

Ontario Midwives

Reflections on a Decade of Regulated Midwifery

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Ce papier utilise une approche gouvernementale pour explorer les implications de la réglementation des sages-femmes. L'auteur assure que cette nouvelle façon de faire est une nouvelle forme de surveillance qui est potentiellement alarmante pour le statut des sages-femmes.

The ... consequences of professionalization may run counter to the reasons for defending the profession in the first place. Midwives, in short, may become more like doctors instead of more like midwives (Oakley and Hood 164).

Prior to the 1860s, midwives were the primary birth attendants in much of North America and Europe. With the ascendance of technology and the professionalization of modern medicine, midwives were removed from the mainstream and subject to prosecution for practicing medicine without a license. By the 1950s, midwifery had all but disappeared in Ontario. In the 1970s, the practise of midwifery began to emerge again as consumer demand increased dramatically (see Bourgeault; Bourgeault, Benoit and Davis-Floyd). Influenced by the feminist movement, calling attention to “colonized wombs” and the marginalization of female professions, the new consumers of midwifery services believed that preg-

nancy and birth were normal, healthy family events and that pregnant women themselves should be the primary decision makers about the health care they receive (Patel and Al-Jazairi 51). During this time, midwifery practise enjoyed an alegal status as authorities paid little attention to the growing movement.¹

By the 1980s, midwifery could no longer be ignored. Two factors led to discussions of public provision. First, the death of a Toronto infant less than 48 hours after a midwife-attended birth spawned a flurry of attention to the practise. Second, a burgeoning crisis in obstetric care was becoming increasingly apparent. The nature of the crisis was twofold. First, fewer physicians were available to deliver babies. On the one hand, the number of obstetricians was declining rapidly with retirements and low enrolment rates. On the other hand, fewer family physicians were willing to delivery babies (see Kaczowski and Levitt). Second, spiralling healthcare costs were becoming a key concern for policy makers (see York; Rachlis and Kushner). Vicki Van Wagner notes,

Midwives seemed the obvious answer, not just to the financial problems of using specialists to provide care but to the overuse of technological and pharma-

ceutical interventions in maternity care. (76)

Advocates of midwifery, including feminists and midwives concerned with ending the “colonization” of wombs and establishing a “legitimate” female profession, presented international studies, backed by the World Health Organization, to show efficiencies and cost savings incurred by midwifery services, in addition to the health benefits associated with midwife attended births (see Bourgeault; Bourgeault, Benoit and Davis-Floyd; Sharpe). This was especially appealing to regulators. As the protector of the “public interest” and as the provider of public healthcare, the state had a vested interest in regulated midwifery. State regulation meant not only monitoring the practise to ensure public safety, but also alleviating the impending crisis caused by a lack of physicians and increasing healthcare costs. In essence, the state needed midwifery to avert a crisis in healthcare.

The questions then arise, how was midwifery to be brought into the state? And what are the practical implications for midwives in Ontario? Perhaps midwifery regulation can best be conceptualized using Foucault’s (1978) “governmentality” approach. Governmentality refers to the centralization and

increase in government power and is reflected by

the ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics, that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its

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principal form of knowledge political economy, and as its essential technical means apparatuses of security. (Foucault 102)

In essence, governmentality is concerned with rationalities of government, especially in producing self-monitoring individuals. It is premised on calculation, surveillance, and specific knowledges giving rise to “experts.”

Prior to regulation, midwifery practise was woman-centred, governed by clients² and midwives. The practise of midwifery, meaning “to be with women,” was based on a philosophy of care that centred on the mother. The midwife assumed the role of facilitator, or coach. Upon entering the public health care system, practising midwives and the Association of Ontario Midwives articulated this philosophy as three key tenets: informed choice, continuity of care, and choice of birthplace. Calculations of risk and notions of expertise were absent since midwifery was prem-

ised on the idea that birthing is a healthy, normal event, not a pathological condition requiring treatment. In contrast, the medical model is premised on informed consent, care is often fragmented, where patients see their physician only during delivery, and no choice of birthplace is offered.

To regulate midwives in Ontario, a model of enforced self-regulation was chosen, which, on first analysis, appears ideally suited to midwifery. This type of regulation would serve several purposes. First, it would allow midwives, the “experts” of practise, to develop, monitor, and enforce their own rules and standards of practise, which, in turn, would be sanctioned by the state (Ayres and Braithwaite 103). Second, it would provide a cost-effective and timely method by which to integrate midwifery into a publicly-monitored system (Ayres and Braithwaite 103). Third, enforced self-regulation would fulfil a symbolic function as it would recognize both the autonomy of women as consumers of healthcare services and the legitimacy of a female-dominated occupation as a profession, rather than a job ghetto; it would protect the public interest by way of quality assurance and redress; and it would provide authorities with a vehicle for monitoring the non-traditional practise (Doern and Phidd 109).

Certainly, no one would argue that regulation in this context fulfils important and necessary functions. And self-regulation is perhaps the least invasive form of regulation available to the state. On the other hand, it is the state, not the practitioners, who defines the boundaries and scope of regulation and practise (Francis 146). R. A. Harris and S. M. Milkis note, “... regulatory regimes exist ... in a political environment defined by a larger regime” (29). Imposed on midwives is a medical discourse that situates itself in opposition to the philosophical principles of midwifery.

Indeed, the resulting structural changes and their implications for midwifery practise cannot be understated. Keeping in mind that the practise of midwifery was originally regulated and governed by clients, the practise is now governed by two pieces of legislation: *Bill 56* and the *Regulatory Health Professions Act* (RHPA), both passed in 1991. This regulatory structure accords considerable power to the Minister of Health to define the scope and boundaries of practise for each profession governed by the *Regulatory Health Professions Act* (RHPA). Ultimately, the Minister can intervene at any time and alter the practise of midwifery and its regulatory framework, both internally, via the *Midwifery Act* (Bill 56), and externally, via the RHPA and its corresponding agencies.

Regulation, then, represents a new mode of surveillance in which the state and its governing bodies monitor the practise of midwives. In this context, the concept of “self-regulation” loses its meaning, since all governing bodies are sanctioned by the state and monitored according to the rules outlined by the state. The practical implications are significant as midwives move from the *object* of government to the *subject*, enforcing and perpetuating the conditions of practise determined by the state. The evidence points to significant changes in practise, which have the potential to undermine the very philosophy of care upon which midwifery care is premised. The remainder of this paper will discuss the specific implications of two aspects of midwifery regulation, risk minimization and the requirements of formal education.³

Managing Risk

Midwifery was brought into the state by problematizing services of midwives. Problematization, Carol Lee Bacchi observes, is

the chief means of instituting

liberal rationality ..., that is, structuring problems in such a way that liberal outcomes, in this case self-monitoring under the illusion of autonomy, follow. (166)

By exposing the potential dangers of non-traditional healthcare, the state was able to impose a discourse of risk on midwifery services. For example, quality assurance and safety guidelines require consultation with physicians in several cases. The College of Midwives, blatantly undermining the legitimacy and competence of the midwife, requires practitioners to consult with physicians upon reception of a new client and transfer care if the pregnancy is determined to be high risk.

This requires midwives to incorporate calculations of risk into their services, assessing and monitoring pregnancies from the perspective of safety. Midwives must categorize clients along three levels of risk. The first category of conditions, which include such symptoms as poor nutrition, obesity, cigarette smoking, adverse socio-economic conditions, to name just a few, requires midwives to consult with *either* a physician *or* another midwife (College of Ontario Midwives). The second category, including conditions ranging from the potentially serious to the trivial, requires *mandatory* consultation with a physician, with the explicit expression that she/he is seeking a consultation, if the client demonstrates one of the following symptoms: repeated spontaneous abortions, cardiovascular disease, family history of genetic disorders, history of significant medical disorders, significant use of drugs or alcohol, and the client is less than 14 years of age (College of Ontario Midwives). Finally, the third section dictates that *care is automatically transferred* to a physician (College of Ontario Midwives). This can include insulin dependant diabetes or cardiac

disease. Susan James observes:

Although the consultation lists are very purposely written as very general guidelines, their very existence causes a challenge to much of what has been highly valued within midwifery tradition. Rather than providing an alternative or challenge to the canons of medical care, midwives will now be required to be accountable to medicine.... Visible or invisible, physicians enter into the relationship and have the potential to influence the decision making process. (185)

In addition, it demonstrates and perpetuates the paradigm of risk which permeates the birthing process and which is upheld by the traditional model of medicine. As James notes, pregnancy is defined in terms of "low risk or high risk, but never healthy or normal" (186).

The discourse of risk places new expectations on midwives, forcing them to assess pregnancies with the medical model as referent. This has the potential effect of removing the mother from the position of central decision-maker. Instead, it is midwives who determine the basis for "treatment," effectively imposing an implicitly hierarchical order on the practise. This new power relationship can have serious implications for the practise of midwifery. Not only does it compromise the informed choice principle, it also has the potential to fragment care, undermining the continuity of care principle. The philosophy of care is further compromised by the formal educational requirements demanded of midwives.

Midwives as "Experts"

Bringing midwives into the state required not only imposing a discourse of risk on the practice, but also imposing a discourse of expertise. These two discourses are not necessarily mutually exclusive. The

role of experts is key to governmentality. Bacchi writes,

... complex social issues are commonly reduced to "problems" which are then assigned to particular groups of professionals or to different departments of government, leaving the impression that the problem is being addressed (165-166).

From this perspective, mitigating "risk" requires experts to adequately handle particular situations. Midwifery regulation, then, fundamentally required the transformation of midwives into "experts," realized through a formal education system sanctioned by the state.

The educational requirements for midwifery practise in Ontario have been contentious to say the least. Some argue that formal education is causing the practice to become increasingly medicalized and has restricted entry to those who can afford the costs of schooling and to those who can speak English or French. Further, critics argue that placement in an educa-

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tion system which favours patriarchal professions and ideals will fundamentally alter the way in which midwifery is practiced (James 190). One midwife notes, "... the process of becoming admitted to the Michener program is a symptom of a male-dominated process.... Pa-

per certificates of competency say ...” (Shroff 23).

The university programs are clinically based, attempting to merge *both* medical and midwife models of care, training women to be midwives while at the same time providing them with the appropriate medical skills to prescribe the appropriate treatment and to treat potential emergencies. Emphasis is

Prior Learning and Experience Assessment program. The program would allow women with previous experience to by-pass the four-year program and gain licensure through demonstration of competency. The program is a noble component of midwifery education, but like the process of formal education within the university system, it has threatened midwifery practice in restrict-

Like the discourse of risk, the emphasis placed on expertise imposes a hierarchical order on midwives and their clients, making it increasingly difficult for women to question the authority of midwives. Compromising informed choice and continuity of care, the demands of formal education have had the effect of medicalizing midwifery practise. Indeed, although the

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now on *treating* pregnant women, rather than *guiding* them. Similarly, a practicum component allows students to train with licensed midwives to gain experience outside of a classroom in a *clinic* setting. This has also been the source of controversy as training itself has become based on skills valued by the medical community, neglecting the philosophical aspects of the practice (James 192). Student interns are taken on because midwives are required to do so, not because a midwife recognizes a potential ability or skill, as pre-regulation training entailed (Sharpe 1997: 226). This practice has altered the relationships between and among midwives, to say nothing of the relationship between midwives and clients. In effect, the continuity of care principle is compromised as students become one more stranger to the client and additional paperwork for registration and assessments take the midwife away from her client.

Attempting to overcome some of the problems that would result from formalized education and as an option to lay midwives practicing prior to regulation, the College of Midwives, with permission from the Ministry of Health, adopted the

ing entry to privileged few. For example, the language requirement has been criticized by many for being too difficult. Indeed, the first time the test was administered 45 per cent failed, including many for whom English was their first language (Sharpe 1997: 226). This type of testing prevents non-English or French speaking women from entering the practice, despite prior experience in midwifery care.

Turning midwives into experts has essentially forced them to accept and perpetuate many of the myths surrounding births. Emphasis is now on qualifications and risk rather than skill and health. In addition, the formal educational requirements have the potential to compromise the informed choice principle. Stanley Gross, questioning the validity and effectiveness of regulating health care professions, posits that regulatory regimes and their corresponding institutional structures, such as professional associations, colleges, and formal education programs, make it exceedingly difficult to challenge the power of such regimes. In the case of midwifery, it is feared that clients will become increasingly reluctant to question the expertise of the midwife (Sharpe 1997: 215).

number of home births are increasing, many women want hospital births attended by midwives. As midwives defer to the medical model, the philosophy of care on which the practise is premised is severely compromised.

Conclusion

Prior to regulation, midwives were woman-centred, governed by clients. It was premised on a philosophy of care that placed the mother at the centre of the birthing process, where midwives were partners or facilitators of birth, not “experts” in obstetric care. Since regulation, midwifery is increasingly state-centred, governed by hierarchically organized institutions that value traditional medicine. This shift has imposed discourses of risk and expertise on the practise of midwives. The implications of these discourses are significant for practising midwives since they represent potential tectonic shifts in the practice, undermining the philosophy of care on which midwifery is premised. Increasingly medicalized, midwifery practise in Ontario is already witnessing serious changes. For example, changes in client-base have meant that only

about 60 per cent of births attended by midwives are delivered at home. In addition, prior to regulation, midwifery was crucial to birthing women in rural and remote locations. Since regulation, however, high barriers to entry for the practise have limited the accessibility to rural midwives. They have also meant that the practise is changing along lines of class and race. Finally, regulated midwifery has divided midwives between those recognized by the state and those who, for any number of reasons, operate outside of the state. Future work needs to explore the ways in which midwives, both state and lay practitioners, are attempting to resist or retard change.

These debates are not new, reaching back at least as far as the initial discussions on regulation (see Van Wagner). Some midwives see regulation as the best way to preserve the practise, observing that "... without legislation, midwives are not free from regulation through coroner's inquests and the criminal justice system. This form of regulation of midwifery is crude, sensational, punitive, and costly" (Van Wagner 78). Perhaps the question then is not about whether or not to regulate the practise, but how best to ensure public access without sacrificing the foundational elements of the practise. After a decade of regulation, it is time to reassess the impact of regulated midwifery for those to whom it matters most, midwives and mothers.

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¹See Bourgeault, Benoit and Davis-Floyd for a discussion of the history of midwifery in Canada. Also note that nurse-midwifery has been governed by the state since the 1920s. See also Bourgeault for an excellent discussion of the advocacy for mid-

wifery during the 1980s.

²It should be noted that this is a post-regulation term (see Sharpe 2004).

³See Sharpe (2004) for an excellent discussion of texts and rulings in midwifery legislation.

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