A New Status for Midwifery: Women and Public Policy

Maureen Baker
Centre for Applied Family Studies
School of Social Work
McGill University

Abstract

This paper examines the history of midwifery in Canada, cross-cultural comparisons of the status of the profession, and Canadian initiatives to legalize and regulate midwifery. The continuing dispute between doctors and midwives is viewed as a power struggle based on professional competition, sexism, and different philosophies of childbirth. Yet this controversy also touches on policy issues such as the control of public health care expenditures, insured services of various health practitioners, legal rights of the fetus, and women's rights to childbirth and medical alternatives.

Urbanization, the growth of the medical profession, specialization and regional hospitals have diminished midwifery in Canada and many other industrialized countries. With the expansion of the feminist and consumer rights movements, however, the public has demanded alternatives to medical delivery, which some see as excessively technological, interventionist and expensive. The possibilities of legislative change are discussed within the context of rising health care costs, health risks and the medical dominance of the health care system.

Introduction

The practice of midwifery has existed historically throughout all cultures. Experienced and skilled women have always assisted other women during pregnancy and childbirth, although they did not always make a living from providing these services. It was not until the twentieth century, and only in some western countries, that the process of childbirth was moved from the home to a hospital environment under the control of physicians.

Throughout history, midwifery has been almost exclusively dominated by women and to some extent the continuing dispute between doctors and midwives has been a power struggle based on gender differences in philosophies of childbirth. Even more so, the present Canadian debate over the legalization and regulation of midwifery is about professional competition and medical dominance within the health care system. The midwifery debate, however, touches on important policy issues, such as whether giving birth requires high-cost medical specialists, how public health care costs should be controlled, which health practitioners should be included in Medicare, whether parents have the right to choose childbirth alternatives, and what legal rights should be granted to the fetus.

In this paper, new Canadian initiatives concerning the legal and professional status of midwifery, and the opposition these initiatives have engendered will be analysed. The medical dominance of the health care system will be emphasized, but also the inherent sexism and elitism of the medical profession's position. Policy implications of potential changes in the status of midwifery will also be discussed.

An Alternative to Medical Delivery

While midwifery views childbirth as a natural creative process, medicine tends to treat it as a pathology or illness and increasingly advocates hospital births using the latest medical intervention. Although the "medicalization of childbirth" is essentially a twentieth century phenomenon, the assumption is prevalent in North America that births "delivered" by physicians in hospitals are the only safe ones. But as will be shown in this paper, the available research from Canada, the United States, Britain and The Netherlands does not support this assertion (Jezioranski, 1987:92). While infant mortality and maternal death rates have declined in most industrialized countries since the 1930s, this cannot be attributed entirely to hospital births or the birthing procedures used by physicians.

Midwifery adopts a holistic approach to childbirth, and encourages midwives to devote considerable time and attention to each client throughout pregnancy, birth and the post-partum period. Midwives also support the formal acceptance of home births, but with the co-operation of physicians and hospitals for emergency situations. Because Canadian medical associations have adopted the position that home births are dangerous and that only physicians should deliver babies, they have advised their members not to co-operate with midwives. Consequently, midwives are not permitted to practise in hospitals without the consent and supervision of doctors, nor are their services included in Medicare. This means that if they practise at all in Canada, they are on the fringes of both legal and health care systems.

Medical associations have opposed both the independent practice of midwifery and home births. Both doctors and nurses, however, have accepted the practice of trained midwives within the hospital setting if they are supervised by doctors and regulated by the College of Nurses. But midwives contend that this would undermine the basic philosophy behind

their profession—that childbirth is a normal, healthy function. Physicians, obstetricians and nurses, they say, are trained to deal with illness (Hossie, 1985).

Due to their ambiguous legal and professional status, midwives may be particularly vulnerable to prosecution under criminal and tort laws. Without professional standards and regulation for midwifery, the courts are likely to defer to medical standards as a benchmark for assessing negligence. Medical organizations, however, are openly hostile to midwifery and have actually made policy statements suggesting that the very practise of midwifery is negligent (College of Physicians and Surgeons of Ontario, 1982).

A further complication for midwives is that there are three parties involved in childbirth: midwife, mother and fetus. The increasing trend to accord rights to fetuses may encourage greater technological intervention on behalf of the fetus to protect physicians and midwives from tort cases. Although the fetus has not been considered a legal person by the Canadian Charter of Rights and Freedoms, courts have awarded custody of fetuses to Child Welfare Agencies when there were grounds to believe its health and safety were in danger (Jezioranski, 1987:114-117).

Recent court cases in the United States relating to the detection of fetal abnormalities tend to impose the duty on physicians and midwives to use all the latest medical technology to attempt to discover birth defects. The philosophy behind midwifery, however, supports natural childbirth and de-emphasizes interventionist procedures. Furthermore, the cost of malpractice insurance, which has increased considerably over the past few years, may also encourage technical intervention, and may reduce the number of family physicians willing to be involved in obstetrics, leaving the field to specialists.

Despite the dubious legality of midwifery, it is becoming increasingly acceptable to Canadians as an alternative to medical delivery, which some see as excessively technological, interventionist and expensive (Ibid:90-91). With the intention of reducing health care costs, and with the appearance of responding to lobby groups arguing for a more humanistic birthing environment, Canadian provincial governments are beginning to re-evaluate the legal and professional status of midwifery, and to consider its integration into Medicare.

Historical Background of Midwifery in Canada

An overview of the history of midwifery in Canada is well presented in the Appendix of the Task Force on the Implementation of Midwifery in Ontario (1987), but some of the highlights bear summarizing as background to this paper. The Task Force indicates that although midwives provided essential health services in the early years of Canada's development, the growing medical profession (and hospital nurses to a lesser extent) began to see midwives as a serious professional threat by the end of the 19th century. Community midwives generally received their training through apprenticeship rather than formal schooling, and physicians argued that their practice was not "professional" or based on science. Since 1795, when the government of Upper Canada passed the first act which made it illegal to practise "physic," surgery, or midwifery without a licence, physicians sought to denigrate the midwifery profession. Yet the absence of doctors and enforcement procedures meant that this law was never enforced. Attempts to denigrate midwifery accelerated in the 20th century with the development of hospitals.

In the 1870s, several attempts were made to license midwives in Upper Canada, but doctors intervened. This did not stop neighbours helping other women with their births, but doctors found themselves in competition with these women who also provided mutual aid for illness as well as childbirth (Ontario Task Force, 1987:208). The first conviction of a midwife charged with practising medicine without a licence was in 1895. This case caused so much public outcry, however, that a sympathetic politician paid the midwife's fine (Cohen, et al., 1988).

In 1897, Lady Aberdeen of the National Council of Women created the Victorian Order of Home Helpers, which compounded doctors' fears of competition. Lady Aberdeen wanted the new organization to provide training for women in midwifery, first aid, simple nursing, household economy and home sanitation, and planned to upgrade existing midwives into salaried official health workers. After opposition from both doctors and hospital nurses, the organization was renamed the Victorian Order of Nurses, and exclusively used trained nurses instead of midwives (Ontario Task Force, 1987:210).

Newfoundland, although not explicitly permitting midwifery, had a long tradition of lay midwives or "granny women" in the villages and outports until the 1960s. In addition to dealing with childbirth and reproductive problems, these women served as lay healers in times of illness. Midwives also worked in local or "cottage" hospitals between 1930 and 1960 (Benoit, 1983; Benoit, 1986:636). Except among particular isolated ethnic groups or in the outports of Newfoundland, however, women whose primary function was midwifery were rare. Instead, farm women assisted their neighbours and relatives

during childbirth but seldom accepted money for their services (Ontario Task Force, 1987:201-202).

At the beginning of the twentieth century, many country doctors learned their delivery skills from local midwives or relied heavily on their knowledge and expertise. In cities and larger towns, however, the medical profession was growing in visibility and strongly advocated hospital births with medical intervention. Yet prior to medical insurance, many families could not afford doctor's fees or hospital expenses, and relied as much as possible on home remedies or neighbours with expertise in childbirth and other health matters.

In the first four decades of this century, doctors and nurses, whose livelihoods were both adversely affected by midwives and informal health networks, conducted a public re-education campaign which tried to change women's expectations about childbirth and the safety of the medical birth (Ontario Task Force, 1987:212). In spite of this, various medical investigations early in the twentieth century found that maternal mortality rates were actually higher in areas served by doctors and hospitals than in areas where there was neither a doctor nor a public health nurse (Ibid:203). Prior to improved sanitation, hygiene and procedures of disease control, hospitals and medical techniques did not foster improved health; indeed, lack of intervention during the birthing process was often beneficial. Concerns about high rates of maternal mortality in Canadian hospitals during the 1920s led to serious attempts to improve hygiene and disease control in hospitals. Some doctors even suggested in the Canadian Medical Association Journal that midwifery should be legalized, because mortality rates for home births were lower than hospital mortality rates. But most doctors tended to blame women for birth problems, and claimed that they did not take care of themselves and consult doctors for prenatal care.

By 1937, however, rates of infant and maternal mortality dropped sharply in Canada. Although this decline has been attributed to the discovery of antibiotics and the enormous increase in hospital births, the decline began a year before the introduction of the first antibiotic. Furthermore, European countries also experienced this decline, despite the continued use of midwives and home births (Ibid:222). The drop in mortality may have been related to improved living conditions, sanitation, hygiene and nutrition.

In northern and other remote areas of Canada, public health nurses were informally allowed to deliver babies in emergencies, but with the shortage of doctors, nurses became extensively involved in midwifery. As more regional hospitals were built, however, policies were established to evacuate women in labour so that doctors could deliver their babies in the new hospitals. Nurses were not supposed to deliver babies, but in fact did so for those women who refused to be evacuated.

As immigration laws prevented European-trained midwives from entering Canada and as non-hospital births became rarer, fewer Canadian-trained nurses felt confident to deliver babies. Although there has been at least one recent experiment using "maternity teams" of native midwives and non-native doctors and nurses, hospital births among strangers have become prevalent for native people living in the north (Ibid:226).

By the end of the 1950s, childbirth in Canada was generally viewed as an unnatural event or a form of illness requiring hospitalization and medical intervention. Husbands were not allowed in the labour room, and drugs, forceps and surgery were commonly used in childbirth. With increasing costs of liability insurance, a desire for regular hours, exclusion from hospital privileges, and technological advances in obstetrics, many family practitioners have stopped delivering babies and allowed specialists to take over. This often means that there is little continuity in maternal health care.

Midwives continue to work in Canada, but generally as nurses in hospital obstetric wards or in remote areas as public health nurses. Many are immigrants who received midwifery training in their homeland but were expected to retrain as nurses when they came to Canada. Most provinces bar the autonomous practice of obstetrics or midwifery by anyone other than licenced physicians, although lay midwives still practice outside hospitals and outside Medicare.

The dying out of the birth culture involving midwives or knowledgeable neighbours and relatives cannot be adequately explained by the introduction of a safer system. As we previously mentioned, there were indications from some parts of the country that undoctored births were safer than medical births at the time. But the neighbour network of mutual aid disappeared with industrialization, modernization, the disapproval of the growing professions of doctors and nurses, and re-education programs by public health nurses (Ibid:220-227).

In recent years, feminists, health reformers, and various consumer groups have attempted to reform the birthing process. They have tried to make childbirth more responsive to women's needs and expectations, to encourage the participation of husbands, and to involve midwives who can provide continuous care for a lower cost to the state.

Cross-cultural Comparisons of Regulation and Quality of Care

Although midwifery is still practised throughout the world in lay form and is the predominant form of birth care, it can now be legally practised in most industrialized countries only if licensed or certified (Jezioranski, 1987:105). Several European countries (most notably The Netherlands, England, Sweden and Finland) rely extensively on midwives in hospital and home births.

In The Netherlands, the obstetrician/midwife debate occurred as early as 1880, when it was agreed that home births should be encouraged because they were safer than hospitalization. Since then, midwifery has been the predominant form of birth care and midwives attend deliveries without the supervision of physicians. In The Netherlands, 30 percent of births take place at home, compared to 1 percent in Britain, Canada and the United States, and Dutch general practitioners and midwives both deliver at home. Like other countries, however, the trend in The Netherlands has been toward hospital births. While 74 percent of all Dutch births took place at home in 1958, this figure had dropped to 48 percent by 1974 and 30 percent by 1984 (Torres and Reich, 1989:406). In the mid-1970s, midwives attended about 67 percent of home births and over a third of all births (Kloosterman, 1978).

The Ministry of Public Health in The Netherlands did not establish a policy on the place of birth, as the National Health Service did in Britain. The Dutch health system is based on private insurance, which covers the payment for prenatal care, delivery and postnatal care only if provided by a midwife—not by a physician—as long as a midwife practises in the community and there are no medical indications for specialized care. Health insurance also covers the cost of nursing aides, which makes home birth easier for women. While Dutch midwives are trained in a special program lasting three years, British midwives initially train as nurses, and then take one year of obstetric training (Torres and Reich, 1989:407-410).

In England, midwifery was regulated in 1902 after years of struggle for recognition as a profession. The Midwives Act made it possible for midwives to work as licensed practitioners but vested control of midwifery in the Central Midwives Board, a body composed largely of physicians. Throughout this century, the role of British midwives has continued to shrink as physicians have assumed more of the tasks relating to pregnancy and birth. Over 80 percent of British midwives work in hospitals where 99 percent of births occur and virtually all midwives are employed by the National Health Service (Weitz, 1987:81). The centralized planning process of the National Health Service helped facilitate the movement from home to institutional births in the United Kingdom, and ensured that the lobbying efforts of the medical profession had a major and rapid impact on the location of childbirth (Torres and Reich, 1989: 409).

Although midwives are still the senior persons present at three-quarters of all British births, the scope of their clinical judgment narrowed significantly once birth moved to the hospital setting. As employees of hospitals, midwives are subject to hospital regulations concerning birth procedures and these are largely set by obstetricians. Consequently, technological intervention increased considerably during the 1960s and 1970s. At the same time, however, the maternity rights and the feminist movements grew in strength, and objected to much of this intervention (Weitz, 1987:82). The Association of Radical Midwives was organized in 1976 as a support and study group but eventually became a political action organization to reduce medical intervention in birth, to develop training programs that do not require the individual to first become a nurse, to promote natural and home birth, and to encourage more continuity of care for pregnant women. Few English midwives, however, consider themselves "radical midwives;" but see themselves more as maternity nurses (Ibid:84).

In the United States, only about 1 percent of births take place outside hospitals. Of these, midwives attended about 74 percent or 28,000 births in 1984 (Butter and Kay, 1988:1167). A national survey was recently conducted to assess the current status and characteristics of state legislation regulating the practice of lay midwives. "Lay midwife" refers to someone who practises in a home setting and who has been trained by apprenticeship. As of July 1987, ten states in the United States explicitly allow lay midwives to practise, ten states prohibit lay midwifery, five states have "grandmother" clauses authorizing practising midwives under repealed statutes, and five states have enabling laws which are not used. In the remaining twenty-one states, the legal status of midwives is unclear. The authors of this study concluded that so-called "enabling laws" have actually restricted the practice of midwifery in comparison to the situation in those states with unclear legal status (Ibid:1161).

In an attempt to compare the safety of midwife-attended births and physician deliveries, researchers have turned to rates of infant and maternal mortality as well as complication rates during the birthing process. The United Nations gathers international statistics both on maternal death rates (caused by deliveries and complications of pregnancy and

qualified or who practises midwifery is guilty of an offence. This suggests that a midwife could conceivably be prosecuted for practising her profession, although this has apparently never happened.

In April 1984, a bill was introduced into the Ontario legislature by a New Democratic Party MPP to establish midwifery as an independent self-governing health profession. It did not progress to a vote because members wanted to await the results of the Health Disciplines Review Committee, established in 1983 to report on the proposed legalization of several new health disciplines in Ontario.

After the 1985 death of a baby attended by a midwife on Wards Island in Toronto, an Ontario coroner's jury recommended that midwifery be legally regulated in Ontario, covered by provincial health insurance (OHIP), and be subject to compulsory malpractice insurance. The Health Ministry, however, would not recommend that the practice of midwifery be licensed until the issue was thoroughly studied.

In 1986, the Health Disciplines Review Committee recommended that midwifery become a legally regulated profession, a recommendation which was accepted by the Health Minister. How to integrate midwives into the existing health care system was to be decided by a Task Force, which included a lawyer, a doctor, a member of the previous Health Disciplines Review Committee and a nurse, but not a midwife.

In October 1987, the Report of the Task Force on Midwifery recommended the training and licensing of midwives as independent professionals (rather than as practitioners requiring physician supervision or as members of the nursing profession). According to the report, midwives should be educated in a four-year university program which would not require a nursing certificate as a prerequisite. The establishment of such a program would probably cost about the same as a nursing program, which is about one-third of the cost of medical training (Fooks and Gardner, 1986:6). The Task Force also recommended the establishment of a college of midwifery to regulate the profession and a series of safeguards to ensure the highest standards of practice. The report noted that there is now enough evidence to suggest that young, healthy women whose pregnancies proceed normally run no extra risks by giving birth at home. If midwives were licensed and incorporated into the existing medical system, they would be able to arrange in advance for emergency backup care in case of home birth problems.

In response to this report, the Ontario Health Minister appointed a council of thirteen health-care experts to set standards of practice and certification requirements for midwives. This council is expected to pave the way for new legislation that will formally regulate the profession and establish a College of Midwives, similar to the colleges which exist for doctors and nurses (McLaren, 1989).

In 1989 there were about fifty practising midwives in Ontario. Because midwives are not regulated, they cannot obtain accident insurance. They rely on voluntary guidelines covering agreements with clients, equipment and procedures laid down by the 125-member Association of Ontario Midwives. Their fees, which are not covered by provincial health insurance, average about $800 for prenatal and postnatal care as well as attendance at labour and delivery.

Quebec

The medical act in Quebec prohibits anyone other than a licensed physician from practising obstetrics. Despite the dubious legal status of midwifery in Quebec, there are about twenty to thirty practising midwives who belong to the Quebec Alliance of Practicing Midwives or l'Association des sages-femmes diplomées du Québec. In remote northern areas, for example, midwives often deliver babies because of the shortage of physicians. Even in urban hospitals, some doctors have been allowing midwives to deliver babies despite the law. In April 1989, however, administrators of a Montreal hospital suspended a physician for six months for allowing a midwife to deliver the baby, yet another Montreal hospital interested in starting a midwifery pilot project immediately offered him a position (Dunn, 1989; Ouimet, 1989).

Over the past decade, several organizations have been promoting natural births and the de-medicalization of childbirth. These organizations, such as Naissance-Renaissance, have used official statistics to show the increasing use of medical intervention in childbirth. They have reported, for example, that 82 percent of women giving birth in Quebec were given episiotomies in 1979 and 18 percent had caesarian sections in 1982 (up from 12 percent in 1977). Advocates of the legalization of midwifery claim that these medical interventions are frequently unnecessary yet they often result in the requirement for further medical attention. Naissance-Renaissance is working hard to promote the legalization of midwifery and the development of autonomous birthing centres separate from hospitals, where giving birth can be less bureaucratic and the family can be present (Martel, 1988:37).

In 1988, the Commission of Inquiry into Health and Social Services, Quebec (known as the Rochon Commission) recommended that midwifery be legally recognized. In addition, the Advisory Council on

Social Affairs urged the government in January 1988 to set up a three-year pilot project using midwives for some low-risk births. The Provincial Task Force on Midwifery also recommended that midwives be regulated. In March 1989, the Minister of Health and Social Services announced her intention to allow midwives to practise in some hospitals on an experimental basis. Initially, she stated that she would wait for approval from the medical association before introducing legislation, but in May 1989 it was made clear that medical opposition would not diminish.

Quebec doctors reacted quickly and angrily to the proposal to legalize midwifery with comments which could be considered both sexist and elitist. When Dr. Augustin Roy, president of the Quebec Corporation of Physicians was interviewed by the press, he was alleged to have said: "Why not legalize prostitution? There are a lot more people asking for the legalization of prostitution than the legalization of midwives?" (The Gazette, 10 May 1989). Clement Richer, president of the Quebec Federation of General Practitioners was quoted as saying that allowing midwives to deliver babies is "like letting an apprentice pilot take charge of a Boeing 747 loaded with passengers" (Picard, 1989). A bill to legalize midwifery in a limited number of pilot projects in Quebec hospitals was introduced into the legislature in June 1989, two days before the summer recess. Quebec doctors threatened to boycott the projects, which cannot succeed without their co-operation. After the September 1989 election in Quebec, a new health minister was appointed, yet the government has reiterated its support for the midwifery bill which passed in June 1990.

Newfoundland

While midwifery was eliminated throughout North America with medical bureaucratization, medical dominance of maternity care and hospital births, it was merely transformed in Newfoundland and Labrador. Lay midwives, who learned their skills through apprenticeship, used to deliver babies at home as well as tend to other sick people, sometimes for a small fee or gift, depending on the family's means. In the 1930s these midwives and other interested women were offered three-month courses to work as government employees in the new "cottage hospitals," which employed five to ten trained midwives in each maternity ward. The cottage hospitals were in many ways an improvement for the autonomous lay practitioners because they provided a steady income, a constant place of work, a division of labour, back-up medical services and facilities, with relative freedom from supervision. Regionalization of maternity care began in the 1960s, however, and many of the cottage hospitals were closed. Only a few nurse/midwives are now employed by large regional hospitals, but these work under the supervision of hospital administrators and medical specialists (Benoit, 1989).

Newfoundland's Midwifery Act, revised in 1970, states that the practice of midwifery is to be controlled by the Newfoundland Midwifery Board. The Board regulates the certification of midwives, issues licences to practise and regulates the areas in which a midwife may work. However, the Board has been inoperative for about twenty-seven years and therefore the Midwifery Act is considered to be obsolete by officials in the Newfoundland Department of Health. In 1987, there was an attempt to repeal the Act, but the Alliance of Nurses and Midwives protested.

Those midwives who still practise in Newfoundland are trained nurses providing prenatal and postnatal counselling and support during the birth, but they do not deliver babies. With no medical back-up, they are unwilling to risk home births. This means that in isolated regions, women in the latter stages of pregnancy must travel to a hospital to await labour, causing harships for themselves and their families. The movement for independent midwifery in Newfoundland appears to be growing but is not strong enough to challenge the Act (Redfern, 1987:9).

Conclusions

Canadian midwives work without the benefit of a regulatory college, recognized training, legal protection or assurance of payment. Because they practise outside Medicare, their fees are beyond the means of the poor. Without educational requirements and standards, it is theoretically possible for anyone to work as a lay midwife outside a hospital setting, although laws in most provinces restrict the delivery of babies to physicians.

Even in provinces where there is some agreement that midwifery should be regulated, there is disagreement on what form this should take. Both medical and nurses' associations have suggested that the College of Nurses regulate nurse/midwives. Yet many midwives feel that if they cannot be autonomous and must work in hospitals under the authority of doctors and nurses, their philosophy of childbirth would be undermined and the legalization and regulation of midwifery would place midwifery under more severe restrictions than it presently faces.

When the place of childbirth moved from home to hospital in Britain, the scope of midwives' judgment was definitely narrowed within a hospital setting, where they became subject to medical supervision and procedures designed largely by physicians (Torres and Reich, 1989). Similarly in the United States, regulation and legalization has

restricted the practice of midwifery rather than enabling it (Butter and Kay, 1988). As long as the health care system is dominated by the medical model, emphasizing illness, curative care and surgical intervention, those who work in hospitals will be forced to follow rules and procedures created by physicians even when they use alternative models of health.

In 1987, the Canadian Medical Association printed a statement about the role of midwives in their journal (Volume 136). They clearly stated that they did not support the establishment of midwives as an autonomous health care profession but believed that nurses could be trained to assume more obstetrical care responsibilities under the direction of physicians. Since nurses already operate under the supervision of physicians, this change would offer no threat to medical hegemony. Furthermore, the CMA study of obstetrical care concluded that the present system contains all the resources and personnel required to provide the highest quality of care to Canadian women. The CMA would not publicly acknowledge that there are viable alternatives to the medical model of childbirth or that any other practitioner could provide adequate maternity care.

Because health expenditures are under scrutiny and governments and hospitals are searching for ways to cut costs, more extensive use of midwives is being seriously considered in some provinces. The fact that Canadian women are increasingly demanding an alternative to the "medicalization" of childbirth and to hospital deliveries by obstetricians has assisted the cost-motivated discussions by policy-makers. Yet attempts to legalize and regulate midwifery have so far been either counteracted or diminished by the medical profession.

There is no doubt that health care dollars could be saved if midwifery services were incorporated under Medicare, and midwives were permitted to provide prenatal and postnatal care as well as attend low-risk births at home and in hospitals. But, in the case of midwifery, the lower potential cost is not the decisive factor in the legalization debate. Despite potential savings to health expenditures, governments are experiencing difficulty changing legislation and policy due to medical opposition.

Our entire health insurance system was designed mainly by physicians and predicated on the medical model of health care. Medical specialists, with the assistance of their professional associations, continue to dominate health policy. The Canadian Medical Association and its provincial affiliates are well-organized and powerful lobby groups. Unless physicians are willing to establish a division of labour and share maternity care with midwives, the legalization and regulation of midwifery will not happen.

Historically, medical opposition to the autonomy of other health care practitioners, such as chiropractors and practical nurses, has been relatively successful. In the case of midwifery, medical opposition is likely to be strong because the all-female midwifery profession holds philosophical differences about the nature of childbirth and is threatening to offer improved maternity care for a lower cost. Midwives, who form a weaker lobby group with fewer resources behind them, are unlikely to be able to muster sufficient political support to change health policy.

References

Alberta Advisory Council on Women's Issues
1988 *Midwifery in Alberta*: A Discussion Paper. Edmonton (12 May).

Anderson, Cheryl
1986 "Midwifery and the Family Physician," *Canadian Family Physician*, 32 (January):11-15.

Barrington, Eleanor
1985 *Midwifery is Catching*. New Canada Publications, Toronto.

Barrington, Eleanor
1986 "A safe and satisfying system is the goal of Ontario midwives," *The Globe and Mail* (17 February).

Benoit, Celia
1983 "Midwives and Healers: the Newfoundland Experience," *Healthsharing* (Winter).

Benoit, Celia
1989 "Traditional Midwifery Practice: the Limits of Occupational Autonomy," *Canadian Review of Sociology and Anthropology*, 26(4) (August):633-649.

Buhler, Lynn; Glick, Ned; and Sheps, Samuel B.
1988 "Prenatal Care: a Comparative Evaluation of Nurse-Midwives and Family Physicians," *Canadian Medical Association Journal*, 139, (1 September)

Burtch, Brian E
1988 "Promoting Midwifery, Prosecuting Midwives: The State and the Midwifery Movement in Canada," In *Sociology of Health Care in Canada*, edited by B. Singh Bolaria and Harley D. Dickinson. Toronto: Harcourt, Brace Jovanovich.

Butter, Irene H. and Kay, Bonnie J.
1988 "State Laws and the Practice of Midwifery," *American Journal of Public Health*, 78(9):1161-1169.

Canadian Medical Association
1987 "The Role of Midwives," *Canadian Medical Association Journal*, 136(15) (June).

Cohen, Lori
1988 "The Baby Who Wasn't," *Alberta Report* (15 August).

Cohen, Lori; Heaton, Greg; and Bunner, Paul
1988 "A Victory for Midwives," *Alberta Report* (25 July).

College of Physicians and Surgeons of Ontario
1982 "Nurse-Midwives," *College Notices*, January.

Dunn, Kate
1989 "MD suspended in dispute over midwife," *Gazette* (12 April).

Dunn, Kate
1989 "Midwives: operating on law's edge," *Gazette* (15 April).

Dunn, Kate
1990 "Medical Association Attackes Midwives," *Gazette* (13 October).

Ehrenreich, B. and English, D.
1973 *Witches, Midwives and Nurses: a History of Women Healers*. New York.

Fooks, Cathy and Gardner, Bob
1986 "The Implementation of Midwifery in Ontario," Current Issue Paper #50, Ontario Legislative Library, Toronto (November).
Gibbon, John Murray, with Mathewson, Mary S.
1947 *Three Centuries of Canadian Nursing*. Macmillan Company, Toronto.
Gilbert, Terry
1989 "Midwives lobby to legalize profession," *Calgary Herald* (19 February).
Globe and Mail
1989 "Study links wealth and caesarians," (27 July).
Hossie, Linda
1985 "The midwives battle for self-rule," *The Globe and Mail* (12 November).
Hurlburt, J.
1981 "Midwifery in Canada: A Capsule History," *The Canadian Nurse, 77*.
Jezioranski, Lisa
1987 "Towards a New Status for the Midwifery Profession in Ontario," *McGill Law Journal*, 33(1):90-136.
Jordan, Brigitte
1980 *Birth in Four Cultures: a Crosscultural Investigation in Childbirth in Yucatan, Holland, Sweden and the United States*, 2nd. edition. Montreal: Eden Press.
Kitzinger, Sheila
1986 *Being Born*. New York: Grosset and Dunlap.
Kitzinger, S. and Davis, J.A. (eds.)
1978 *The Place of Birth*. Toronto: Oxford University Press.
Kloosterman, G.J.
1978 "The Dutch System of Home Births," in Kitzinger and Davis (eds.), *The Place of Birth*. Toronto: Oxford University Press.
LEAF Newsletter
1989 "Midwives' case next in fetal rights' debate," *LEAF Newsletter* (7) (Summer).
LeBourdais, Eleanor
1988 "Despite CMA Misgivings, Support for Midwifery Appears to be Growing," *Canadian Medical Association Journal*, (139) (15 October):769-772.
MacKay, R.
1981 "Poor Relief and Medicine in Nova Scotia, 1749-1793," in S.E.D. Shortt (ed.), *Medicine in Canadian History: Historical Perspectives*. Montreal: McGill University Press.
Manitoba Advisory Council on the Status of Women
1987 Midwifery: A Discussion Paper. Winnipeg (May.)
Martel, Marie-Claude
1988 "Ou Accoucher," *The Canadian Nurse* (April):34-37.
Mason, Jutta
1990 "The Trouble with Licensing Midwives," Paper No. 20, CRIAW Feminist Perspectives, Ottawa (September).
Mate, Gabor
1987 "It's time to legalize midwifery," *The Globe and Mail* (8 January).
McLaren, Christie
1989 "Midwives move closer to recognition," *The Globe and Mail* (5 July).
Oakley, Ann
1986 *The Captured Womb: a History of the Medical Care of Pregnant Women*. New York: B. Blackwell.
GOuimet, Michèle
1989 "Ces sages-femmes dont on parle tant," *La Presse* (13 Mai).
Picard, André
1989 "Quebec doctors denounce proposed midwifery law," *The Globe and Mail* (11 May).
Rauhala, Ann
1987 "Task force endorses role of midwifery," *The Globe and Mail* (30 June).
Refern, Deborah
1987 "Midwifery in Newfoundland," *Healthsharing*, (Winter):9.
Stevenson, Judi
1986 "Fetal Positions," *Toronto Life*, (May):52, 73ff.
Sullivan, Deborah
1988 *Labor Pains. Modern Midwives and Home Births*. Yale Press.
Task Force on the Implementation of Midwifery in Ontario
1987 *Report of the Task Force on the Implementation of Midwifery in Ontario*. Chaired by Mary Eberts. Toronto.
Torres, Alberto
1989 "The Shift from Home to Institutional Childbirth: A Comparative Study of the United Kingdom and the Netherlands," *International Journal of Health Services*, 19(3):405-414.
United States Department of Health, Education and Welfare
1979 *Cost and Benefits of Electronic Fetal Monitoring: a Review of the Literature*. DHEW Publication no. 79-3245, Washington, D.C.
Van Wagner, Vicki
1988 "Women Organizing for Midwifery in Ontario," *Resources for Feminist Research*, 17(3) September.
Villedieu, Yanick
1989 "Le Québec aura-t-il ses sages-femmes?" *Actualité*, 14 (December):64-66, 68ff.
Weitz, Rose
1987 "English Midwives and the Association of Radical Midwives," *Women and Health*, 12(1):79-89.
Wertz, R. and Wertz, D.
1979 *Lying-In: A History of Childbirth in America*. New York.
Wood, Nancy
1989 "Time to settle midwife dispute, minister told," *Gazette* (13 April).