legalize midwifery, a dear friend and colleague, Karen May, sent a congratulatory note. She drew on Robert Frost's poem to remind me that there were "miles to go before you sleep". I realize now how prophetic that quote was.

The pressures of integrated midwifery practice include long hours, sleep deficit, stresses on our children, spouses, and stressful/critical incidents involving clients and other members of the medical and nursing team. Committing to the evolution of our profession has meant far more than full-time work. We had to be "on" about midwifery as we returned this honoured profession to its rightful place within the existing health care system, working as advocates, diplomats, and change agents. The development of the profession involved countless hours of committee work, phone calls, e-mails and, of course, births. No one promised it would be easy; however, I was not quite prepared for the workload.

Sleep—that vital need—is often sporadic and decreased for midwives. Researchers report that chronic sleep deprivation has a major impact on life expectancy, increased risk of serious driving accidents, decreased cognitive functioning, and significant compromise of the immune system.[1] "Accumulated sleep deficit may

lead to other serious problems: insomnia, sleepiness at work, and chronic fatigue. Common complaints of shiftworkers include sleepiness at work, general fatigue, frequent dizzy spells, mental exhaustion and the (dreaded) irritability."[2]

Most of us can relate to that research and have concerns about our ability to continue with care after many hours of labour overnight and into the next day. Our backup resources are scarce. Our challenge is to find appropriate backup so that our safety to practice is not compromised.

Stressful situations such as a difficult birth, a poor outcome, an emergency transfer, or the need for emergency skills at a birth, can stimulate a stress response. These responses over a prolonged period can result in psychological and physiological reactions. Our practices expose many of us to these events. "Following a critical incident a midwife may experience feelings of horror and guilt. She may become anxious and hyper-vigilant at other births. She may also experience nightmares and intrusive thoughts about the event."[3]

Counseling and peer support are invaluable in the weeks and months following an incident. Midwives must identify what helps them alleviate stress symptoms. I need balance in my personal life to maintain mental, spiritual, and physical health. Balance fosters inner strength and energy. I need that strength and energy so I can love and care for women and their families during birth. Ironically, I spent many midwifery department meetings sitting opposite a poster for mental health:

To Eat

To Sleep

To Work

To Play

To Love

To Laugh

To Live

Mental Health is Priceless

Many days I think that the only criteria I meet from the above list is work. I agree with the statement, but like many other midwives, I have not yet found the balance. I consider that quest is the greatest long-term challenge to individuals and certainly to midwives. We ignore this challenge at our peril.

We struggle to find out what works best for us as women, partners, midwives, mothers, and friends. We leapt optimistically into our call schedules and shared responsibilities. The opportunity to finally practice midwifery drew me in. But it is not enough to *keep* me in, not in the current structure. I believe that we should take a critical appraisal of what works for midwives and what does not. Two major issues influence the way we work: continuity of care and the funding model.

How to integrate these issues affects the ability of many midwives to achieve balance in their personal lives. The difficulty I have found in developing my practice is finding a way of maintaining continuity of care that does not require long periods on call. Working with another midwife in a shared care model requires one midwife on call for births; the second midwife attends to the prenatal care and office administration. We work one week on and one week off call. The person off call is also second on call. This situation of being second on call even on days off is stressful. When you are called, your personal time with family and friends is interrupted and even with the best of relationships, disappointments and loss of intimacy are inevitable. My own feeling at times like this is that I have no control over my workload or personal life, a situation that is extremely detrimental to mental and physical well-being.[4] In my own practice, therefore, I have integrated continuity of care but at the cost of personal well-being.

So far, time off the pager has been an unachievable goal. Consider this: two or three women are in labour at the same time. Who do you call? Mostly we have called our practice partner even if she has just gone "off call". The situation where you may be with someone in early labour and the day progresses and the labour does not. You are up all night and into the next day. What do you do? The cyclical nature of birth compounds the problem. It seems as if all the midwives are busy at the same time.

Our department at the B.C. Women's Hospital and St. Paul's Hospital has developed a call schedule which identifies midwives in our community who are willing to be called to give relief to midwives who have been with a woman in labour overnight. All midwives in our community make themselves available for this. This is one solution. However the midwives are also on call for their own clients, so the availability of relief is not consistent. The small number of registered midwives in British Columbia worsens this situation. Increasing the numbers of midwives in the next few years and the flexibility of work schedules will eventually mitigate this. Consideration of flexibility with the model of care is essential.

The definition of continuity of care is a core principal of midwifery care and in our resolution of our own health maintenance we shall take care to address women's needs as central to the discourse. At this point though, the sustainability of our profession is pivotal on the health and well-being of practicing midwives.

Flexible work conditions, adequate time off call, and vacation time from the pager, are key to a balanced lifestyle.

Our funding model of fee for service or billing for a course of care has some drawbacks. The sporadic numbers of births each month due to early or late abortions or client relocation result in an unpredictable amount of income in any given month with the same overhead to be met. Unexpected events-such as a family member's death-can become an even greater burden due to financial costs of covering the practice.

Returning from my father's funeral, my bereavement was deepened by a significant anxiety, caused by the decrease in my monthly income to cover my practice, as three births occurred in my absence. In my anxiety to relieve my colleagues of the extra work, and possible further cost of coverage, immediately on my return from my bereaved family, I recommenced working. My own need to rest and grieve was denied because I felt I could not afford to be "off call" any longer.

The cost of locum coverage, overheads, high costs of malpractice and long-term disability coverage, annual dues, etc., has eroded what I had anticipated to be appropriate payment.

The need for vacation during summer months or time when our spouses and children are on vacation has been very difficult to arrange due to the small numbers of midwives available for locum work. Instead of the cost of a locum, many of us have taken holiday time for a month and reduced our client numbers usually to a half. The remaining practice partner is now on call for a month 24 hours a day. Clearly this scenario is not a healthy option.

Some have suggested that better financial planning for these contingencies is required. I have not yet been "in the black" since I began practicing, although I certainly planned to be. This is due to my first six months as a full-time conditional registrant without any remuneration. I lived off my line of credit for that period of time and maximized the credit available. To many of us with partners, who have supported us, hold mortgages with us, this was and still is a stressful situation to be in. Although this is not a funding model issue, any evaluation of integration of midwives into practice needs to be sensitive to the individual family and financial responsibilities of midwives.

I'm divorcing my pager in September. When a medical colleague teased my spouse about my leaving practice in September, my spouse said dryly, "It's best for Carol to leave while she's alive". I think there is more than a little truth to that, not only in the sense of drawing breath, but also of living fully in the balance we all deserve. I sincerely wish to remain working in midwifery, however the challenge is to find the flexibility within our existing funding model and model of care.

I note with sadness that little or no literature addresses the sustainability of our profession from the perspective of health maintenance of midwives per se. The time to evaluate the major changes implemented by legalizing and funding midwifery is now. It is almost five years since we began practicing within our model of care and funding. "The evaluation of the effects of such change is an integral part of the innovation itself, examining the process and effects of the change, and in itself adding to more effective processes and outcomes." [5]

For years I treasured a quotation from George Bernard Shaw. It reads, in part, "Life is no brief candle to me. It is a sort of splendid torch which I have got a hold of for the moment, and I want to make it burn as brightly as possible before handing it on to future generations."

I also cherish advice from a minister who cautioned me that it's better to burn on than to burn out. In the context of future midwifery care for women we must address the lifestyle and health care needs of midwives. Healthy people need adequate amounts of sleep, regular nourishment, exercise, and significant contact and nurturing from loved ones. Our beloved profession needs to be nurtured in the same way we believe women in our care need to be. If we collectively cannot pay the same attention to our own lifestyle and health needs we will burnout. Then, who will be there for our clients?

Endnotes

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I. Midwifery in New Zealand: Revolution and Evolution

Deborah Harding, RM, MA, PhD (student)

In her presentation, Deborah Harding reflected on the changes to New Zealand's maternity care environment during the past ten years due to the introduction of autonomous midwifery. She considered the combination of factors that led to midwives providing over 70% of the care to birthing women and described the multiple models of midwifery practice the system supports.

New Zealand has now had over ten years of autonomous midwifery practice and midwives are now reflecting on the changes and challenges of that major transformation in maternity services.

In 1990 when midwives achieved the right to practice independently with an amendment to the 1977 Nurses Act, it is estimated there were 50 midwives in independent practice. Many of these midwives had a home birth practice, but many also had recently been or were still currently employed by hospitals.[1]

Midwives in New Zealand are central to the provision of maternity services and now provide over 70% (about 43,000 births) of Lead Maternity Carer services to women. The Lead Maternity Carer (LMC) is the practitioner responsible for the care provided to the woman throughout her pregnancy and postpartum period, including the management of labour and birth. Current estimates of LMC for 2001 are: midwives 73%, general practitioners 15%, obstetricians 12 %, with a small percentage of women presenting straight to secondary/tertiary hospitals for care.

What are the factors that shaped this significant achievement? There are many, and they constitute a complex web interwoven with politics, positioning, partnership, economics, and a wave of health reform. During my recent visit to New Zealand I put this question to a focus group of midwives, to eight midwives I interviewed individually, and to faculty members at the Graduate School of Nursing and Midwifery at Victoria University of Wellington. Based on their responses and current information from the New Zealand midwifery literature, I am going to discuss: (1) The recognition of all registered midwives, their autonomy and their ability to practice in a variety of settings, and (2) the continuing replenishment of the pool of midwives by education and registration.

Opportunities for Practice

Midwifery practice in New Zealand has gone through many changes in the last 12 years and continues to evolve. Midwives went from being supervised by physicians to being completely autonomous practitioners practically overnight. Midwives began to move out of the hospitals into community practice. Many moved not because they believed in autonomous midwifery practice, nor because of the

philosophy of midwifery care (continuity of care and the primacy of women's choice and control of the birthing process), but because as autonomous practitioners their remuneration for maternity care was equal to physicians and many were ready for a change.

In New Zealand there are a variety of settings in which midwives can practice. During the discussions I had with midwives regarding their options for practice they related how the variety of settings are positive for women, for the midwifery profession, and for midwives individually. The exposure and experience had enhanced their professional careers and enabled them to meet their changing personal and professional needs. Many midwives stated that without these diverse options their choices would have been to leave the profession or return to nursing. Midwives who had worked solely in hospitals found themselves several years later practicing in an almost exclusive home birth practice. Independent midwives undertaking higher education were able to work in hospitals and meet their financial needs. Midwives reported that although independent practice was the initial pure vision of midwifery care, they are now cognizant that one model does not fit all midwives, all women, nor the complex requirements of the health care system. The fact that a midwifery presence is possible and evident in so many areas means that the midwifery philosophy and fundamental principles can be practiced and promoted in all areas and have a major impact on maternity care.

Some of the major options for practice are discussed below.

Independent Practice

Independent midwifery practice was considered a key mechanism to protect the autonomous role of the midwife, rebuild the profession, preserve and support woman's choices and control over childbirth, and promote the key tenets of woman-centred care and continuity of caregiver.[2] This has proved to be true, with midwives now providing lead maternity care for 73% of birthing women.

The midwives who moved into autonomous practice had several challenges, one of which was an issue of confidence within themselves and with the public, and the other a hostile media and a hostile medical profession. Funding mechanisms also played a large part in the changes that followed.

The exposure to independent practice and the experience of working with women in the community has inspired many midwives to move from shared care with GPs to independent practice, and some have become exclusively home birth midwives. The home birth rate is increasing and is estimated at about 7%.

Independent midwives practicing full-time carry a caseload of 40 to 60 women per year. They are on call 24/7 unless they are in a group practice or have arrangements with other midwives in their area. There are many part-time

practitioners: midwives with families who book two births a month, or midwives who are feeling "on the edge of burnout" will often reduce their caseload for several months of the year. I talked to three midwives who have periodically taken a year off. Midwifery lecturers at the Wellington Polytech have a small faculty practice. Midwives provide backup for each other at home births and, if the hospital is busy, for hospital births also. Most independent midwives negotiate access agreements with hospitals, similar to having admitting privileges. Home birth supplies can be obtained from hospitals; otherwise payment for them is included in the maternity schedule.

Previously the majority of independent midwives had provided all prenatal and postnatal care in the woman's home. Midwives often joked about their "office in the car". This has proved to be extremely time-consuming for the midwife with a full-time caseload and many practitioners are now seeing women in their own clinic space or "rooms". Women generally carry their own notes. Postnatal care is mandated by the new Section 88 payment schedule to be a minimum of 7 visits, 5-10 of which are to be provided in the home.[3]

Mentoring is a significant part of independent practice. Many group practices will provide mentoring for new graduates and new registrants. Payment is negotiated with each practice or midwife depending on individual circumstances and usually involves fee splitting of various proportions.[4] Independent midwives play a large role as preceptors for midwifery students. They are generally paid a fee for this service (although not always) and this varies according to the area.

Shared Care

Many of the midwives who moved into the community provided shared care with GPs or, in lesser numbers, obstetricians in private practice. This took various forms: sharing prenatal care, the midwife providing intrapartum care which sometimes included the birth (sometimes the GP would come just for the delivery), and the midwife providing the postpartum care. Initially funding covered both the midwife and the GP until it became clear the maternity care budget could not stand paying two practitioners for the same service. Within the health care restructuring maternity provider organizations emerged, and separate midwifery groups negotiated specific funding contracts with the health care ministry, resulting in 22 different contracts. Some received better contracts than others did because of skilled negotiations and different presentations of the same services. What this meant for midwives was that they had to negotiate payment with the GPs with whom they provided shared care. Many midwives ended up with a 48% (for the midwife) 52% (for the GP) split, when the midwife actually provided more care. Shared care midwives often carry a heavy caseload and this has motivated many midwives to move out of shared care into independent practice. However, there is a general consensus that shared care was a necessary transition for a public that was not sure about a midwife as the primary caregiver and for midwives that had spent most of their professional lives working in

hospitals. The home birth rate for midwives working in shared care is generally quite low.

Group Practice

Midwives, particularly in the larger centres, formed group practices. These practices vary from 2 to 3 midwives to 13, with an average of 5 to 6. Some of these groups are attached to birthing units and other facilities. As previously stated, several of these groups negotiated separate funding agreements. These groups have many different arrangements for sharing care: the most common system is to carry a primary caseload and have backup for time off and holidays. Some work in teams of three or four. Many groups have various methods of clients meeting the other midwives, from alternate prenatal visits to coffee mornings, drop-in afternoon tea, and prenatal evenings. Several of the group practices play a large and important role in mentoring new graduates or registrants. Group practices generally report a steady home birth rate (30 to 70%).

Community Health Centre

There are two centres in the Wellington area that provide community health services and employ midwives. There are more in other parts of the country. These centres, run by the community, with a staff consisting of physicians, nurses, social workers, and other resource people, generally serve a socially and economically disadvantaged population. The midwives are salaried with paid holiday and sick time and enjoy regular time off call. The midwives generally carry a primary caseload of 40 to 60 and regularly meet each other's women. The midwives are well supported by the centre and the other health services provided and have all their expenses covered. There are generally four full-time midwives on staff, but at times one or more of these positions has been part-time. The midwives state they have a great deal of support, flexibility, and autonomy. Prenatal care is often provided in the women's home or at the centre. The majority of births take place in a hospital. However, this is often due to the circumstances of the population the midwives serve. Home births are available as desired. Postnatal care is usually provided at home. Care is transferred back to the centre GPs at six weeks.

A midwife recently conducted research (for her master's thesis) of six midwives in six different settings for practice in New Zealand. According to her findings the community health centre setting was the preferred practice model providing the most advantages for women and midwives.

Caseload or Team Continuity of Care Practice

Some institutions or facilities within a given health authority have instituted caseload midwifery care with teams of midwives. The practice manager I interviewed described the setup of the practice at Burrowed Hospital near

Christchurch, New Zealand. This is a program that has been in operation for seven years. There is a team of 5 midwives providing continuity of care to a caseload of 50 women each per year (250 births). The women have one primary care midwife (Lead Maternity Carer) and one designated backup midwife. The women usually meet all the midwives at some time during the pregnancy, during visits or prenatal classes/gatherings. The midwives are employed by the hospital (birthing unit) and are salaried. They generally have seven designated days off per month usually taken as three- and four-day weekends. They also have 13 extra days (to account for the missing day off each month) which can be taken as a block. Holidays are 4 weeks per year plus 10 statutory days. Prenatal care is provided at the unit, early labour care is often in the woman's home, and postpartum care after discharge is also in the home. The midwives will relieve each other during long births as necessary. Other independent midwives in the area also provide care at the unit and there is one core midwife and one health care assistant on staff at all times.[5] A practice manager (a midwife) covers the administrative duties and can provide clinical assistance during daytime hours.

The birthing unit is designated as a primary care facility and if complications arise that require a higher level of care, the women are transferred to a secondary hospital (approximately 10 km away) accompanied by her attending midwife. They have a blend of experience among the midwives and, where possible, employ new graduates as part of the team.

Most hospitals provide some option of team/caseload midwifery within the facility's services. Some are specific to certain areas of care such as the high-risk team at Wellington Hospital that works in conjunction with obstetricians providing continuity of care to women with complex conditions.

Core Facility Midwives

These midwives are employed by a core facility on a full-time, part-time or casual basis. Hospital midwives work in all areas of the maternity care provided by the hospital, antenatal clinics, antenatal care in-patient units, labour and delivery suites and postpartum care. Midwives may work on one area consistently (some for several years) and some will rotate through the various areas, especially those midwives working part- time or casual. Remuneration is usually on an hourly basis with holidays, sick time and other benefits included. The midwives work 8-hour, 10-hour or 12-hour shifts.

Many newly graduated midwives will spend time in hospitals to gain experience. Several midwives with young families reported that they worked for short periods in the hospital as the regular hours enabled them to continue to work and maintain expertise in all areas and also meet the needs of their families.

The Professor of Midwifery and Women's Health for the Capital Coast Region states "there is a steady stream of midwives from the hospitals into independent

practice and a steady stream back from independent practice into the hospitals".[6] Midwives report hospital midwifery practice provides an opportunity to continue providing midwifery care when the demands and requirements of independent practice are not compatible with their individual circumstances.

Postpartum Care

Some midwives provide postpartum care in the woman's home as a private service and are employed by core facilities (hospitals) or physicians' groups. This is a valuable service and provides a work opportunity for midwives who need to work part-time with regular hours, e.g., midwives with new babies or young families. Postpartum care as mandated by Section 88 requires that each woman receive a total of between 5 to10 visits at home by a midwife.[7] This creates a need in the community that is successfully filled by midwives not in full-time or independent practice.

Registration

The registering and regulatory body for midwifery in New Zealand is the Nursing Council of New Zealand. They have the responsibility for setting and monitoring standards for registration and ensuring safe and competent care for the public of New Zealand.

In 2001 the Nursing Council of New Zealand issued 4,800 annual practicing certificates for midwives; the majority of these will be dual registration.[8] The current fee for Annual Practicing Certificate is NZ $45.00. According to the New Zealand College of Midwives the midwifery workforce is about 2,018 and 1,920 of these are College members. Membership in the College of Midwives is voluntary. About half of these 2,018 midwives are identified as having a caseload, e.g., providing care in a continuity of care and carer model.[9] Many of these midwives are independent midwives (or self-employed). Others are practicing in a variety of settings: hospitals, health centres, community health groups, or shared care practices with physicians. Some are registered as working primarily in other areas of midwifery-for example, midwifery education, administration or management, research-but may in fact provide midwifery care in a locum arrangement, postpartum care services, shifts at core facilities, or small caseloads such as in a faculty practice.[10]

The Nurses Act 1977 sets out the conditions for registration of midwives. Registration is for life except in the case of a finding of professional misconduct when a midwife's name may be removed from the register. Annual practicing certificates are issued following application and documentation of current competency. Impending legislation, the Health Professionals Assurance Competency Bill, requires that midwives maintain a portfolio that demonstrates their ability to meet the competencies required for registration, namely:

- The applicant/midwife works in partnership with the woman throughout the maternity experience;
- The applicant applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care;
- The applicant promotes practices that enhance the health of the woman and her family/*whanau* and which encourage their participation in their health care; and
- The applicant uses professional judgement as a reflective and critical practitioner when providing midwifery care.

This does not mean practicing in a specific model (e.g.. with a caseload). It has a broad definition requiring a practitioner to provide the evidence that supports her competency to provide "hands-on" midwifery care as set out by the Competence Based Practicing Certificate professional practice guidelines.[11] There are no other specific requirements for active practice, neonatal resuscitation, emergency skills or continuing education. It is the midwife's professional responsibility to ensure she is competent and her skills are current.

This approach has not created a safety issue with regard to clinical outcomes.

The registration process is designed to protect public safety. It is an individual process and each applicant is assessed as meeting the standards for public safety. Generally the process proceeds very smoothly, although issues do arise from time to time, usually with documentation being found to be valid. Competence is assessed at the level of a newly-graduated midwife, e.g., meeting the undergraduate requirements of the New Zealand midwifery programs. Periodically, the Nursing Council conducts audits of midwifery curricula and education programs to ensure the implementation meets the standards for registration. The Nursing Council considers registration to be a continually evolving process.

Applicants will be considered for registration where the applicant has:[12]

- Undertaken a midwifery program that is similar in all specified content and length to the equivalent program in New Zealand;

- Supplied (certified copies) data including:
    - verification of current registration
    - transcript of midwifery program
    - passport, birth certificate, etc.
    - curriculum vitae
    - professional reference
    - character references;

- Practiced as a midwife within the last five years;

- Supplied information and evidence of the applicant's ability to speak and write in the English language where English is not the applicant's first language;

- All applicants are required to complete a learning that covers relevant New Zealand legislation and specific pharmacology and prescribing information.

Fees for registration are NZ $211.00.

Further Requirements

Where these requirements are not met (e.g., lack of recent practice or an unknown program), the applicant will be asked to undertake a language assessment, then a competency assessment, before the Nursing Council will consider registration as a nurse or a midwife.[13]

Competency assessment programs are provided through a contractual arrangement with an education provider: e.g., a polytech in conjunction with a major hospital and an experienced practicing midwife. The applicant is responsible for negotiating the arrangements for the experience and for informing the Nursing Council of the arrangements. Information is provided regarding available sites and opportunities. Competency assessment programs may comprise of a clinical issue or a theory issue or sometimes both. Common issues include specific pharmacology and prescribing rights and applicants may undertake an educational component at a polytech and then be eligible for registration. Competency assessment programs are driven by policies set by the Council. The assessments can be as short as 4 weeks or as long as 12 weeks. They may be a combination of assessment and mentorship and may recommend a period of clinical experience in the community. The applicant provides midwifery care under supervision and at the end of the assessment program the provider "signs off" and recommends registration or otherwise.

The costs incurred are paid by the applicant and are generally not large amounts.

Overseas Applicants Registered April 1, 1999 - March 31, 2000	
Overall number of applicants	1146
Dual qualification: Nurse and Midwife	64
Midwife only	28

Recent information from the Nursing Council estimates that 10 to 15% of overseas midwifery applicants required competency assessment programs.

Complaints and Problems with Registered Midwives

For the year ending 31 March 2000, there were two new (two ongoing) health and disability hearings before the Nursing Council. The disabilities considered may include physical and mental disability and drug dependency.

There were 20 complaints relating to midwifery care, only one of which was taken to a hearing and after which no further action was taken. The conduct alleged in the complaints received for nurses and midwives included failure to visit clients or document visits in the community, borrowing money from a client, medication errors, making inappropriate statements to other staff, accepting large sums of money from a client, administering increased doses of medication to clients without authorization, restraining a client, and providing inappropriate information to a mental health service client.[14]

Medical Misadventure Claims

Liability insurance for midwives in New Zealand is no-fault insurance and is provided by the Accident Compensation Corporation (ACC). If a person experiences a personal injury resulting from treatment by a registered health professional they may make a claim for medical misadventure to the ACC. The ACC awards payments for support services, ongoing medical or rehabilitation treatment, and health and disability services. The public may bring a civil suit for damages, but this is rare and unlikely to result in large damages being awarded.

The claims are determined to be medical mishap or medical error. Medical mishap is defined as having had the right treatment and it was properly given, however, a complication occurred that was both rare and severe. The complication must clearly be as a result of the treatment and not because of the medical condition. Medical error occurs when the injured person does not receive treatment of a reasonable standard, given the circumstances.

The ACC injury statistics for 2001 report the medical mishap and medical error claims accepted for midwives as follows:[15]

Medical Mishap						
1994/5	1995/6	1996/7	1997/8	1998/9	1999/2000	2000/2001
8	5	4	1	3	1	4

Medical Error Claims						
1994/5	1995/6	1996/7	1997/8	1998/9	1999/2000	2000/2001
3	2	7	1	1	4	4

Liability Insurance premiums are covered as part of the membership fee in the New Zealand College of Midwives, which is NZ $600 per year. Insurance coverage is also available through other sources, e.g., the New Zealand Nurse's Organization.

Education

Education was an important part of the renaissance of midwifery in New Zealand.

Prior to 1990 midwifery education had devolved into part of a one-year Advanced Diploma in Nursing course, resulting in six to eight midwifery registrations per year.[16] The midwifery and consumer organizations supporting the changes in midwifery advocated strongly for the direct entry midwifery education that was reintroduced as an "experimental" program in 1992 at the Otago Polytechnic and the Auckland Institute of Technology. There are now five schools (three polytechs and two universities) for basic midwifery education in New Zealand that provide a three-year Bachelor of Midwifery program. Access programs are available for registered nurses. In Australia, two (direct entry Bachelor of Midwifery) schools have recently opened, one in South Australia and one in Victoria and two more are scheduled in the next two years. There are four universities in New Zealand providing graduate programs (Masters) in midwifery, and there are two universities providing postgraduate programs (PhD) in midwifery.

The programs generally graduate 80 to 100 midwives per year. The Nursing Council of New Zealand Annual Report for the year ending 31 March 2000 notes registering 125 new graduates for the year 1999/2000. There is a commitment to increase the number of Maori graduates and provide mentoring in the first year of practice.

Where Do All the Midwives Go?

A study conducted by Pairman and Massey (2001) looked at the work histories of midwifery school graduates for the years 1994-1998.[17] The project was a quantitative study that sought to establish baseline statistics about the practice style and location of direct entry Bachelor of Midwifery graduates in New Zealand.

The findings reported that most midwives remained in the regions surrounding the institution from which they graduated (which is more likely with a choice of five locations). The majority of positions taken up were in an urban setting (69.5%). Respondents who were located in a rural setting were more likely to be carrying their own caseload. Most positions were taken up in a hospital setting (61.2%). Across all positions 45.8% of midwives were caseloading, 51.6% worked in core facility positions and 2.6% worked in other positions such as management, education, and casual postnatal. The majority of respondents worked continuously since graduation; 28% took a break. For their first employment position the majority of the midwife respondents were employed in a public hospital (57%) followed by 33% in independent practice (self-employment). However 11.3% of the hospital-employed graduates were caseloading in their first position. The trend in practice style was toward caseloading. Future practice intentions indicated that 91.2% of respondents intended to continue to work as a midwife and 71.6% intended to practice within a caseload model.

A guaranteed income, paid holidays, and the opportunity for professional development (paid study leave) were cited as the main influences for taking a

caseloading position within a hospital. A consistent movement between caseloading and core facility midwifery practice was found, (which continues to occur as stated by Professor Foureur of Capital Coast Health), resulting in both primary and tertiary care experiences for the new graduates. Pairman (1999) states that the midwifery profession is working to redefine the role of the core facility midwife to that of a "wise woman" in the institutions who uses her knowledge and expertise in secondary maternity care to support the primary midwife/woman as necessary.[18]

The Questions Ahead

In conclusion, this brief overview of midwifery in New Zealand (a country that has recognized midwifery for almost 100 years), has shown that rapid change can happen. And that minimal regulation and the absence of micro-management of midwives' practice are appropriate for safe practice. Multiple "models" in practice allow midwives the freedom to move between different areas within the midwifery scope of practice, increasing the retention of midwives and the number of caregivers available. This also allows midwives the opportunity to practice skills, gain experience, and make a continuing contribution to the health care system.

The evolution of the midwifery profession and midwifery practice in New Zealand continues. Shifting to a new paradigm of midwifery care brought many challenges. Where once the focus was on the goal of autonomous practice, when it was reached it became clear it was only a beginning. Many of the problems surfacing in New Zealand are similar to ours. In fact it is almost certain the problems are global rather than local. The sustainability of the one-to-one, continuity of caregiver, on call 24/7 model of care is under scrutiny. As one midwife explained, "One of the things that has changed... at the College level is that we are creating a much wider understanding of what it is that a midwife does in terms of pure practice."

The average age of midwives in New Zealand is 44.6 years and there is recognition that most of these women have families and children and many require breaks in service and changes in practice to accommodate changing life circumstances.[19] The problem of burnout has been discussed for some time. Many midwives noted that the midwifery profession has been attached to a pendulum and it was time to strive for and achieve some balance. In other words, a partnership model means equality for both partners.[20] Midwives want to have some energy for the tasks ahead such as improving the normal birth rate, and reducing the overuse of technology.[21] There are new legislative changes ahead that will necessitate further examination of practice. Midwives said that the growth of midwifery and indeed its survival depend upon being open to new perspectives. To look at the possibilities in change and not hold tight to cherished ideals that may not be feasible in practice. In the end this will benefit our profession, our practice, and our own lives as well as the women we serve. Pairman and Massey (2001) affirm,

"For the midwifery profession to continue to exert significant influence over the development of the maternity services in New Zealand requires midwives who can work autonomously and confidently in all areas of the maternity service".[22]

Endnotes

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19. Guilliland, 2001.
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1. Questions & Comments Session

Issue: Integration of midwives into hospitals in New Zealand

Participant: I have a question about the extent to which midwives are integrating into hospitals. Am I right in assuming that, in part, that came about because somewhere the United Kingdom model [was adopted] where virtually every caregiver working in hospitals has a midwifery qualification?

Deborah Harding: Yes, in 1990 there was an amendment and pretty much everyone working in maternity care was a midwife.

Issue: Scope of practice

Participant: I know there has been discussion about the scope of practice at ICM particularly in relation to reproductive care, family planning, and those kind of things and it's been the New Zealand midwife who has spearheaded, in my observation, a very strong opposition to expanding the scope of practice in that area. Is there anything happening with regard to reproductive care, particularly contraceptive care, which seems to be a real political hot point?

Deborah Harding: This is not a major issue for them, there are no initiatives to change that. They do have bigger issues. When you are looking after 73% of the women in the country, you are really concerned about just delivering care to those women. Roughly the caesarian section rate for midwives is around 15%, but the overall rate is about 20% and I am told that the statistics for 2000/2001 are going to be higher than that, so this has now become more of a pressing issue. Midwives have not had a good relationship with physicians, particularly GPs, so if they start looking to move into other areas of practice that will be a huge battle and I don't think that is something midwives think of as important right now.

Participant: I wonder if you have included details like the CHC model. How many midwives normally work in a community health centre, how do they manage their off call/on call thing? I also noticed with the hospital-based teams they tended to be 5 with 250 women, 50 per midwife, it looks like 21 x 8 hour shifts a week to cover in the hospital, so how do they work their prenatal care? I didn't hear mention of postpartum care but what are the logistics?

Deborah Harding: Well, that was just one little scheme that I looked at. Often there are teams of 6 in some of the major core facilities but in that particular group (Burwood Midwives), they had 5 on and those midwives did prenatal care, they did labour/delivery care, they did postpartum care and they shared that work amongst a call rotation. The core midwife is a separate midwife or separate

midwives, actually, because there is one on staff and she has a health care assistant to help her. That would be the same in other institutions, they would have core facility staff who work shifts and then the team midwives are a separate entity. Generally one of the midwives is off (on holidays or something).

Issue: Remuneration

Participant: Recently a colleague from Ontario has been in New Zealand having her year's leave and she looked into practising there and found out that she could only be paid $16/hour for hospital work. What do you think about level of pay in New Zealand?

Deborah Harding: Compared to here I don't think it's great, compared to nursing salaries here I don't think it's great. The economic situation in New Zealand is different, but for some, regular money and all the benefits are okay. Many of us wouldn't go to work in a hospital, but if it's $16 or nothing you might just want the $16!

V. Messages to take home

At the end of the symposium, all participants were asked to write down what they felt was the most important "take home" message. Running through many of the participants' messages is a tension between a perceived need for urgent change and a concern over challenging the integrity of the existing model. Several participants felt that change to the model of care was the crucial first step in addressing the concerns and issues raised. Others felt creative solutions could be found within the existing context. The importance of a national forum- such as the symposium-to facilitate a dialogue on the issues was recognized. A participant commented that those who attended the symposium could not speak for all midwives or claim to be representative. Underlying all discussions was the recognition that in order for the profession of midwifery to contribute to the provision of maternity care in Canada, and sustain itself, the profession must increase its numbers.

1. We need to open up the model of practice so that Registered Midwives can provide care to meet the needs of ALL women - it's too restrictive. Need to move quickly.

2. The College of Midwives needs to stop micro-regulating midwifery practice.

3. Need to make changes now while there is a window of opportunity.

4. Balance/clarity on differences between changing "the model" vs. developing new practice arrangements to better serve clients while sustaining healthy midwives.

5. Importance of carefully considering implication for changing "model" both with respect to client satisfaction as well as "what makes midwives different?" in light of how new and still in the integration phase our profession is.

6. Must be careful regarding "burnout, stress" etc. becoming a contagious theme. It is important to hear voices that are well and happy in their present midwifery work life, especially for new, student, and aspiring midwives.

7. Midwives are deeply committed to midwifery practice.

8. Midwives need to integrate with other colleagues to improve childbearing care for all women, especially with regard to mutual respect.

9. Evaluate the effects of continuity of care to determine how much is necessary to maintain in our care.

10. Increased funding will cover a more fair and effective work life-funding for break relief, vacation, administration.

11. It is time to take a close look at the health sustainability of midwives and to come up with creative solutions and workable call schedules, etc.

12. I believe the underlying issue is midwives are feeling a lack of autonomy. This frustration is coming out in various ways, increase volume, change the model, etc.

13. This symposium was not widely representative. Be careful around assuming we speak for many or all.

14. Change is good-should not be fast.

15. Tap into grants for researching present model.

16. Open discussion for midwives nationally.

17. Midwifery is an evolving, maturing (as opposed to aging) profession and as such, I would expect it to be flexible enough to respond to women's needs, providers' needs and health-care systems' needs. As individual practitioners we can be trusted to provide the essence of midwifery in a variety of practice models and settings, especially if supported by orientations, education, etc.

18. If some change does not happen, midwifery in any sustainable form is in jeopardy.

19. Need for increased flexibility regarding the model of care, i.e.: less micro-management, [more] flexibility regarding practice structures.

20. Need for the profession to grow in numbers through recruitment and retention (sustainability).

21. Need for improved financial compensation in terms of money and benefits.

22. What next? Ongoing dialogue with national and professional midwives' organizations to formulate strategic plan to address our collective issues and concerns.

23. Move to provincial/national standards regarding the implementation of midwifery care.

24. There is a strong commitment amongst midwives present to reconsider the role of the college in determining how midwifery is practised and for colleges to focus on public safety instead of micro-management.

25. Willingness of interdisciplinary approach to practice (i.e. sharing care with MD's.)

26. Creative call schedules to decrease the time on call.

27. Realization that there is more room for flexibility within the model for different ways to practice.

28. Main message is that midwifery needs to be open to change (evolution) in order to maintain momentum in the progress to become central to maternity care.

29. Good maternity/midwifery care is possible within a variety of models.

30. Midwifery should be dynamic and possess the ability to change to meet the needs of the current birthing population.

31. Stop micro-managing midwifery practice—relax regulations and focus on numbers.

32. Increase interdisciplinary practice (integration).

33. Increase the number of practicing midwives.

34. Reaffirmation of our philosophy of woman-centred care, informed choice, community-based and evidence-based practice.

35. Midwives are ready for a change in the way midwives practice in order to sustain our profession.

36. Sustainability of the profession can only occur in a climate where the CMBC limits its regulations to issues of public safety in order to allow midwifery to evolve and be assessed and evaluated.

37. Balance, balance, balance—one size does not fit all, be open and flexible, change is hard but inevitable.

38. Need more research to look at informed choice, continuity of care. Keep the community involved. There were no community representatives at this conference. Maybe next time!

39. Flexibility needed in model of care, particularly around continuity of care.

40. Care of the midwife as well as the women we serve; needed to sustain the profession.

41. Importance of opening our minds to explore new options so midwifery can evolve.

42. Renewed hope that by bringing our intelligence and inquiring minds to the situation midwifery can be sustainable and can greatly contribute to the maternity-care crisis. Great conference-thank you!

43. Is there genuine and urgent will of the colleges, especially CMBC, to be more flexible about the model of practice and number of births as well as continuity as it relates to continuing registration?

44. Is there openness on the part of regulatory bodies to enable practice of part of the scope and continue registration? E.g., with particular ethno-cultural groups.

45. I left feeling excited that people feel there is room to embrace multiple models of midwifery care to co-exist. This would give flexibility and options for me as a midwife currently working full-time to work part-time or shift work, or be an employee etc. in the future years of my practice.

46. I was inspired about practical solutions to make life as a midwife more liveable, i.e.: different call schedules, multidisciplinary approaches, etc. Thank you so much for making this invaluable dialogue possible!

47. Thank you for this proactive conference! I was encouraged to continue with our venture of an integrated pregnancy service in our community.

48. Midwifery in Canada is at an exciting crossroads-onward into the mainstream.

49. We have more in common that we might have thought.

50. Next steps: Compile and integrate the suggestions made by midwives at the symposium into "boiled down" summary. Have CMBC, MABC, and other regulatory bodies (other provinces) made aware of the viewpoints of this conference and ask for their responses.

51. Midwifery model of care needs to be more inclusive/diverse and not regulated.

52. Rural/remote maternity care can and should be continued and studied NOT closed down.

53. Need to form alliances, strengthen relationships now during this time of opportunity, given the people who are currently in positions of power/influence. Move toward collaboration now, to be proactive in pursuing relationships and support wherever we find it.

54. Protect the resources we already have. There is much to do, we need to find resources to support our work and goals so that we don't overuse, stress, lose precious resources-i.e., midwives.

55. Provincial associations and colleges of midwives need to respond to the need for change expressed by participants. Change is necessary *now*.

56. Midwifery practice needs to be expanded and a larger vision implemented soon. The present course that midwifery is on is not serving midwives, the health care system, and ultimately women.

57. It is time to create and manifest a larger vision of midwifery in Canada and detail what it will look like, how to get there, what is needed, and time lines.

58. The provincial government has provided an opportunity for midwifery to re-evaluate its status as it stands and how it will fit into the evolving health care system.

59. How to help midwifery to become a sustainable career (lifestyle?) for an aging membership while and/or until the number of midwives increases. What models will optimize satisfaction of women and midwives, while maintaining optimal outcomes?

60. The need to be creative in ways to maintain the sustainability of the profession by: a variety of call schedules; safety of number of hours worked; change active practice; and encourage not only "clinical" midwives but also teachers, administration, and researchers.

61. Remove barriers thus making it easier for midwives to enter the profession, e.g., flexibility with the model, change of continuity of care requirement.

1. Appendix 1 – Speaker and Registrant List

Speaker List	
Ann Liebau	BC
Bob Woollard	BC
Carol Hird	BC
Deborah Harding	BC
Diane Angelini	R.I. USA
Eileen Hutton	Ont
Elaine Carty	BC
Holliday Tyson	Ont
Jan Christilaw Pres. SOGC	
Jennifer Murdoch	Ont
Jude Kornelsen	BC
Karyn Kaufman	Ont
Kim Campbell	BC
Lee Saxell	BC
Linda Knox	BC
Liz Whynot	BC
Lorraine Greaves	BC
Luba Lyons Richardson	BC
Maggie Ramsay	BC
Margaret Howarth Brockman	MB
Michael Klein	BC

Registrants	
Alex Vander Wal	Jill Sivers
Alison Rice	Judy Rogers
Angela Esplin	Kristy Hook
Babette Mattheys	Marilyn Kleidon
Barbara Kemeny	Michele Buchmann
Carolyn Johnston	Michelle Kryzanauskas
D. Clelland	Miranda Gillespie
Daine Rach	Patty Keith
Darlene Birch	Rena Porteous
Deanna Wildeman	Rita Stern
Deb Little	Sarah Robinson
Deborah Kaley	Sarilyn Zimmerman
Florence Klassen	Shannon Norberg
Heather Lee Hall	Sheila Sanderson
Jane Kilthei	Toni Fehr
	Trang Duong - student

2. Appendix 2 – Conference Agenda

Midwifery

Building Our Contribution to Maternity Care

A Working Symposium • May 1-3, 2002 • Vancouver

Hosted by the Department of Midwifery, Children's & Women's Health Centre of B.C. & Providence Health Care (St. Paul's) and the B.C. Centre of Excellence for Women's Health

Wednesday, May 1st

G. F. Strong Centre

1:00 – 1:30	**Registration and Check-in**
1:30 – 2:00	**Welcome & Opening Remarks** **Liz Whynot**, Vice-President of Medicine, Women's Health Centre, Children and Women's Health Centre of B.C. **Lee Saxell**, Acting Head of the Dept of Midwifery, Children's & Women's Health Centre of B.C. and Providence Health Care **Lorraine Greaves**, Executive Director, B.C. Centre of Excellence for Women's Health **Jan Christilaw**, President, Society of Obstetricians and Gynecologists of Canada **Kim Campbell**, President, Canadian Association of Midwives *Workshop Chair:* **Elaine Carty**, Professor and Director Midwifery Education Program, UBC
2:00 – 3:30	**Perspectives on the national maternity care crisis** ♦ Jan Christilaw –MD, President, SOGC ♦ Liz Whynot – MD, C & W Health Centre ♦ Penny Ballem – MD, Deputy Minister of Health ♦ Bob Woollard – MD, UBC, School of Medicine ♦ Eileen Hutton – RM, PhD (candidate) ♦ Lee Saxell – Acting Department Head, Midwifery
3:30 – 3:35	**Break**
3:45 – 5:00	**Taking the pulse of B.C.'s midwives** ♦ Results of B.C.'s Midwifery Practice Questionnaire – Jude Kornelsen, PhD, Research Associate, BC Centre of Excellence for Women's Health & Department of Midwifery, C&W ♦ Results from the study of non-practicing midwives – Lee Saxell

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Thursday, May 2nd – Addressing the Crisis

9:00	–	10:00	**Keynote Address**: "Developing a Plan for Growth & Sustainability in Midwifery Practice" Holliday Tyson, RM, MSc
10:00	–	11:15	**Midwifery's Contributions to Maternity Care: Are We Able to Meet Canadian Women's Needs?** ♦ Karyn Kaufman, RM, PhD (Ontario) ♦ Margaret Haworth-Brockman (Manitoba) ♦ Jennifer Murdoch – RM (Ontario) ♦ Ann Liebau, RM, BA (B.C.)
11:15	–	11:30	**Break**
11:30	–	12:00	**Midwifery's Contributions to the Maternity Care Crisis – A Family Physician's Observations –** Michael Klein, MD
12:00	–	12:30	**Midwifery's Contributions to the Maternity Care Crisis – An Obstetrician's Observations –** Jan Christilaw, MD
12:30	–	1:30	**Lunch (provided) Elaine Carty**
1:30	–	2:30	**The Midwifery Model of Practice: Building Contributions** ♦ Research & Practice: Implications for our Future – Eileen Hutton ♦ Flexibility in B.C.'s Midwifery Regulations – Luba Lyons-Richardson (RM, RN, Past President, College of Midwives of B.C.)
2:30	–	2:45	**Break**
2:45	–	4:30	Large Group Discussions with the Day's Panel Members & Symposium Participants

Friday, May 3rd – Building the Profession

9:00	–	10:00	"Developing A Plan for Growth & Sustainability in Midwifery Practice – Part II" Holliday Tyson
10:00	–	10:45	**The Midwifery Model of Practice: USA** ♦ The Midwife's Expanded Role of Practice in Interdisciplinary Education– Diane Angelini, CNM, EdD
10:45	–	11:00	**Break**
11:00	–	12:15	**Reflections on Midwifery Practice in B.C.** ♦ Rural Practice – Maggie Ramsey, RM, RN ♦ Practicing in a Shared Care Model – Linda Knox, RM, MA (student) ♦ Lifestyle Changes of a Practicing Midwife – Carol Hird, RM, RN, MA
12:15	–	1:15	**Lunch (provided)**
1:15	–	2:00	**New Zealand's Successes in Growing their Profession** ♦ Rebuilding Midwifery – Debbie Harding, RM, MA, PhD (student)
2:00	–	2:45	Small Group Sessions: Formulating a Plan of Action
2:45	–	3:00	**Break**
3:00	–	4:00	**Panel: Formulating a Plan of Action for B.C. (Chair – Holliday Tyson)** ♦ Elaine Carty, UBC Midwifery Education Program ♦ Luba Lyons-Richardson, College of Midwives of B.C. ♦ Kate Kelly, Midwives Association of B.C. ♦ Lee Saxell, Dept of Midwifery, C & W and Providence Health Care
4:00	–	5:00	Recommendations for Moving Forward a National Agenda