20001-113-022

Creating the Midwifery Profession in Ontario

Dissatisfaction with maternity care services has led to public demand for change. Criticism has focused on:

- The rising rate of surgical and pharmaceutical intervention in childbirth
- The overuse of specialist care in a normal physiological process
- Impersonal and fragmented care
- The need for a greater range of choices in childbirth, including flexible family-centered maternity care in hospital, an out-of-hospital birthing centre, and an adequate back-up system for safe home birth
- The desire of the consumer to be a more responsible and active participant in decision making
- The need for preventive care, education and counselling

In January 1986 the Ontario government made a commitment to legally recognize midwifery with the establishment of the Ontario Task Force on the Implementation of Midwifery. It will make recommendations to the Minister of Colleges and Universities and the Minister of Health on standards of education, relationship of midwives to other health professionals and setting of practice.

The attention of such prestigious bodies as the International Confederation of Midwives and the World Health Organization to the development of midwifery in Ontario indicates the importance of the opportunity we have to develop a model midwifery system. In order to provide optimal care for Ontario's mothers and babies, midwifery must be established as a separate self-regulating profession, in accord with international standards, and not be limited to a specialty of nursing or an adjunct to medicine. Midwifery in name only will not answer the need for real changes in the maternity system. To create a strong midwifery profession, the Association of Ontario Midwives and the Midwifery Task Force advocate:

- Adoption of the international definition of a midwife
- The midwife as a specialist in normal childbirth
- Continuous personalized midwifery care promoting informed choice and parent education
- The midwife as primary care giver and full member of the health care team
- Formal direct entry education
- Self-regulation and licensing

Every midwife and midwifery supporter must take advantage of this opportunity to be part of the creation of midwifery in Ontario.

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Legalizing Midwifery 1983 - 1986

The Health Professions Legislative Review (HPLR) was commissioned by the Ontario government in August 1983. Midwifery was one of over 180 health professions considered under this review. In 1983, the HPLR committee approached the two midwifery associations - the Ontario Nurse Midwives Association (ONMA) and the Ontario Association of Midwives (OAM) - to make submissions detailing the legalization of midwifery as a self-regulating profession. The two associations formed a coalition to submit a common legislative brief. Representatives of both organizations came together to work towards a vision of midwifery that would best serve the public and create a strong profession. The formation of a single professional body, the Association of Ontario Midwives (AOM), was undertaken in 1984 to represent the common goals of midwives in Ontario.

The "Midwives Coalition" submitted its first brief to the HPLR in December 1983. This brief outlined how midwifery could be legislated under the Health Disciplines Act and detailed principles for integrating midwifery into Ontario's health care system. Principles of the midwifery model recommended in the brief include:

> **direct entry** midwives, providing **continuous care,** as **primary contact** professionals for **normal pregnancy and birth,** working in **co-operation** with, but not under the supervision of the medical professional as members of the health care team.

A second brief, submitted in June 1984, clarified questions raised by the first, and outlined in greater detail the role of the midwife and her scope of practice.

By early 1985 midwifery was one of 37 professions still under review; 34 professions did not meet the criteria for self-regulation under the HDA. In 1985 the coalition was requested to submit a third brief addressing two key issues of self-regulation—compliance and education. The brief is divided into three chapters: the willingness of Ontario midwives to comply with regulation; the history of compliance within the profession and mechanisms to promote compliance are discussed in Chapter One. Chapter Two details the goals and structure of a "phase in" plan designed by the AOM to gradually integrate midwives into Ontario's health care system. In the third chapter, the history and future of midwifery education are outlined with particular emphasis on a curriculum proposal for a degree program in midwifery.

Perhaps the most exciting part of the brief is its vision of midwifery. The brief projects the future of midwifery as a self-regulating independent profession setting its own standards with the power to ensure compliance to these standards. Legislated midwifery would mean that all midwives practising would comply with AOM standards. Midwives would not lose their consumer perspective or their individual styles of practice, but all midwives would achieve the same high standard of practice. With this consistency would come increasing public recognition and respect and an even greater demand for midwifery care. The Midwives Coalition recognizes that currently practising midwives must be incorporated gradually but formally into the health care system, and that these midwives, with their established practices, have a great deal to offer both to their clients and to future midwives. As well, the brief acknowledges that the increasing consumer demand for midwifery care brought about by the recognition of midwifery will necessitate new generations of midwives educated in Ontario.

While we cannot expect that every detail of the vision of midwifery's future put forward in the brief will be wholly adopted and made a reality in Ontario, the brief provides the Ontario Task Force on the Implementation of Midwifery and others involved in midwifery legislation with a strong starting point from which to begin the demanding but worthwhile process of legislating independent, self-regulated midwifery. Even after the announcement, by Murray Elston, the Provincial Health Minister, in January 1986, midwifery supporters should expect it to take many months, if not several years, for consumers, legislators, and midwives and other health care professionals to achieve a workable model for legalized midwifery in Ontario. The process of legislating midwifery may take a long time, but we can all hope that it will result in the kind of midwifery we want. Then the goal will have been worth the wait.

Postpartum follow-up is a very important part of the continutiy of a midwife's care. Many times new parents need reassurance that they are doing a good job and that their baby is healthy. Others need counselling to help them cope with the numerous adjustments of parenthood. Having one person who they know and trust to answer questions and provide suggestions gives parents confidence in their abilities as capable caretakers.

Midwifery care usually ends with a six week follow-up visit where the woman's recovery is assessed. At this point many women want advice about birth control. Advice and counselling about birth control can be a sensitive subject but the established relationship and basis of trust between a woman and her midwife can aid in making the most appropriate decision.

Many midwives' clients remain in contact with her throughout the first year of their child's life, seeking advice about vitamins, supplements, pediatricians, immunization, teething and weaning.

Parents want the care of midwives because it answers their needs as individuals. It helps families take responsibility for health care and to participate actively in the birth of their child. Midwives assist families during a difficult transition period by building confidence, offering advice and support.

Midwives play an important role within institutions and in the community.

> ***The midwife is the professional person who has been intimately concerned with the family at those critical family building times when its members are changing and developing, and when it is most in need of counsel and support. The value of the intimate caring concern of a single identifiable person can hardly be overestimated.***
>
> (Prince and Adams, 1978)

Integration of Midwifery: Phase In Plan

Establishing a midsifery profession in Ontario is a unique challenge both for practitioners and legislators. Most professions have a history of gradually evolving standards of practice, improved education and development of a regulatory process. Such development normally takes place over an extended period of time. Midwifery in Canada, unlike in European countries, has not followed this pattern.

In most countries the midwife is a respected, invaluable member of the maternity care team; yet in Canada the practice of midwifery has never been regulated. This poses both problems and opportunities which cannot be addressed simply by changing legislation.

It is clear to the Association of Ontario Midwives members that integrating a new profession into Ontario's multi-faceted health care system needs to be a gradual process including careful evaluation. Therefore, the association has prepared a detailed phase in plan for the profession of midwifery in Ontario. The phase in plan illustrated in Figure 1 was developed and unanimously accepted by the Association of Ontario Midwives. Phase in acknowledges the skills of currently practicing midwives, the growing demand for their services and organizational structures already in place, and provides a formal structure for their integration into the system. It will also provide a period for skills assessment and upgrading of Ontario midwives while developing a prototype for the future midwifery educational program. The Phase in plan would facilitate public input, education of health care professionals and the public, standardization of midwifery education and effective regulation, monitoring and assessment of midwifery practice.

1) Phase One: Planning

Phase One is the first step towards self-regulation under legislation. It involves planning and establishing mechanisms in the current midwifery organization in accord with the Health Disciplines Act requirements for self-regulation. This phase is currently in process within the Association of Ontario Midwives.

2) Phase Two: Investigation

In this phase (Figure 2) two steps are taken towards establishing midwifery as part of the health care system. The first step involves developing the education program necessary for training and licensing of midwives. The second step involves identifying and evaluating models of practice, and developing a system for ongoing assessment of the profession.

3) Phase Three: Integration and Assessment

In this phase (Figure 3) midwives trained in the pilot project would begin to practice in target population projects. Groups who have a demonstrated need for midwifery services would be eligible for the care provided by this first licensed group of midwives. Possible target populations projects include: teenage mothers, Northern Ontario, home birth, birth centers, specific hospital projects, and specific physician and practice groups.

4) Phase Four: Self-Regulation

In Phase Four, the governing body (College of Midwives) would begin to function when sufficient numbers of midwives are licensed to practice in Ontario; and when the utilization of midwives increases, the Association of Ontario Midwives would divide to become the professional association whose mandate is to protect and promote the profession of midwifery and its member midwives, and the governing body whose role is to protect the public.

The Implementation of Midwifery Care in Ontario

RECOMMENDATIONS OF THE AOM/MTF TO THE ONTARIO GOVERNMENT

1. That Ontario adopt the international definition of a midwife

2. That Ontario adopt the principles of midwifery outlined in the Midwives Coalition submissions:
   a. midwife as primary caregiver in normal birth
   b. midwifery as a self-regulating profession
   c. licensing of midwives to practice in Ontario
   d. formal direct entry midwifery education

3. That compliance be facilitated through integration of currently practicing midwives into the health care system

4. That compliance be facilitated through the integration of current mechanisms into official statutory regulations

5. That compliance be facilitated through legal recognition of the practice of midwifery in Ontario

6. That the Association of Ontario Midwives four stage phase-in plan for midwifery care and official self-regulation be implemented by the Ministry of Health

7. That the phase-in plan aim to promote public input and education, education of health professionals and institutions, team approach in maternity care, standardization of midwifery education, integration of currently practicing midwives, careful monitoring and assessment of practice and education, and effective regulation

8. That the phase-in process involve four stages: planning, investigation, integration and assessment, and self-regulation

9. That the Association of Ontario Midwives' Professional Advisory Council act as a provisional governing body during the phase-in period

10. That the skills assessment and upgrading programs be developed to standardize midwifery education in Ontario

11. That a system for the ongoing monitoring of midwifery practice and education be developed

12. That midwifery services be integrated into the health care system through target population projects providing midwifery care to those populations with a demonstrated need

13. That an officially recognized professional association and governing body be developed from the Association of Ontario Midwives' professional and governing committees

14. That Ontario adopt international standards for midwifery education

15. That midwifery education be through a four year degree program leading to the Bachelor of Science of Midwifery

16. That midwifery education involve an extensive clinical component with minimum experience attending 50 births

17. That the Association of Ontario Midwives proposed curriculum be implemented in Ontario

Direct Entry Midwifery

The international definition of a midwife is...

"The midwife's sphere of practice demands of her an ability to give the necessary supervision, care and advice to women during pregnancy, labour and the post partum period, to conduct deliveries on her own responsibility, and to care for the newborn infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in counselling and education, not only for women and their families but also within the community. The work involves antenatal education and preparation for parenthood, and extends to certain areas of gynaecology, family planning and child care."

This definition for the sphere of midwifery practice has been adopted by the International Confederation of Midwives, the World Health Organization and the International Federation of Obstetricians and Gynaecologists. It is a definition the Association of Ontario Midwives and the MTF have also adopted.

Internationally, the midwife is able to function in a variety of settings such as hospital obstetrical units, neonatal intensive care units, birth centres, homes, maternity clinics and community health centres. In all of these settings, the midwife works as a primary caregiver and member of the health care team.

This definition is endorsed by the World Health Organization, the International Confederation of Midwives and the International Federation of Obstetricians and Gynaecologists. Canada is the only western industrialized country that has no legal provisions for midwifery. Eighty percent of babies in the rest of the world are delivered by midwives. It is only in 20th century North America that midwifery has not been a prominent part of the health care system.

For this reason, it is understandable that many North Americans misunderstand the role of the midwife, and often confuse midwifery with nursing. Many nurses and physicians on this continent are surprised to find out that in most European countries midwifery education is completely separate from nursing. In Holland a nurse receives no credit towards the three full year midwifery training program. In some countries such as Sweden and Finland a nursing training at the high school level is a prerequisite for midwifery education; however this system is quite different from our own post-secondary nursing programs.

The history of the midwifery profession helps explain why it has traditionally been seen as a separate discipline. Midwives were recognized as health care givers long before the development of medicine or nursing. Midwifery has had a clearly defined scope of practice for centuries and was regulated in Europe as early as the 14th century. Midwives in North America are aware of this tradition and feel themselves to be a part of a well established profession with a distinct history of both education and regulation.

During the last decade in Ontario, midwifery has experienced a revival as women have sought out care givers to provide alternatives to traditional obstetrical care with its rising rates of surgical and pharmaceutical intervention. The Ontario Association of Midwives formed in 1980 to represent the practicing midwives working in this province. Some of these women were foreign trained, some educated themselves through apprenticeship with experienced midwives or physicians. The members of another midwives group, the Ontario Nurse-Midwives Association were all trained both as nurses and as midwives, usually in Britain. Both groups aimed to achieve legal recognition for their profession. They began to meet to discuss their goals in 1983 and decided to cooperate by working in the Midwifery Task Force, a consumer based lobby group. After working together on two submissions to the Health Professions Legislative Review, the OAM and ONMA realized that they shared the same vision of a strong midwifery system and the same definition of the role of the midwife. Through ongoing research and discussions into midwifery systems in other countries and the renaissance of midwifery in North America, both groups agreed that:

1. The midwife is the primary care giver for normal childbirth
2. That midwifery should be a self-regulaing profession
3. That midwives should be licensed to practice in Ontario and regulated under statute
4. That a formal training program, of direct entry midwifery education be established

Our submissions have argued that nurses and other health professionals with related training be given advanced entry to the direct entry program, but have asserted that it is crucial that midwifery training not be exclusively limited to nurses, and that midwifery be established as a separate discipline.

The Midwives Coalition (the ONMA, the OAM and MTF) based their position on direct entry education on their study of the experience of other midwifery systems.

In North America, two past presidents of the American College of Nurse Midwives, Dorothea Lang and Sister Angela Murdaugh, and the current president, Judith Rooks have all advocated acceptance of and cooperation with direct entry midwives. Lang and Murdaugh were founding members of the Midwives Alliance of North America (MANA) which was formed to unite midwives with all varieties of backgrounds and to establish education and regulation for direct entry midwives.

In Europe, countries with strong midwifery systems such as Holland, France and Denmark have direct entry programs. Dr. Kloosterman, former head of Obstetrics and Gynaecology at the University of Amsterdam is a strong advocate of non-nurse midwifery. In Holland nurses do not gain advanced entry to the three year midwifery program. Kate Newson, a Brisith nurse midwife who also studied direct entry programs in Holland, France and Denmark has published a series of papers explaining the benefits non-nurse midwives bring to a maternity care system. Dr. Marsden Wagner, WHO Perinatal Epidemiologist and director of maternity care services in 33 European and Asian countries, is also firmly in favour of direct entry education and self-regulation of the midwifery profession. In his view independent midwifery is a key factor in ensuring choices in childbirth and providing a midwifery service with an equal footing on the health care team.

All of these experienced experts, warning against an exclusively nurse-midwifery system *have* influenced our position. The other significant factor is the reality of the current situation in Ontario. We have a group of midwives, very few of whom are nurses who have accepted the responsibility of meeting the growing public demand for midwifery care. Many of these women have a very well-established and rapidly growing practice. It is imperative that new midwifery legislation acknowledge the skills and experience of these midwives and integrate both them and their practices into the health care system. The consumers who are seeking out the care of the currently practicing midwives are very well informed and have clearly articulated demands about the kind of care they expect. We want to avoid the kind of situation which occurred in Washington State where nurse midwives were legally recognized, but the demand for the services of lay midwives still continued to grow, so that the state later had to recognize direct entry midwives and establish a midwifery school.

It is not in the interests of the public to have unregulated health care providers practicing outside of the system, when we have an opportunity with the Ontario Task Force on the Implementation of Midwifery to establish a midwifery service that is based on international experience, and that could be a model for the rest of our country.

Both the McGill Master of Nursing Program and the MacMaster Medical School are seen as leaders because they have recognized that a wide variety of backgrounds strengthens a profession. Direct entry midwifery education provides a focus on normal childbirth and extensive clinical experience unavailable in a nursing program. It would vastly reduce the cost of midwifery education to the taxpayer, and allow Canadian midwives to be accepted at an international level. Internationally, midwifery is *never* seen as a specialty of nursing, but a separate profession with its own scope, tradition and practice. We have been involved in a series of discussions with the College of Nurses, the Registered Nursing Association of Ontario and the Ontario Nurses Association on these issues. We urge Ontario nurses to recognize their sister profession and support our efforts to gain legislation which will provide formal training and legal recognition for non-nurse midwives.

Future Midwifery Education in Ontario

Having surveyed a variety of educational models, the Association of Ontario Midwives recommends a four year degreee program, leading to the Bachelor of Science in Midwifery degree (BScM). The program would include a strong clinical component. Association of Ontario Midwives research into midwifery education internationally and education of other health care professions in Ontario has identified aspects of existing programs which should be incorporated into midwifery education in this province: a four year degreee program completed in three calendar years; an emphasis on immediate and ongoing clinical experience under supervision; direct entry to midwifery education; and admission policies allowing for a variety of educational backgrounds. It must be emphasized that midwifery has its own distinct philosophy, process and scope of practice. The educational needs of midwives are unique; a future midwifery education program must be based on the application of a midwifery model.

Degree Program for Midwifery

A four year degree program provides the midwife with a comprehensive in-depth education which prepares her for practice as a primary contact health professional. Internationally midwives are recognized as independent health care practitioners after three calendar years of education (Appendix 20). In Ontario public trust in midwifery care would be fostered by a consistent standard of university education leading to the the BScM.

Formalized university education would ensure that every licensed midwife has been examined on a standardized body of theoretical knowledge prior to licensing. The university environment allows the development of graduate programs in midwifery, with advanced level research. Such research would have practical application to midwifery practice and would raise the standards of care in midwifery.

Clinical Component

There are a number of ways in which a student midwife can obtain clinical experience. These include clinical observation in hospital and community settings; clinical skills seminars and practice sessions at the university; clinical practice sessions in hospital and community; preceptorship units with practising midwives and internships in hospitals and in the community. The great strength of self-directed midwifery education has been preceptorship. A formal educational program must include the benefits of preceptorship along with the previously cited methods of obtaining clinical expertise.

Philosophy of the Midwifery School

The school endorses the international definition of a midwife:

> A midwife is a person who is qualified to practice midwifery. She is trained to give the necessary care and advice to women during pregnancy, labour and postnatal period, to conduct normal deliveries on her own responsibility, and to care for the newly born infant as well as having training in gynecology and child care. At all times, she must recognize the warning signs of abnormal or potentially abnormal conditions which necessitate referral to a doctor, and carry out emergency measures in the absence of medical help. She may practice in hospitals, health units, or domiciliary services. In any one of these situations, she has an important task in health education within the family and the community.

The School believes that midwives should be responsible for normal deliveries on her own responsibility, and to care for the newly born infant as well as having training in gynecology and child care. At all times, she must recognize the warning signs of abnormal or potentially abnormal conditions which necessitate referral to a doctor, and carry out emergency measures in the absence of medical help. She may practice in hospitals, health units, or domiciliary services. In any one of these situations, she has an important task in health education within the family and the community.

The School believes that midwives should be primary contact professionals who will provide continuous care throughout pregnancy, labour, delivery, and the post-partum period.

The School's program will be oriented to normal birth, but students will be given suficient clinical training and theoretical education to allow them to adequately assess abnormal or potentially abnormal conditions and make proper consultations and referrals to other health care professionals.

The School will accept students from a variety of backgrounds and experience and supports access to health education for people in isolated communities.

The School will support the right of parents to actively participate in their birth experience. A midwife's training will enable her to facilitate the decision-making process and to respond effectively to the individual choices made.

The School believes that midwives must be accessible and accountable to the people of their own communities.

Key Competencies

The aim of the school is to educate midwives who:

a) promote health for the mother, the newborn, and the family during the childbearing cycle;

b) assess the health needs of the mother, the newborn, and the family throughout the childbearing cycle;

c) assess clients experiencing deviations from the normal childbearing cycle;

d) assess clients requiring referral to other members of the professional health care team;

e) utilize the problem-solving process in giving thrapeutic care to clients during the childbearing cycle;

f) assess the progress of labour and demonstrate skill in the management of delivery of the baby and of the third stage of labour;

g) act as a teacher and counsellor to the mother and/or family during the childbearing year and facilitate the client's decision-making;

h) demonstrate professional values in all aspects of midwifery practice;
i) relate to and communicate effectively with clients during the childbearing cycle: and
j) function in a collegial relationship with other members of the professional health care team.

Proposed Curriculum

The Association of Ontario Midwives has corresponded with midwifery associations in at least 20 different countries during its curriculum survey. The proposed curriculum is modeled after countries with the highest standards of maternity education, especially Denmark and Holland. It includes courses in Anatomy and Physiology, Pharmacology, Gynecology and Family Planning, Pediatrics, Pregnancy, Labour and Birth, Postpartum, Education for Childbirth, Psychology and Counselling, Statistics and Epidemiology, History of Midwifery, Laboratory Techniques, and Obstetric Pathology.

Clinical experience will be integrated throughout the three years of the program. As well as completing specific units of clinical training associated with the theoretical courses, each students must work with at least three preceptors approved by the school as clinical instructors, of whom at least two must be practicing midwives. During these preceptorships the student will be involved in the documented continuous care of 50 clients throughout the maternity cycle. In the first two years of the program the student will complete the major part of the theoretical education and associated clinical training. During this time the student will be involved in prenatal and postnatal care, and observe and assist at at least 20 births. In the final year the student will be involved in providing primary care under the direct supervision of a preceptor for at least 30 births. The student's experience should include both hospital and community practice.

Educational Needs of Ontario Midwives

The Association of Ontario Midwives has proposed skills assessment and upgrading programs be developed to standardize midwifery education. These programs would act as a kind of "granny clause" to allow advanced entry and special training for currently practicing and foreign trained midwives.

Practicing Midwives

Currently practicing midwives may be apprentice-trained, self-trained or trained in other countries. Some are nurses, both with and without formal midwifery training. None have worked in Ontario hospitals as midwives, and upgrading and refresher courses will be essential before they can practice as full members of the health care team. Midwives currently practicing in the community may be highly skilled practitioners, with extensive experience in providing prenatal care, conducting deliveries and monitoring the postpartum period. However, in order to smoothly integrate them as midwives with hospital privileges, both orientation programs and further preparation will be necessary.

Apprentice-trained midwives work in domiciliary settings and as patient advocates in hospitals. Some midwives, notably those trained in apprenticeship systems, will require further academics and clinical education which has previously been unavailable.

Some currently practicing midwives will also have worked as midwives in hospitals elsewhere, and will need to become acquainted with the Ontario maternity care system and current procedures.

Non Practicing Midwives

All midwives trained in countries such as Holland, Denmark and France and many from Britain have direct entry training and have never practiced as midwives in Ontario or worked within the health care system. Although they have had extensive formal education (three years) direct entry midwives need upgrading and orientation to Ontario's health care system.

Some nurses practicing in Ontario have varying degrees of supplementary midwifery training. If they trained in Britain prior to 1981, they have at most, 12 months of midwifery education. (The European Economic Community's standardization of midwifery education recently increased this requirement to 2 years). Many Ontario nurses with British midwifery qualifications never practiced, and will require upgrading.

Eligibility Criteria

It is imperative that eligibility for the phase in training program be carefully evaluated. (The needs of various groups have been described above). A "granny clause" was proposed by the McLaughlin-Harris inquest jury (Appendix 13). It suggested that all midwives with five years of experience take only the final year of a three year training program.

Because of the diversity in training and experience of Ontario midwives, we believe that more specific eligibility criteria are necessary. In accord with international educational standards, the Association of Ontario Midwives recommends that only midwives who have attended a minimum of 50 births, 30 of them as primary caregivers, be considered. These midwives must have been trained and/or practiced in the last five years, either in Ontario through an apprenticeship program, or in a foreign jurisdiction.

To be eligible, midwives must have:

1. practiced for over five years in Ontario and must provide documentation of at least 50 births attended in the last five years, or .
2. attended a minimum of 150 births within the last five years and must provide documentation of at least 50 births attended in this time period, or
3. attended 50 to 150 births in the last five years and must provide extensive evidence of experience and training, i.e. apprentice clinical records (Appendix 18) and/or birth records (see Appendix 10 for a sample of birth records)
4. Foreign trained midwives who have been trained or practiced in the last five years should provide evidence of graduation from an accredited midwifery school.

Cost Effectiveness of Midwifery

Midwifery is a recognized and subsidized part of health care systems all over the world. Governments support midwifery programs because of their excellent record of safety and their cost-effectiveness. Countries with government health insurance plans similar to OHIP encourage midwifery. As well, private health insurance plans in the U.S. are increasingly covering midwifery care because of its cost-effectiveness, despite opposition from the medical profession. Midwifery is the most cost-effective form of maternity care for many reasons.

Increased Safety

Integrating midwifery into the health care system will reduce the cost of maternity care through improved mortality and morbidity. For example, midwives' preventive and individualized care reduces the rates of prematurity, and therefore decreases the amount of intensive care necessary for the newborn. (Stewart, 1981, p.117-125). With midwives attending all births in Sweden, there is a very low rate of brain damaged infants requiring institutionalization. (1.5/1000 in Sweden vs 5.4/1000 in the U.S.)

Appropriate Use of Technology

The midwife's ability to facilitate normal childbirth decreases the routine and unnecessary use of expensive technology. For example, in countries where midwives are not encouraged the rate of cesarean section is three to four times the rate in countries where midwives are numerous. The cesarean section rate in the U.S. and Canada is 14-18% while in Holland it is 3.8%. A study of episiotomy, in a paper presented at the 23rd British Congress of Obstetrics and Gynecology in July 1983, reported that an estimated 10,000 hours of staff time and £65,000 would be saved through the limited use of episiotomy, per year per hospital.

Efficient Use of Medical Specialists

Increased safety, decreased use of technology and the ability of midwives to accurately detect abnormal conditions and refer to medical specialists results in the efficient utilization of medical expertise. In a midwifery based system obstetricians are used for high risk births where their skills are necessary. A decreasing number of family physicians are willing to attend births. Under the present system only obstetricians are left to provide antepartum care, even though the vast majority of births are not complicated. As specialists in normal childbirth, midwives can fill this gap with sizeable savings to the health care system. The continuity of care provided by midwives would help to streamline the personnel currently involved in delivering maternity care, streamlining costs as well. A study by a joint committee of the Canadian Nurses Association and the Canadian Medical Association indicated that in Canada, savings (using non-physicians in birth) would be at least $8.2 million/annum (CHA, 1972).

Community and Home Care

An increasing number of women wish to give birth in out-of-hospital settings and at home. Using midwives in community settings and to provide home care either for delivery itself or to facilitate early postpartum discharge would lower costs involved in hospital centred care. In a brief presented to the Alberta College of Physicians and Surgeons, Dr. E.B. Toane estimates that the savings to the health care system of only 100 home births is $19,512.16 (Toane, E.B., 1981, p.60).

The widespread support of governments all over the world for midwives as important members of the health care team speaks to both its safety and its cost-effectiveness.

Meeting Ontario's Maternity Care Needs

1) The Midwife: Specialist in Normal Birth

The midwife's orientation is toward the normal physiological process of childbirth. She is trained to facilitate this process with a minimum of medical interference.

At present, parents have a choice between the care of a specialist in high risk obstetrics or a family physician who, because of the broad range of his/her practice cannot be a childbirth expert. The nurse who monitors the pregnant woman throughout labour has not participated in her prenatal care and is not familiar with her needs or wishes regarding the birth, and has little specialized training for maternity care. As a result, the care received by childbearing families is fragmented and often impersonal. The midwife can fill this gap and make maternity care not only comfortable for the entire family, but also safer. Midwifery's specific focus on normal pregnancy and childbirth, contrasts sharply with both the broad scope of nursing and general practice medicine, and the narrow pathological focus of the obstetrician.

2) Formal Training

Currently there are no formal educational programmes for midwives in Ontario. Women trained as midwives have attended schools in other countries or have been self-trained, usually through apprenticeship. Through formal education, combining both intensive theoretical and practical training, the public would be assured of a standard of training.

The midwife's education prepares her to give the necessary supervision, care and advice to women during pregnancy, labour, and the postpartum period; to conduct deliveries on her own responsibility and care for the newborn and infant. Although midwifery education is focused on normal childbirth, advanced midwifery education would include specialization in administration, research, education and high risk maternity care. As professionals concerned with the childbearing cycle, midwives would take an active part in all new developments in maternity care. The midwife's training prepares her to meet the increased demands of parents for personalized physiological care, teaching and sensitive counselling. The midwife has an important task in health counselling and education, not only for the pregnant woman but also within the family and community.

3) Multiple Routes of Entry to Practice

Because of its unique approach to the care of the childbearing family, it is important that midwifery remain a separate, autonomous profession. Direct-entry training programmes, where nursing is not a prerequisite are recognized as an important means of preserving the distinct qualities of midwifery education and practice.

In evaluating midwifery care systems around the world, the Midwives Alliance of North America (MANA) and the International Confederation Of Midwives (ICM) support direct-entry training, for its role in protecting the integrity and independence of midwifery.

There are many well-educated midwives from foreign countries now living in Ontario and unable to practice their profession; acceptance of multiple entry would allow midwives trained in other countries to sit a challenge exam, update their skills and practice in Ontario.

Entry into midwifery from related professions would require a shorter training due to overlaps in knowledge and skills. However, training and practice in either nursing or medicine is not adequate preparation for midwifery practice. Multiple routes of entry to midwifery training acknowledges overlap with other health professions while maintaining the distinct sphere and special education of the midwife.

4) Self-Regulation

Self-governance is another important mechanism to ensure that midwifery is not limited by the interests and orientation of another profession. A College of Midwives would administrate, set standards of practice, and entry to practice standards, and maintain continuing education for the profession.

The ability of the midwifery profession to set standards of ethical and professional practice and conduct is demonstrated internationally. Midwifery is not a discipline in which the quality of the performance of its members is effectively monitored by members of another profession. In order to remain responsive to public concerns it is essential that there are mechanisms available to the consumer to express concerns regarding the quality of midwifery care. Increasing public demand for greater participation in health care, especially childbirth, has prompted significant changes in maternity care in the last ten years. Public participation in the bodies responsible for setting standards and reviewing midwifery practice would encourage this trend.

5) Licensure

It is common practice in the regulation of health professions that disciplines which function independently (i.e. not under supervision), are required to be licensed in order to practice.

Registration and licensure exist to prevent harm to the public by protecting them from potentially unsafe practitioners. Therefore, in order to provide a high quality midwifery service a College of Midwives would license those who practice midwifery.