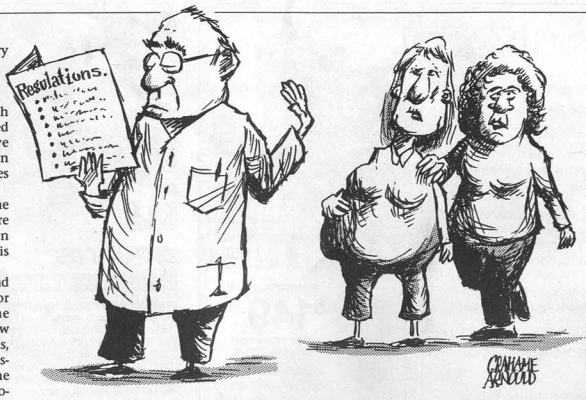

Birthing Pains

A year after B.C. legalized them, midwives are still treated as second-class caregivers ~ By Caitlin Hicks

With the legalization of midwifery in Ontario in 1993, Canada became the last nation in the industrialized world to recognize this ancient profession—even though 80 percent of the world's births are attended by midwives. British Columbia took five more years to catch up with Ontario. On January l, 1998, the first registered midwives were funded by the Ministry of Health.

So, are B.C. mothers safer because of the registration process? Do women have more choice in birth here, in rural and urban areas, because midwifery is funded? How is the whole thing working out?

Almost a year later, midwives, doctors, and mothers across the province report major snags—along with some progress—in the process. Although registered midwives now have admitting privileges in 15 B.C. hospitals, there have been delays with registration, resistance from doctors, a dispute between the Ministry of Health and the B.C. Medical Association, and hospitals dragging their feet in changing their bylaws to allow midwives on staff. All of these, including problems unique to rural communities, are contributing to keeping midwives as second-class citizens in the mainstream of modern health care.

Before registration, less than one percent of the population gave birth in the care of a midwife. Now, more are lining up for it. "In Vancouver and Victoria, the number of midwives are almost sustaining demand," says Mission's Debbie Clelland, spokesperson for the B.C. Midwifery Task Force, a consumer group that advocates for midwifery. "Everywhere else in the province, I would say, is underserviced at this time, and lots of areas are not serviced at all."

"We've been very lucky in Vancouver," says Linda Knox, president of the Midwives Association of B.C. "We have privileges in three hospitals. We're run off our feet; we're working harder than we've ever worked." The College of Midwives of B.C.—established to ensure standards of professionalism through qualifications assessment and testing—reports 48 registered midwives in 18 B.C. communities, with about a dozen more expected to register in 1999. All passed rigorous written and practical exams and qualified with required hands-on experience in both home and hospital, yet almost half the practising midwives in B.C. service only two cities: Vancouver and Victoria.

The remaining midwives service mainly the Lower Mainland, southeast Vancouver Island, Prince George, Nelson, and Kelowna. Women in the rest of the province have no access to care from registered midwives. Prior to registration, there were approximately 60 to 70 women practising as midwives in B.C., according to MABC's Knox.

Paradoxically, because of the required midwife registration, many people who have grown to depend on midwifery are now denied care altogether. A small number of the original 60 or 70 chose not to be registered, and are now not allowed to practise. Those who want to practise but did not qualify for full registration must work under supervision until competency requirements have been fulfilled. However, some midwives in rural and relatively small urban centres are unable to work due to lack of qualified supervision. In Nelson, five midwives applied, but only one achieved full registration. In Nanaimo, four applied—none are fully registered. On the Sunshine Coast, three midwives with 32 years of experience between them are unable to find the required supervision. That means there's no income coming in for the would-be practising midwives.

"Consumers are left without midwives," Clelland says. "Midwives who were previously practising successfully are unable to practise. This has been their livelihood. My midwife asks herself: 'Do I really want to do this?' I've experienced her as being very professional; I'd hate to see the future mothers of B.C. lose someone like that because she can't financially wait to jump through many more hoops to qualify."

Big issues are the integration of registered midwives into the hospital system and the establishment of guidelines for transferring emergency patient care from home to hospital.

"Prior to legalization, there were a number of inquests into deaths in the care of midwives, and one of the problems identified was the delays in the transfer [to hospital in emergencies]," Knox says. "Before registration, the hospital receiving the call didn't know if they were dealing with a professional. Time was lost in reassessing the client in an emergency situation. The role of the coroner's court was very powerful; they advocated the legalization of midwifery, that midwives be fully integrated into the health-care system. Midwives have to have their own admitting and discharging privileges for the system to work safely."

In Comox-Courtenay, Nanaimo, Nelson, and the Sunshine Coast, hospital privileging has been a difficult process. "Midwifery was a new idea to a lot of physicians," says Courtenay midwife Deborah Kozlick, whose hospital took seven months to grant privileges. "They didn't seem very well prepared, and we found resistance."

ANALYSIS

Although the necessary hospital bylaws are in place in Nanaimo, midwife Lillian Sly says, "We still don't have privileges." Sly describes a runaround similar to what has been reported from other hospitals: bylaw meetings where midwives are excluded; hospital requirements that cause delays; and, in Sly's case, a bylaw that requires midwives to respond to hospital employment advertisements as if they were being hired by the hospital and not the mother-to-be. "I'm sick of this whole thing," a frustrated Sly says, "and I no longer trust any medical person who smiles and says they can't wait to work with midwives. There has been very little outright hostility, but I've come to believe we have very few friends in medical circles in this town."

In Nelson, meanwhile, there was "an immediate negative response" from doctors, according to Nelson's only fully registered midwife, Ilene Bell. "We heard wild threats, like 'Maybe we'll just close down maternity.' " The regional health board stepped in to smooth things over, and, after months of meetings, it was announced that the Health Ministry's new provincial template for standardizing basic requirements for hospital bylaws was unacceptable to the doctors. This led to more meetings and another conclusion: doctors would not accept a midwife who hadn't graduated from an accredited midwifery institution (even though there are none in B.C.). The board did eventually accept the Health Ministry and College of Midwives recommendations of midwife competence, but the bylaws have yet to be changed.

This fight between doctors and their B.C. Medical Association and the Ministry of Health seems to be a tool that reticent doctors and hospitals are using to stall the implementation of midwifery. As Dr. Vicki Foerster, medical consultant for acute and continuing care at the ministry, points out, health boards can add midwives simply by changing hospital bylaws to include the word *midwives* on staff, then all involved "could leisurely approach the new model". A few hospitals have taken that route: Surrey, Langley, B.C. Women's Hospital in Vancouver, and Comox.

The new bylaw template handed down by the Health Ministry requires, among other things, that midwives be members of the hospital medical staff. "They have no choice about that," says Foerster.

"No choice" aside, three Fraser Valley hospitals still voted against incorporating midwives at all, prompting the local health board to step in to ensure development of the necessary bylaws.

On the Sunshine Coast, the process slowed to a halt in the summer months. Mothers and consumer advocates have reported "busy" doctors, friction between hospital administration and doctors, and the doctors' provincewide "reduced-activity days" as some of the reasons. The other snag is availability. The Sunshine Coast has a plethora of general practitioners and only one obstetrician, who, understandably, doesn't want to be on call 24 hours a day.

"The model for [childbirth] is, unfortunately, based on an urban, large hospital, says Dr. Morris Van Andel of the College of Physicians & Surgeons of British Columbia. "That's fine if you're at Women's Hospital and large hospital settings, but it doesn't work in Quesnel or Williams Lake. With midwifery, there is an expectation [for the doctors] to be available for backup. In a rural hospital with a medical staff of six, you're not going to have someone sitting around waiting for something to happen....It's up to midwives to make sure there is a backup system in place. Unless there is some recognition and some compensation, do we have a responsibility for someone who is not our patient?"

"Midwives are not the cause nor the solution to the problems with rural maternity care," says Dr. Michael Klein, head of family practice at B.C. Women's Hospital. "In 1997 in B.C., there were 21 hospitals without any cesarean-section capacity; 10 to 12 hospitals have it some of the time. In some communities, hospitals have stopped doing maternity care altogether; it's difficult to sustain in the face of budget cuts. But midwives need the same backup and support that doctors do. You can't have midwifery or home births without the support of the hospital system."

In the North Okanagan, Midwifery Task Force representative Andrea Harwood Jones says it is important for doctors to respect midwives and their clients: "We want to know that this process is going to be safe, that the hospital is going to be ready. Women don't want to get into the hospital and have the doctors dissing them. Fortunately, our nurses are not as disrespectful as the doctors."

"It's safe to say that doctors don't support home birth anywhere in the province," says the MTF's Clelland. In the Fraser Valley, formerly midwife-friendly doctors surprised many by going public to announce their plans to take job action by refusing to see any new maternity patients.

"A lot of it was about money," Clelland says. (Doctors' pay of $900 for approximately 12 hours of work during the course of a pregnancy, or $75 per hour, wasn't enough, apparently, when compared to the midwives' fee of $2,250 for about 45 hours of care—$50 per hour.) What resulted was a public debate in which the MTF wrote letters to the local papers, explaining to the public about midwives, the continuity of care they provide, and how midwives save money for the health-care system as a result of fewer costly childbirth complications and medical interventions.

"The hospitals who are unwelcoming are in some difficulty, ethically," says Klein. "The midwives have got to be integrated. I'm waiting for the BCMA and the College of Physicians and Surgeons to urge expeditious integration of midwives into hospitals. So far, they're silent."

BCMA spokesperson Lynn Haley says her association's position is simple: "Our primary concern is the focus on the health of the mother and child," she says. When questioned about the emergency-care transfer process, she adds: "We're going to have to come up with something more definitive."

"It's harassment," says Nelson midwife Ilene Bell. "They're putting a limit on my professional right to practise. The ministry should step in; it's irresponsible. The ministry brought us into the system and stepped back and let us be eaten by the lions."

"We never set a deadline," says the ministry's Foerster about the implementation of new hospital bylaws. "Midwifery is only a small piece of it [the hospital-bylaw changes], and, besides which, what if they didn't meet it? We can't put them in jail. There's no point in being hard-line unless you have a penalty. What we're wanting for the medical boards to do is get on with it, get it done collaboratively. Most of the big ones [hospitals] are well along in the process."

The "noncompliant client" is also an issue that will have an impact on the way midwifery will be practised. Some doctors feel it is midwives' responsibility to force their clients to comply with their medical protocols. Midwives traditionally attract well-informed, independent-minded clients, as well as some who have had negative experiences in hospital. Midwives also support a mother's informed choice, and they don't feel it is their duty to force a medical visit on a client or recommend procedures such as ultrasound. And although some doctors would like to write compliance into their hospitals' bylaws, midwives believe there will always be women who will choose nonintervention and who will birth at home.

"It's an ethical debate," says Knox. "Midwives have a commitment to support a woman's choice. When a woman makes a truly informed choice of birthplace and, as a normal, healthy woman, falls within the scope of practice of a midwife, there is no data worldwide to show that hospital is safer for low-risk women attended by skilled practitioners."

Midwives are still short of the model of an independent, self-governing profession. In Maple Ridge, midwife Jean Cooper must be supervised by two doctors for two births before she is granted hospital privileges—and she must repeat the process for each hospital there. Although physicians must also be supervised to get privileges, they are supervised by members of their own profession, and physicians have a say on almost every committee that has anything to do with midwifery.

The Ministry of Health did not put a deadline on the hospitals for the implementation of midwifery, but there *is* one for the contract to fund midwives' services, and it expires in March 1999. The ministry itself funds midwifery, but if a new government comes into power, it can do what it likes with its budgets. Doctors, by contrast, are funded by the Medical Services Plan, which doesn't change with each new government.

In the final count, only 48 midwives serve the province's population, a province where, in 1996, 45,883 babies were born. For some women, the process of legalization has temporarily taken away the choice of home birth. For those with deep beliefs about hospital as an inappropriate place for birth, this can mean birthing alone. Some midwives who work in restaurants and clean houses to pay bills in this interim period fear losing their skills. Others fear the philosophy and practice of true midwifery will be lost as midwives adapt to a medical setting and as they're judged by a medical profession that is skeptical of the safety of home birth.

Still others, who are working harder than they've ever worked before, feel the pressures of their own expectations, the expectations of the public, the scrutiny of the medical system and the government—and the future of their own profession.■