health problems among women (Royston and Armstrong 1989, 45–74). There are efforts within many developing countries to secure better services and legal rights for women. For example, midwives associated with the Movement for Humanitarian Birth (*Movimiento Pro-Parto Humanizado*) have outlined ten "fundamental rights for the pregnant woman." These rights include free prenatal care and education, active participation in all stages of birth, attention and assistance by professionals, and the right to choose where to give birth and those who may attend the birth. Concern over the half-million women who die or are injured as a result of pregnancy or childbirth-related problems has led the International Confederation of Midwives and others to favour a stronger role for the midwife. This role would include community education, administration of various health-related projects and resources, and greater access to research and education (International Confederation of Midwives 1987, 18–22).

There is substantial controversy over the part played by medical science in reducing infant and maternal mortality, and the influence of improved hygiene, sanitation, and diet (McKinlay and McKinlay 1976). Regardless, in Europe and other industrialized countries there has been a great reduction since the eighteenth century in the proportion of children who die in childbirth or in the first few years of childhood. Historical records from parishes in Finland, for example, indicate that the infant mortality rate in 1809 in one rural parish was 970 per 1,000 births (during a typhoid epidemic). In 1881, the rate was 375 per 1,000 births. Many infants who died between one and six months of age suffered from gastric illnesses or contagious diseases, and breast-feeding provided greater protection against these illnesses (see Lithell 1981). Higher rates of infant mortality within western societies have been noted for black infants in the United States (Yankauer 1979; Seager and Olson 1986, section 10) and for native infants in Canada. A greater incidence of low birth weight and infant mortality in the Northwest Territories in 1972 was noted by Smith (1976). Mortality rates among reserve Indians in Ontario in 1898 were three times the provincial rate (Weaver 1972, 43).

There is a substantial difference in birth rates in comparison with Third World countries. Studies early in this century recorded what are today regarded as high rates of infant mortality. Two studies noted by Kitzinger (1978, 75, 107) address miscarriages in a South African tribe between 1929 and 1935. One study found that 12.5 per cent of pregnancies in another African village resulted in miscarriage, while 28 per cent of newborns did not survive to maturity. Even in modern times comparatively high rates of infant mortality have been documented in non-industrialized areas. The authors of a 1973

UNICEF report estimated that 17.6 per cent of babies born in an Arabian community died in their first year. By age two, this statistic exceeded 23 per cent (Eickelman 1984, 126, 181).

Dangers to the mother during labour, delivery, and post-partum were also evident. In the Yucatan, birth attendants are vigilant in watching for placental retention, which can cause maternal deaths (Jordan 1981). In many cultures maternal deaths are attributed to supernatural powers, including witchcraft. Smith-Bowen (1964, ch. 14) wrote a poignant account of the death of her friend Amara, a woman from a bush tribe in Africa. Her friend's death revealed the clash between reliance on western medicine as a life-saving measure and the tribe's cultural belief in powers of magic. Others have noted the belief in spirits as causes of death in childbirth. In Malaysia, the *badi mayat* – an evil spirit or principle believed to exist in a human corpse – was associated with the wasting away of an infant (Laderman 1982, 95–102). The author attributed the infant death to a misdiagnosis at a medical clinic.

One former nurse I spoke with in the early 1980s had assisted Bedouin women in Saudi Arabia in the late 1950s and early 1960s. She recounted one instance in which western medicine was well received by the tribe.

> I suppose it was about eight o'clock in the morning and I went out to this infant that had been born between four and five a.m. The doctor had delivered it. It was a Friday, a religious holiday, and since it was a day of rest he had gone off to Kwaittown; as far as he was concerned it was a fairly standard delivery. It was the first time I've taken a pulse that I couldn't count quickly enough: the pulse rate was so high. The infant's temperature went off the thermometer, over 108 degrees. I had never seen anything like this, and what I did in panic (not through skill), was to move the mother and the family into the jeep and we drove across the desert to a medical clinic which happened to be air-conditioned. I sponged the infant down and his temperature came down nicely. I was scared to take him out again ... I waited until the sun went down to take him to a doctor at a neighbouring oil company. This was the seventh baby this women had birthed, and every one had died on the first day of birth. Their metabolic rate followed the sun's temperature ... and of course they would die once the sun was out ... We kept this seventh child in the air-conditioned room and gradually exposed it to the outside. Eventually this infant's system just corrected itself and it grew, it coped. This made an incredible impact on the local people.

A common theme in reconstructing childbirth ritual in Third World countries is the control women usually exert in birth attendance. This

control extended to reproduction generally, including contraception and abortion. Some scholars conclude that men were excluded from these matters or involved only marginally (Oakley 1976, 19–23). In some Philippine villages fathers were expected to be present, while in some northern India locales fathers were excluded from childbirth (Whiting and Whiting 1979, 112). Indian fathers in Guatemala were expected to assist their wives in childbirth by bracing them in a supported squatting delivery position (Maynard 1974, 90).

This theme has been qualified by other accounts pointing to the folk perception of women as dangerous in a number of cultures (Chodorow 1971, 274). Childbirth ritual has been specifically interpreted as devaluing women while consolidating a medical model of technologically based, professionally managed birth.

Traditional Practices and the Medicalization of Birth

The medicalization of childbirth is evident in Third World countries and elsewhere. Increasingly, traditional midwives, many of whom apprenticed with other lay midwives and practised in their villages for decades, are being displaced in favour of nurses trained in obstetrical nursing or midwifery, or by physicians. The traditional reliance on touch, on amulets, and so forth has likewise been overshadowed by technological machinery and the role of technicians in medicalized antenatal, postnatal, and labour and delivery stages. Record-keeping is emphasized, registration of births and deaths is required by law, and control over licensure and training is formally vested in such government bodies as departments of health.

Traditional midwives in Malaysia – *bidan kampung* – have been trained in principles of hygiene, sterile techniques, and family-planning. Home deliveries have tended to shift to formally trained nurse-midwives. There has been some degree of adaptation on the part of government-trained midwives to local customs. Nevertheless, the legislation requiring midwives to be registered (and the lack of registration procedures for new village midwives) means that village midwifery is likely to disappear when the current *bidans* retire. The *bidan kampung* are responsible for instruction in breast-feeding (or the proper preparation of formula) and family planning, but not for assistance in labour and delivery (Chen 1977).

Western influences on traditional birth practices are not entirely irresistible. Opposition to western medical practices has been noted among rural women in Guatemala, Malaysia, Papua New Guinea, and the Yucatan (Cosminsky 1976; Chen 1978; Jordan 1980). Never-

theless, there has been a clear movement away from home delivery and toward hospital or clinic deliveries in many Third World countries. The shift toward medical management of births has benefited some infants and mothers through the availability of modern equipment and improved training of birth attendants in nutrition, sepsis, and careful management of labour, delivery, and post-partum complications.

McClain's (1975) fieldwork in Ajijic – forty kilometres from Guadalajara, Mexico – revealed a variegated system of maternity care. Women delivered at home with traditional birth attendants (*parteras*) or with an attending physician. Increasingly, women in Ajijic delivered in hospitals. Accompanying this trend away from home deliveries was a decline in the number of practising *parteras*, coupled with the aging of two of the three practising midwives.

There are numerous instances of resistance to the western model and the incorporation of valuable aspects of western medicine (asepsis, more nourishing diets, encouragement of earlier breastfeeding to provide colostrum to newborns) with traditional rituals (McClain 1975). A detailed biography of Jesuita Aragon, a senior midwife in Los Vegas, a small community in northern New Mexico, captures the incorporation of traditional healing practices with modern principles of hygiene and professional attendance. At the time of writing, folk beliefs in supernatural elements coexisted to some degree with the use of sterilized equipment, procedures for emergency transfers to hospital, and instruction by nurses (Buss 1980). Traditional Hispanic midwives have nevertheless fallen in numbers, and it seems more appropriate to speak of the replacement or displacement of folk healers and midwives by professional healers (see Brack 1976). One point of commonality between latter-day and modern lay midwifery is a spritual dimension in maternity care. Black "granny midwives" in the southern United States sang spirituals during meetings with nurses. The advent of formal midwifery instruction was not always opposed by the granny midwives, and in some instances it was welcomed (Campbell 1946, 23–4). Source materials on the retention of African practices by Southern black midwives include documentation of practices in folk midwifery. The authors claim that many of these folk practices have been adopted by modern obstetricians to improve birth outcomes for mothers and infants (Conklin et al., 1983, 79). Hull (1979, 316) found that midwives in rural Java believed that colostrum was contaminated, used septic bamboo blades to sever the umbilical cord, and manually removed the placenta, sometimes causing serious infections. A Western-trained midwife observed four village midwives in India

engaging in harmful practices such as performing vaginal examinations after touching cow dung (thus producing tetanus and other infections), rupturing membranes with fingernails, exerting manual pressure on the fundus (see also Dole 1974, 24 regarding Peruvian midwives), and a cultural prohibition on "cold" foods and substances that led to dehydration and ketosis poisoning (Tyson 1984, 5–6).

Some researchers have disagreed with favourable assessments of the work of traditional midwives in Third World countries. Midwives in rural Vietnam were described as lacking precise knowledge of the management of complicated deliveries. Their ineptitude could lead to "disaster" for mothers or their infants (Coughlin 1965, 213). Midwives in Mexico were perceived as not being knowledgeable about diagnosis of pregnancy, midwifery techniques in uncomplicated deliveries, and appropriate responses for complicated deliveries when a doctor was unavailable to them. Moreover, criticisms of indigenous midwives have emerged from their home countries – for example, in the Philippines (Velimirovic and Velimirovic 1981, 91–2)

Other beliefs in traditional cultures clash with medical science. McClain's (1975, 40–1) study of birth in a small Mexican community touched on the folk belief that a father's blood-drop created female embryos, while a mother's created male embryos. Congenital deformities, spontaneous abortions, and stillbirths were attributed to factors external to the mother, not to genetically determined abnormalities.

It has been generally reported that septic procedures by traditional midwives in tropical countries contributed to serious infections (da Cruz 1969, 354). One program in rural Bangladesh was designed to incorporate some traditional practices with principles of hygiene and adequate diet. The attendance of the traditional midwife, the *dai*, was supervised by paramedical staff and complemented by a local clinic consisting of a physician and other paramedics. The custom of withholding breast-feeding for three to five days after birth did not allow the newborn to receive colostrum (which aids the developing immune response system). Education regarding appropriate supplementary feeding when breast-feeding continues into the sixth month was also carried out, as was instruction in sanitation and hygiene to reduce the substantial numbers of children dying of post-partum tetanus and sepsis during infancy (see Bhatia 1981, 70–1).

High rates of infant mortality have thus been linked with inferior skills of traditional birth attendants. However, it has not been established that decreases in infant and maternal mortality rates are attributable primarily to advances in the medical and nursing sciences. A wider context of health care is needed. One researcher studying birth

practices and infant mortality on a Guatemalan *finca* (plantation) commented: "The main causes of this problem do not lie in the birth practices themselves, but in the poor nutritional and health state of the mothers, the poverty and the larger socioeconomic problems of the *finca* population" (Cosminsky 1977, 101). Research in American cities has likewise documented a positive correlation between poverty (and race) and infant mortality. It is generally accepted that many deaths of neonates (babies under twenty-eight days old) are caused by congenital factors, whereas post-neonatal mortality is more likely to be associated with low income of mothers (Brooks 1980, 2–11).

The crosscultural evidence helps to identify cultural patterns that promote high-quality midwifery care, or to restrict it. Jeffery and her associates studied childbearing and other events in northern India. They found that health policy had to some extent followed a grassroots strategy of using *dais*, traditional birth attendants, as part of maternity care. The authors pointed out that many other developing countries have not taken up recommendations for similar programs, and that even in northern India there are unsafe practices that endure in the care of mothers and infants, as well as official limitations in offering the best possible service. They conclude that, in practice, "the state is demonstrating no firm commitment to maternal medical services, either of the conventional clinical kind or the so-called grassroots version put forward as an alternative. Commercial and other interests prevail, thereby reducing official policy to empty rhetoric" (Jeffrey, Jeffrey, and Lyon 1989, 220).

The diversity of birth ritual and belief systems in the countries mentioned above is not absent in more affluent western countries. There is no question that there has been an entrenchment of obstetrics and technological monitoring and management of childbirth, such that what Arney (1983, 9) calls "obstetrical space" has been extended. Davis-Floyd (1990) is critical of the misrepresentation of American "obstetrical rituals" as progressive and desirable. Instead, these rituals help to establish a patriarchal system of birthing in which women's bodies are often treated mechanistically. Birth as a natural process is thus often displaced, recast as a perilous journey that must be monitored by obstetrical staff. Davis-Floyd's critique of the medical model of birth makes an important link between seemingly benign interventions and wider structures of control in American society.

There are variations within cultures that are predominantly but not wholly dependent on professional maternity care. Hazell (1974) found that many of the women giving birth at home in California used a variety of birthing positions, including supported squatting

and delivery on all fours. He noted that in many non-European countries the upright birthing position and the side-lying positions were commonly used, while the lithotomy position remains standard practice in western obstetrics. Odent provided data favouring the use of supported squatting delivery positions, and suggesting that episiotomy rates can be reduced through such initiatives. Of 898 births in Pithiviers in 1980, only 8 per cent required episiotomies; the rate of caesarean section was 5 per cent (Odent 1981, 7–15). Midwives have also studied alternatives to medical interventions – for example, methods for managing shoulder dystocia (Meenan et al. 1992).

The meeting of east and west is captured in the following excerpt from a letter sent by a British Columbia midwife working in the former Soviet Union to another British Columbia midwife. The writer, who was part of an exchange program involving American and Russian midwives, commented on outmoded rituals of routine enemas, perineal shaves, artificial rupture of membranes, and use of the lithotomy position in state-supported maternity hospitals (see also Shea 1991). She described a "deep revolution" in birthing protocols in a private hospital in St. Petersburg:

> We decided to do a presentation [to staff]. We would try and show (and back up with statistics) alternative techniques. We showed slides of women birthing upright, or on their sides, or on all fours. And a long, long discussion ensued ... Soon after the discussion I went to the labour-delivery floor. A few of our midwives were there because a woman was in labour, and actually delivering the baby when I arrived ... at least 3 doctors were in the room – they had been at the presentation – plus 3 [Russian] midwives and 2 of "us" ... [The birth attendants] were given permission to leave the woman on the bed, not on the delivery table. She was allowed to deliver on her side, no drugs, no episiotomy. The baby was quietly placed on the mother's belly and she held her baby for at least 20 minutes before the baby exam had to happen ...
>
> Soon afterwards, another woman hit second stage and the Russian midwife and doctor working with her got excited and said, "We're doing it that way!" So another woman delivered on the bed, in a semi-sitting position, the boy placed on her belly, etc. [The staff] were grinning from ear to ear. Whether or not anyone was conscious of it, I suspect the sense of empowerment hit everybody and some sort of deep revolution is happening at this hospital ... Later that afternoon, another woman delivered her baby in a quasi-squat on the bed. It was a complete, "hands-off" birth. It is obvious that the staff at this hospital have reached a point of no return ... (letter from Michelle Buchmann to Barb Ray, 3 December 1992)

Jordan's (1980) award-winning study of childbirth practices in four countries pointed to significant differences in childbirth management between western nations: specifically, the Dutch approach retained domiciliary deliveries and discouraged routine medication, whereas Swedish practitioners relied on painkillers and hospital-based obstetrics. Home birth is not only a feature of contemporary Third World countries. In Holland, for example, approximately one-third of births occur at home (Brook 1980, 7). Nevertheless, the list of contraindications to home birth in Holland has increased over time, while the percentage of births at home has slowly but steadily decreased in recent years (Kloosterman 1981, 9–24). A hallmark of Dutch birthing policy is the reliance on midwifery assistance in birth, whether at home or in hospitals or clinics.

Midwifery in Japan and China

The majority of published works on cross-cultural midwifery practices pertain to Europe, North America, and Third World countries. A sense of midwifery practice and of kinship practices surrounding birth in the Orient is provided by some recent studies. For example, Kitahara (1982) reported that midwives in Japan must be licensed and, as in Denmark, must practice in hospital settings. Bradley-Low (1984) viewed birth in Japan as hospital-oriented, technological, and medically dominated, with some counter-trends in domiciliary and clinic midwifery practice. In her detailed observations of health care customs in Japan, Jacobson (1974, 108) drew attention to the incorporation of scientific medicine with established kinship relations. Specifically, the practice of *satogaeri* – returning to the natal home for delivery of a first child – is fairly common, and stands in some contrast to the usual practice in Canada of women delivering in their own locality (Jacobson 1974, 108). The blend of modernity and tradition is also evident in the frequent use of the pregnancy sash (*iwata-obi*), which is thought to promote easier delivery by restricting the size of the fetus, and in the reliance on obstetricians, hospitals, and clinics (Ohnuki-Tierney 1984, 181–8).

The global movement toward professionalized attendance in childbirth is apparent in China and Japan. This movement appears most pronounced in urban centres. In the early 1970s, it was reported that Chinese babies born in cities were usually delivered in hospitals, with doctors supervising the births. Babies born in the countryside were delivered at home with the assistance of midwives. Anaesthesia was not routinely used for uncomplicated deliveries (Sidel 1973, 59–61).

CONCLUSION

Cross-cultural birthing practices reflect considerable variation in birthing customs and the role of the midwife. Crucial to an evaluation of midwifery development in Canada, however, is the finding that only 9 of 210 nations studied by the World Health Organization made no provision for midwifery service. Canada was one of these nine nations, and the only major industrialized nation without established midwifery services in the infrastructure of national birth attendance. The history of midwives in Europe reveals important variations: the promotion of scientific midwifery in France and Germany, for instance, contrasts with the general absence of publicly sponsored midwifery instruction and government regulation in England.

The conflict over midwifery in British North America reflected many of these European concerns. Much of the literature on midwifery in Canada is critical of the takeover of birth by physicians and the displacement of midwifery. Nevertheless, serious consideration must be given to benefits that have accrued from medical research, nursing, and medical training. These benefits include a stronger knowledge base on pregnancy, birth, and child development, and the translation of this knowledge into improved clinical care.

The point remains, however, that these benefits are not clearly predicated on medical dominance in childbirth. Substantial research has been undertaken and clinical programs have been established in many countries worldwide in conjunction with developed midwifery programs. Further work in understanding Canada's anomalous policy on midwifery could be connected with Lipset's interpretation of greater deference to élites in Canada and the identification of deference as a trait in Canadian political culture (Lipset 1986, 138). Despite the renaissance of community midwifery and demands for direct entry midwifery training (autonomous midwifery), less than 1 per cent of deliveries in North America are planned home births.

Not all jurisdictions in Canada and the United States expressly prohibit the practice of community midwifery or nurse-midwifery (Barrington 1985, 40–1; Sallomi, Pallow, and McMahon 1981). The regulation of midwives in North America also varies from province to province. The variations in provincial statutes lend support to the historically specific nature of states, as opposed to a monolithic view of state regulation of midwives. Federal, provincial, and state levels are not uniform in their statutes and may vary in their enforcement of these statutes.

Historical accounts of midwifery in Canada have generally highlighted the struggle between men and women evidenced by the exclusion of women from the universities, and the ideology of a "proper sphere" of reproduction and domesticity (Cook and Mitchinson 1976). The fault-finding remarks by some physicians about midwifery practice are misplaced, especially those concerning the competency of trained midwives practising as members of an autonomous or semi-autonomous profession. As this chapter has indicated, the general rejection of independent midwifery practice in North America stands in contrast to its acceptance in many other countries. The review of midwifery practice in Canada in the next chapter provides additional support for the viability of regulated midwifery practice in home and hospital settings. It also strikes a strong note of caution in connection with opting for regulation at any cost if historical patterns of denigrating midwives are to be avoided.

CHAPTER FOUR

"To Be with Woman": Midwifery Practice in Canada

The autonomous midwife – frequently self-trained – is a major anomaly in Canadian health care ... Over 200 midwives ... have provided care for thousands of women in their homes over the past 15 years in Canada. This is a situation that organized medicine, nursing and properly trained midwives should not contemplate with satisfaction.

Robert A.H. Kinch, "Midwifery and Home Births"

Women in our post-industrial culture are effectively captive in childbirth. The zoo may be run on scientific principles, the keepers may be considerate and may pride themselves on the good condition of the animals and the low mortality rate. Visiting times may be frequent and the zoo may be a friendly, welcoming place. In the confines of the cage there may be space to move about, and those in charge may have tried to replicate the natural habitat. Yet captivity restrains and dictates the behavior of the captives.

Sheila Kitzinger, *Homebirth*

INTRODUCTION

In Canada there is a tremendous controversy over the implementation of midwifery. This chapter presents a detailed examination of midwifery practice and birth outcomes, using Canadian data in conjunction with studies from other countries. Before moving to this discussion of midwifery practice – in home births and in hospital settings – it is necessary to review how the research was conducted.

Community midwifery has endured since the early 1970s, but it has not flourished. The Midwives' Association of British Columbia (MABC) lobbies for legalized, autonomous midwifery and appropriate guidelines for midwifery practice. They consult with sympathetic

medical and nursing practitioners, and only a few births out of thousands assisted by community midwives in Canada have resulted in criminal prosecution or prosecutions for violations of the British Columbia Medical Practitioners Act. Although there are comparatively few prosecutions, community midwifery is marginalized and illegal. Out-of-hospital births comprise less than 1 per cent of births in British Columbia (and nationwide). Community midwives are unable to bill for their services through the provincial medical services plan, and they do not have established hospital privileges. Community midwives are also more likely than medical personnel to be prosecuted for criminal negligence causing death. They are also subject to the quasi-criminal charge under the Medical Practitioners Act of practising medicine without a licence.

Community midwifery in Canada illustrates the structural limits placed on female birth attendants working outside the norm of professionally accredited, hospital-situated childbirth. For the past 20 years a debate over home birth – and more generally, midwifery – has been evident in Canada and other industrialized countries. This debate addresses several issues: maternal and infant wellbeing throughout pregnancy, delivery, and the postnatal stage; women's control over pregnancy and childbirth; and personal liberty and the overreaching powers of the state (including the institution of the hospital and the powers allotted to the professions). There is concern over the increased use of childbirth technology in labour and delivery, and what some regard as the alienation of health-care practitioners from their direct work with women (Arney 1982; Ruzek 1991; Kargar 1990).

Community midwifery emphasizes the decentralized nature of childbirth attendance, along with the more personal relationship between the community midwife and her constituency. Community midwifery has in general become better integrated with international associations, and more concerned with education, certification, and standards of practice. A case in point was the founding of the British Columbia School of Midwifery in Vancouver in 1985. Accredited in Washington state, the school offered a theoretically based curriculum along with opportunities for preceptorships (clinical experience in midwifery) in Holland, England, Jamaica, Germany, and the American state of Georgia). The tenuous legal status of midwives in British Columbia and the costs of operating a school without government support led to the suspension of school operations in 1987. This decision by the school board was seen as a temporary one, until such time as midwives achieved a more secure legal and clinical footing in the province.

COMMUNITY MIDWIFERY IN CANADA

This section focuses on a study of attempted home births, primarily in British Columbia and Ontario. Where possible, reference is made to midwives' practices in other provinces and regions. The community midwife network in British Columbia is complex. Most midwives have learned their skills through a mixture of apprenticeship with senior midwives, their own experience, and reading, and some have moved into community midwifery after completing formal nursing requirements. The dichotomy between the traditional midwife and the professional midwife seems more appropriate for non-westernized societies, in which there may be substantial gaps in literacy, formal education, knowledge of hygiene, and birth management between the two groupings.

Empirical Training and the Midwifery School

One development in the community midwifery movement has been the extension of formal instruction into the movement. A full year of academic training was recently completed sub rosa by seventeen students through a midwifery school established in Vancouver by local community midwives and some of their supporters (Anderson 1986, 11). The academic phase, paid for by the students, staffed by midwives, and examined by midwives with international training, is followed by a clinical phase of preceptorship. While many of the new community midwives have not completed formal nursing requirements, a number of British Columbia midwives are either registered in (or are eligible to join) the Registered Nurses' Association of British Columbia. One practising community midwife expressed her ambivalence toward formal nursing training in childbirth: "The nursing was a mixed blessing. Nursing gave me a lot of the skills. I was comfortable giving injections, comfortable with catheterizations, with taking blood pressure and pulse, just those basic nursing skills that a midwife apprentice has to learn. And it can be difficult learning those skills. The thing that was really difficult for me was that even though I basically knew that women could birth babies, and birth them graciously and have them at home, it took me a long time to understand that on a gut level, and to really believe, yes, that women could give birth."

Against the norm of professionalized nursing, situated in the hospital and supervised by physicians, some nurses have opted for community midwifery practice. Midwives have nevertheless sought

out other sources of training. Some out-of-province midwives report attending workshops as a form of instruction. A Manitoba community midwife noted: "After those first four births I went and took a very good workshop in Vancouver. I invested money and bought books and equipment and felt a little more like I knew what I was doing ..." (see Yusuf 1984). Another example is a Master of Midwifery (M.A.) program under development (in 1993) at Thames Valley University and Queen Charlotte's Hospital in London. Five Canadian midwives began this program in 1993. This said, the overall historical pattern of discouraging midwifery as a distinct, legally recognized profession continues in many provinces, except for Ontario and Alberta (Williams 1991).

Teamwork

A general principle is that community midwives prefer to assist in labour and delivery with at least one other midwife present. It is rare for them to attend births by themselves, with the possible exception of emergency situations when another midwife or birth attendant cannot be present. The philosophy of the Freemont Birth Collective (1977, 20) is clear: two midwives are ordinarily present for births, sometimes a third, but never one. There are instances in Canada where a midwife attends a precipitate labour and delivery by herself. These appear to be very much the exception. Senior community midwives explained that, where possible, they are accompanied by other midwives. The sole responsibility for managing a birth alone is onerous, and there is a commonsense basis to this. Midwives may be faced with emergency situations that require the judgment and skills of two attendants. One community midwife recalled an incident where a home birth became dangerous for mother and the newborn child:

> Probably the highest stress of any year in my practice was handling all the responsibility at births for about a year ... it's a huge disadvantage, there is no advantage as far as I am concerned. It's really high stress. And it's really important to have a second opinion, especially if you are emotionally involved and often you have an attachment to the woman. It is helpful to have someone present who doesn't have that rapport and who can look at it more objectively. The turning point for me was when I did a birth alone (in an area where a hospital was not at hand). The woman had a precipitate labour, one hour start to finish for her first birth, which runs a lot of risk for the mother and the baby. The baby didn't breathe and the mother had a massive post-partum haemorrhage. There was a real sense of having only two hands

... the father completely flipped out and left the room. It was managed by giving the mother an injection to stop the bleeding with one hand, and using the other hand to stimulate the baby ... That was the last time I did a birth alone.

Another British Columbia midwife agreed with the wisdom of a shared practice, with at least two midwives attending a home birth: "I always work in a team, unless the birth happens so quickly that the back-up midwife doesen't have time to get there. I have done one or two births under those circumstances, but it is the exception. It isn't planned that way. We always work as a team." This arrangment allows for collegiality, and if midwives work in small groups – for example, four midwives in rotation – they can be spared the around-the-clock demands associated with solo practice (see Benoit 1991).

Community midwives also maintain contacts with general practitioners. This may involve referrals of the midwife's clients to a physician for a check-up; in other cases the contacts are more direct. "The back-up physician for one birth had been at the home, as a friend only, and had been completely informed about the care of this client. The physician knew an hour before we arrived that [this client] would be transferred from home to hospital. The physician called in a specialist that we knew would not be hostile: this specialist likes women and is cooperative with us ... I knew there would be no repercussions against any of us because the whole team had been in on it."

Collaboration between general practitioners and obstetricians and the community midwives indicates that midwifery is not entirely an oppositional movement, and that some medical personnel are sympathetic to the midwives' efforts to re-establish more autonomous midwifery services. One practising midwife recognized that few physicians can afford to support community midwives openly: "There are a few sympathetic physicians in B.C. Some are totally committed to supporting midwives, and will not be pressured out of it. There are physicians who will no longer collaborate with midwives if they face political pressure. These physicians are at the bottom of the list to work with. They aren't committed to home birth or autonomous midwifery, and they really don't believe in a woman's power to give birth. They are quite uptight about this, and like to screen out women seeking home births for *any* risk factor, however slight."

The point remains that physicians who are active with midwives may face sanctions from the College of Physicians and Surgeons. Attending home births is strongly discouraged for physicians, as is

collaboration with midwifery initiatives such as the now-disbanded midwifery school. Dr. Marsden Wagner (see *Midwifery and the Law* 1991) of the World Health Organization puts this situation into perspective: "There are physicians in Canada who have the courage and vision to support midwives. They have been punished by their peers. In some cases, physicians have lost their hospital privileges. That's a disaster for a physician."

Caseload

The available literature on lay midwives indicates that caseloads are not particularly high, perhaps because of the organization of lay midwifery practice relative to more formalized practices of obstetricians and general practitioners. A midwifery practice shared by two midwives in a rural area of Montana ranged between twenty and thirty women (Sutley 1982, 80–1). Community midwives in British Columbia generally report that they have more demand for their services than they can provide. It is now fairly common for a community midwife to attend between two and four births monthly. This caseload allows a sufficient monthly income for midwives. It also is a manageable number, since the midwives' time must be allocated to prenatal visits, postnatal check-ups, and time with their own families (most community midwives have children), and meetings and formal instruction. Barrington (1985, 14) found that the contemporary community midwife in Canada plays many roles: "She is a domestic helper, a community worker, and a feminist health activist. Chances are, she is also someone's mother and someone's sweetheart. A midwife doesn't get much sleep!"

Community midwives interviewed by me confirmed that their work was very demanding. They were usually on call for their clients; care for their children was not always at hand if they were called to a birth; and financial pressures added to their stress. It is noteworthy, however, that a number of these midwives have since restricted their caseloads and made arrangements for child care and some additional time for themselves. One midwife spoke of wearing out her welcome, and having to be more resourceful: "I used to rely on friends, but I am doing more births now. I have to really organize the babysitting. I have regular childcare for my youngest child, and after-school care for my oldest. Otherwise, your friendship wears thin with people ... If we were in a tighter community where there was more support, then we probably could exchange goods for services and could rely more on our friends. It just makes it so much easier to do prenatal and postnatal visits without the kids if you have a regular set-up."

While this midwife continues to practise in 1993, many other midwives have discontinued practice. Only a handful of the midwives interviewed in 1983–85 now attend home births. This pattern of leaving independent practice as a midwife has become the norm, even for midwives who are now licensed midwives (through the British Columbia School of Midwifery, and accredited in Washington state).

Fees and Payment: "Eggs for a Year"

In the early days of community midwifery, some midwives accepted payment "in kind" in lieu of cash payment (Campbell 1947, 45–7; Klein 1980). In a discussion with a senior community midwife in 1987, she mentioned that she had been given "eggs for a year" after attending a birth in the Kootenay region of British Columbia. An important change has been a clear trend toward more standardized cash payments. One midwife commented that she could no longer afford the altruism of attending births without a clearly specified fee: "Money is not one of my strong points. That was something I have had to deal with. I went through a thing where I had given birth to my first child and had a heavy experience. I felt really grateful to the midwives who attended me. I heard Ina May Gaskin [author of *Spritual Midwifery* and a founder of The Farm in Tennessee] talking about how birthing should be free, so I decided to exchange goods for services and accept donations. It was something I negotiated with the client and felt really relaxed about. At the time, I was relying on my husband to support me. Since then, my marital status changed, and I have had to become more independent. That meant becoming really clear with myself in how I deal with money, and ensuring that I have a certain amount of work ... What I do now is to find out from other midwives what they are charging, and I charge the same fee."

The spiritual inclination of the 1970s and 1980s has shifted toward a more businesslike stance on the part of some community midwives. The days when a midwife took the bus to a birth or hitchhiked (because she could not afford a car) have passed. One community midwife in British Columbia charged $400 in 1983 for prenatal and postnatal care, labour, and delivery (Padmore 1983, A7). Within limits, this fee may be negotiated by clients of some midwives: "In 1985, my fee for prenatal care, attending the birth, and postpartum care is $600. Often, that will slide down a bit for people who have a low income, but usually not too much. I don't pay fees for a back-up midwife, because I have a partner and we trade births. Many

midwives pay the back-up midwife $100 for assisting at a birth. The man I live with also has an income, so we have a combined income. The fees have increased over the years. Now, I have fewer births to attend, and clients are almost guaranteed access to me, 24 hours a day, seven days a week. On average, I attend four births a month. In contrast, I have a friend who practices midwifery in Washington State. Her prenatal visits are probably half the time of mine because she has a busy clinic. Her fee is $900 U.S. And that seems about right."

In the mid-1980s, midwives reported charging approximately $600 for their work, including prenatal and post-partum care, as well as birth attendance. Community midwives may enjoy tax advantages, since they are currently self-employed. Supplies, transportation costs, and costs of electricity, telephone, and office space can sometimes be deducted as employment expenses from taxable income. Nevertheless, midwives rarely make much of a living compared to other health professionals, and many British Columbia midwives have ceased practice in favour of more established work in nursing and public health.

Supplies

Community midwives differ from institutionally based caregivers with respect to access to medical supplies and equipment, including oxygen, intravenous equipment, and drugs. The establishment of professional medical and nursing schools and practices has been accompanied by a degree of control over birthing supplies as well as technical knowledge and practice. Community midwives in British Columbia have access to surgical gloves and scissors, oxygen, and pitocin. It has been observed that practising midwives in British Columbia have fewer difficulties obtaining such supplies than midwives in the United States. One community midwife relied on oxygen supplies, a fetal monitor, and (unspecified) drugs in her practice (Brook 1980, 6). Community midwives in North America can also avail themselves of a variety of technological aids, including telephone answering machines, pagers, and answering services.

Home Births by Province and Year

The records used for the documentary analysis were drawn primarily from community midwives who were active in British Columbia, Ontario, and Saskatchewan. There seems to be a lower incidence of home births in Saskatchewan in comparison with British Columbia, Ontario, and Alberta. One source indicated that there were approx-

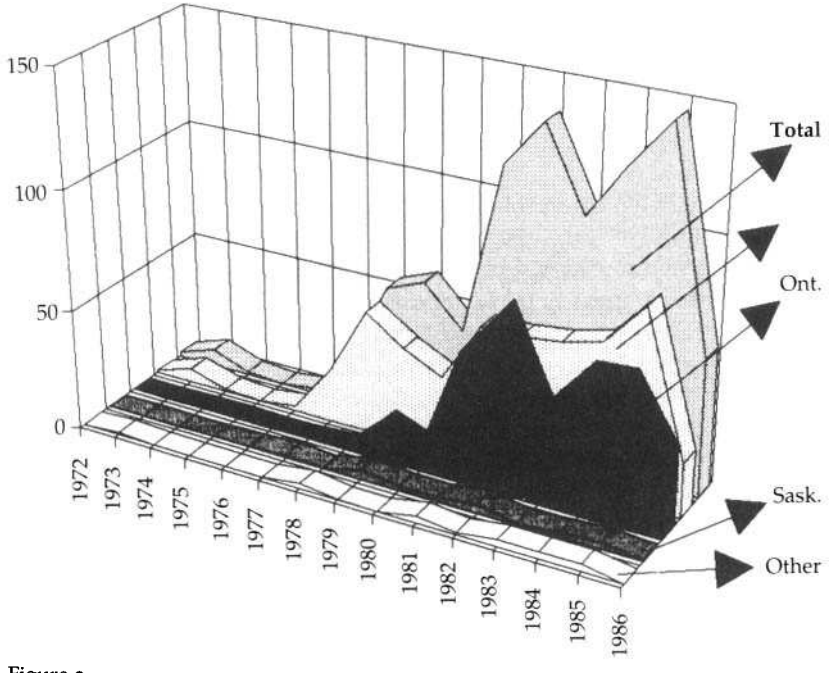

Figure 2
Home Births by Year and Province

imately four home births per month in Saskatoon (Devine 1981, 6). Until such time as a nationwide system of registration is in place, it is impossible to determine exact variations in the percentages of women electing home births. A few home birth records from Manitoba, New Brunswick, California, and Washington state are also included. These births were attended by Canadian midwives, and included with the bulk of births occurring in Canada. The entire sample of records spans the period between 1972 and 1986, with most records concentrated in the 1980s. Because of incomplete records, some information, such as the exact year of birth, was not always recorded by the midwife. Figure 2 outlines the profile of birth records by year and province.

The difficulty in obtaining records from 1972 to 1977 is apparent in figure 2. A number of the midwives who were active with a birthing centre in Vancouver and in attending births have since moved out of province. Moreover, record-keeping for many midwife-assisted births in this period was not extensive. This stands in some contrast to the current emphasis on careful charting of prenatal and postnatal developments, as well as labour and delivery. Nevertheless,

most births analysed in this chapter occurred between 1978 and 1986, and primarily in British Columbia and Ontario. More recent reports on home births in Europe, Australia, and Canada are discussed later in the chapter.

Clients

The clients of community midwives vary considerably within British Columbia. There has certainly been a stronghold of New Age philosophy in the Kootenays, where alternative lifestyles have taken root, including adaptation of Navajo rituals and traditional healing (Barrington 1985). Dissatisfaction with standard maternity services was often noted on the prenatal records of home birth clients. The following passage is excerpted from a birth record I reviewed. The mother had written a letter to her baby, to be read when the child is older: "I went to a doctor who left me feeling birth care with her would be like being an object on an assembly line: a woman went to the hospital when in labour, could continue without intervention *if* she performed to the doctor's specifications. Any beliefs I had about the benefits of a calm, relaxed delivery seemed to be in the hands of fate. The doctor was too busy to be concerned about such beliefs."

Community midwives expect that their clients will take precautions against poor nutrition and other factors that might pose problems for the fetus or mother. Midwives acknowledge that their clients are generally health-conscious. One midwife in British Columbia who had attended hundreds of home births stated: "I have only screened out one woman for alcohol and drug abuse. The average woman who comes to me does not have that kind of lifestyle."

Midwives may provide a structure of expectations for women interested in midwife attendance. The following statement of the parents' role and responsibility is part of an "Informed Choice Agreement" prepared by two senior community midwives in British Columbia.

> We request that the mothers we are involved with be responsible about the health of themselves and their babies, follow a balanced diet, receive good prenatal care and get adequate sleep and exercise. We also request that the couple acquire knowledge and skills necessary for labour and birth and relaxation, either through completion of prenatal classes, or a sufficient program of self education. A midwife's care is individualized according to the clients she serves. It is important for you to make her aware of your expectations. In order for us to be effective as caregivers, we require that parents keep us well-informed as to problems or situations which may affect their care.

This sense of clients' responsibility is connected with the understanding that not all pregnancies will be carried to term successfully. Noble (1983, 15) puts this well: "Pessimists may comment that one should not aspire to natural childbirth in case complications develop. This is like saying one shouldn't bond with the baby in case it dies, or one shouldn't fall in love in case one gets hurt. Such timidity and antilife sentiments lead to self-fulfilling prophecies and deny the human potential to respond to the unexpected."

The natural childbirth "style" is often captured in the mother's intention to breast-feed. Of the women attempting to deliver at home, 99.5 per cent intended to initiate breast-feeding. This percentage even exceeds the 93 per cent figure of breast-feeding among members of a Parents' Choice sample – that is, women inclined to breast-feed their infants on discharge from hospital. Other comparison groups in a Vancouver-based study did not rely as extensively on breast-feeding. The percentage of women who initiated breast-feeding, by ethnicity, was as follows: English-Canadian (79 per cent), East Indian (59 per cent), Italian (50 per cent), Greek (47 per cent), and Chinese (31 per cent) (see Bradley et al. 1978, 18–19). A study of 123 Malaysian women found that 75 per cent breast-fed their babies, 22 per cent combined breast-feeding with bottle-feeding, and only 3 per cent used formula milk exclusively (Laderman 1983, 84). For virtually all women in the home birth sample, breast-feeding was seen as clearly advantageous to mother and infant (see Minchin 1985; Riddell 1992). Midwives I spoke with encouraged mothers to breast-feed, and were aware of cultural factors that might discourage women from initiating or continuing with breast-feeding (see also Hefti 1992; Hewat 1992, 89).

The ages of women attempting home births ranged between 17 and 42 years. The median age of women in the sample was 28 years. Figure 3 indicates that while births in British Columbia closely parallel trends across Canada, the home birth sample comprised fewer younger women (teenagers) and proportionately more women in their thirties and forties.

Other midwives practising in Alberta report a similar profile of clients' ages. Their ages ranged from 20 to 42, with an average age of 28.3 years (Walker et al. 1986). The average age for women (having live births) in Canada in 1985 was 27.3 years; the median age was 27.1 years (Statistics Canada 1986, 17). Two age groupings that some regard as high-risk – in terms of statistical risk of birth complications – were underrepresented. Only a few teenagers attempted a home birth, and there were few women over 35 in the home birth sample.

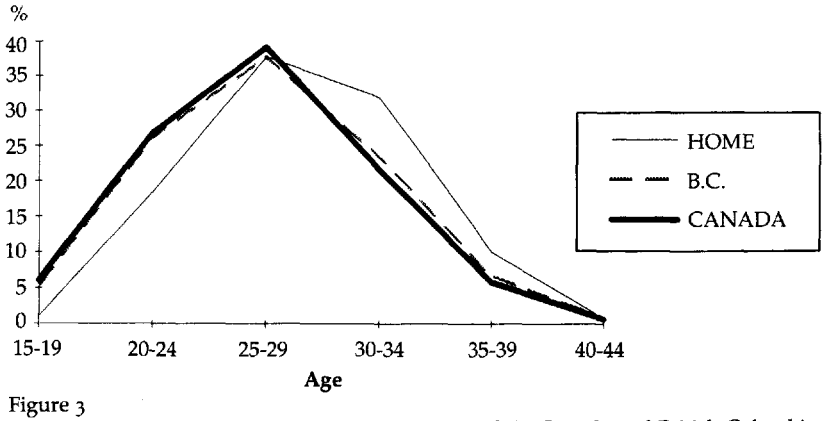

Figure 3
Ages of Home Birth Clients and Women Giving Birth in Canada and British Columbia
Sources: home birth records and Statistics Canada, *Births and Deaths: Vital Statistics 1985,* November 1986 (Ottawa: Supply and Services Canada) 6–7.

It is important to note that this designation of women over 35 as high-risk has not been upheld by more recent studies.

Gravida and Parity (Pregnancies and Births) of Clients

The number of pregnancies and the number of previous births are two significant variables in establishing a client profile for community midwifery. "Gravida" refers to the number of times a woman has been pregnant, including her pregnancy at the time she is seen by the midwife. "Parity" indicates the number of times she has given birth.

A minority of the sample (22.2 per cent) had previously given birth at home. Most of these women had just one previous home birth (n = 156), twenty-one had two previous home births, and one Mennonite woman had seven previous home births (see also Barrington 1985, 93–100). Approximately one-third of these attempts at home births were made by women who had not given birth previously; about one-third of the sample had had one previous birth.

Income and Occupation of Clients

The variables of income and occupation have been linked with birth outcomes in previous studies of health care. As noted in chapter

Table 1
Gravida and Parity of Home Birth Clients

	Gravida		*Parity*	
	N	%	*N*	%
None	na*	na	411	40.9
One	220	22.1	369	36.7
Two	318	31.9	162	16.1
Three	247	24.8	42	4.1
Four	123	12.4	16	1.6
Five	50	5.0	3	0.3
Six	25	2.5	2	0.2
Seven	7	0.7	0	0.0
Eight	1	0.1	0	0.0
Nine	2	0.2	0	0.0
10+	3	0.3	1	0.1
Total	996	100.0	1,006	100.0

Source: home birth records.

* The minimum gravida for this sample is 1. This measure includes the current pregnancy at the time of contact with the midwife.

three, there seems to be a positive correlation between greater income and higher status occupation, and lowered rates of infant mortality.

Community midwives did not usually indicate income of their clients and spouses, although one Ontario midwife tended to record these incomes, along with occupation. What is presented below, then, is a partial profile of couples attempting home birth. It serves, however, as an indicator of the diversity of occupations held by these people. My impression is that fewer lower-income people are evident in the home birth sample in recent years. Community midwives did not usually indicate the income of their clients and the clients' spouses, although one Ontario midwife often recorded these incomes, along with occupations. Table 2 indicates that there is considerable variation in reported family incomes for this sub-sample of women seeking home births.

There is considerable variation in the occupations of the home birth clients and their spouses. There were 54 homemakers listed among the women attempting home birth. Sixteen women were listed as unemployed. There were 10 nurses in the sample. The majority of women (29 of 182 listed) were working in clerical or secretarial positions. There was also a great range in occupations among the spouses of the women attempting home birth; artists and salespersons were the two most frequent categories. A full profile of occupations is

Table 2
Family Income: Home Birth Clients

Gross income	*N*	*%*
$10,000–$14,999	4	8.7
$15,000–$19,999	5	10.8
$20,000–$24,999	6	13.1
$25,000–$29,999	9	19.5
$30,000–$34,999	9	19.5
$35,000–$39,999	5	10.9
$40,000 +	8	17.5
Total	46	100.0

Source: home birth records (Ontario sample).

impossible, since most midwives did not indicate clients' occupations on their records. It appears that the home birth alternative is attractive to a fairly broad cross-section of people, and certainly not to a small range of occupations or incomes. Linda Knox, a senior community midwife and president of the Midwives Association of British Columbia, described her clientele as follows: "We have a wide range of backgrounds, including professionals. We have doctors, nurses, lawyers, police officers, upper-middle-class people ... It's important to get away from the picture of the 'lunatic fringe,' which is a statement that a lot of people opposed to midwifery use ... We get people who are well-educated, who have researched the issues around childbirth thoughtfully, before coming to the conclusion that this is what they want: a midwife to look after them, no matter what their place of birth is ... we get a lot of people who are into alternative and more natural things, but the bulk of my clientele are older people ... who have given a lot of thought to their choices" (Interview transcript, *Midwifery and the Law* 1991).

Previous Caesarean Section

There is a continuing debate over the advisability of attempted home births for women attempting a vaginal birth after caesarean (VBAC). The dictum, "Once a caesarean, always a caesarean" has been challenged by research findings that rupture of the uterine scar occurs in a small minority (0.005 to 1.0 per cent) of attempted vaginal deliveries after a caesarean delivery. It is revealing that the Society of Obstetricians and Gynecologists of Canada recently supported a motion favouring VBAC trials of labour (editorial 1986, 62–3). While there is sympathy among many community midwives for women

Table 3
Previous Caesarean Section

	N	%
No births*	252	32.9
No previous C-section	496	64.8
Previous C-section	18	2.3
Total	766	100.0

Source: home birth records.
* This indicates the number of women who had not given birth previously and therefore could not have had a previous caesarean section.

Table 4
Home Birth Clients' Diets

Diet	*N*	%
Meat	465	70.6
Vegetarian	156	23.7
Seafood	38	5.8
Total	659	100.1

Source: home birth records.

wishing to attempt a VBAC at home, many community midwives regard this as a clear contraindication to a home birth: only 3.7 per cent of the birthing clients in this sample attempted a VBAC. If the clients who had not given birth previously are excluded, about 5 per cent of the remainder were attempting birth at home after a caesarean section.

Diet and Alcohol Intake

A stereotypical interpretation of midwives' clients is that they are countercultural, and often espouse a vegetarian philosophy. The birth records suggested a more cosmopolitan orientation regarding diet. In fact, the midwives' documents indicated that while a substantial minority of home birth clients were vegetarian (23.7 per cent), over two-thirds included meat in their regular diet.

Heavy alcohol intake during pregnancy may harm unborn children. Fetal alcohol syndrome (FAS) refers to fetal malformations such as dysfunctions of fine motor functions, slower weight gain and linear growth, smaller head circumference, and mental retardation. The

Table 5
Home Birth Clients' Alcohol Use during Pregnancy

	N	%
None	355	60.9
Occasional	20	37.7
Daily	8	1.4
Total	583	100.0

Source: home birth records.

Table 6
Smoking among Home Birth Clients

	N	%
Never	560	86.6
Occasionally	16	2.5
Daily	71	10.9
Total	647	100.0

Source: home birth records.

effects of FAS tend to persist after birth (Jensen, Bensen, and Bobak 1979, 809–12; Little and Pytkowics 1978).

According to midwives' birth records, home birth clients were moderate in their alcohol intake, if they consumed alcohol at all during pregnancy. This moderation, combined with the very high percentage of mothers intending to breast-feed and the relatively low percentage of daily smokers, supports the notion that these women tend to follow some standard advice directed toward pregnant mothers and to be responsible in preparing for birth. Only a small percentage of the midwives' clients were daily smokers (see table 6).

This minority of daily smokers very likely reflects a "self-screening" process whereby women interested in a home birth are in general conscious of the risks associated with daily smoking. Midwives are often reluctant to attend women who smoke. Kitzinger (1991, 45) suggests that "many midwives in the USA and Canada will not accept home birth clients who smoke during pregnancy, because of the associated risks." Community midwives are likely to encourage clients to abstain from smoking or to reduce smoking, citing the known risks. This said, not all midwives would categorically screen out clients who smoked. There was a tendency to interpret the smoking in terms of the woman's health and circumstances. A community

midwife offered her approach: "I don't automatically screen out a smoker. I tend to base my assessment on how and why they are smoking, and how it affects their nutrition and general health. Some people smoke and are relaxed and enjoy it; other people smoke and are extremely nervous and don't eat well. The person who is a nervous smoker I would not do a home birth for. But someone who smoked, and it was a relaxing, enjoyable thing, and her baby was growing normally and she was eating normally, then I would help deliver the baby at home."

Approximately 80 per cent of the clients reported not using drugs other than alcohol or cigarettes. The most commonly used of these other drugs was marijuana (13.9 per cent), followed by painkillers (3.2 per cent) and insulin for diabetes (0.3 per cent).

Prenatal Visits

Community midwives and midwives working in hospital-based demonstration projects (see Carty et al. 1984) emphasize continuity of care throughout pregnancy. Knowing the client well is part of sound midwifery practice, just as the client's comfort with the midwife is seen as crucial to the best possible delivery. This was evident in the home birth records. Of 466 birth records in which the exact number of visits by the midwife were recorded, only a few cases with no visits or three or fewer visits by the midwife were found. The median number of visits was five, and over a quarter of the women were seen on seven or more occasions. Figure 4 sets out the frequency of prenatal visits as noted on the birth records.

It should be kept in mind that most women also had visits with general practitioners or obstetricians in addition to visits from their midwife (or midwives). Therefore, the statistics presented above do not represent all prenatal visits or consultations for the home birth clients. It is important to note, however, that many visits from midwives lasted an hour or more, sometimes substantially longer. This allowed midwives to build a rapport with clients, and avoided the feeling of being "rushed" sometimes associated with prenatal visits with physicians.

Midwifery Practice and the Course of Labour

Midwives usually claim that their training allows them to minimize interventions during labour and delivery. The available studies from Canada, including updated statistics from community midwives in Alberta (see Hanley 1993, 16), suggest that surgical interventions are

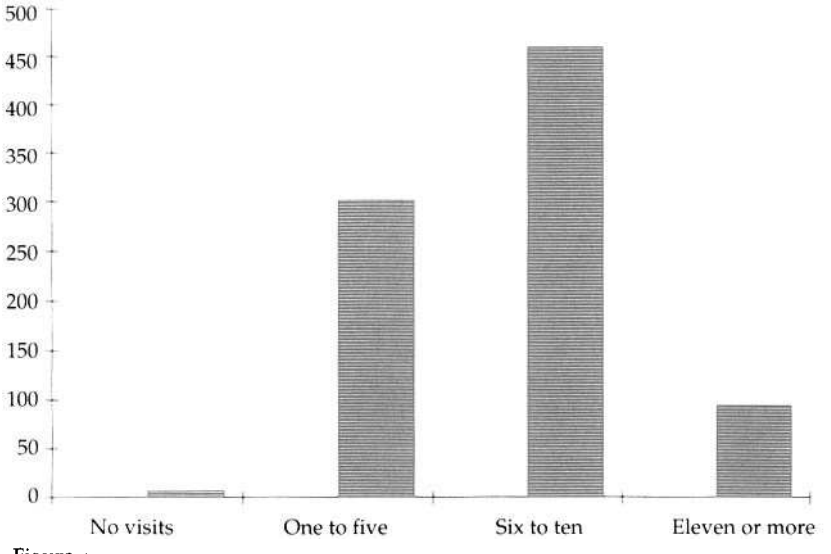

Figure 4
Prenatal Visits by Community Midwives

reduced dramatically for home birth clients. Moreover, measures of morbidity (injury) are also appreciably lower. In my study it was clear that community midwives did not routinely rupture their clients' membranes artificially. Midwives were sparing in the use of oxytocin to induce or augment labour (or expedite delivery of the placenta after birth), and in reliance on painkillers during childbirth. Immobilization of women in labour was also discouraged. Midwives encourage women to move about and to bathe during labour. Furthermore, in keeping with the premise that birth is a personal process, women were encouraged to use delivery positions other than the lithotomy position if they wished (Burtch 1987a, 1988). The following section provides a profile of interventions and techniques associated with the sample of attempted home births.

Rupture of Membranes

A key premise of the community midwives is that by respecting the normal course of labour they provide a service to their clients, and that this protects the unborn child. One measure of their practices is the rupture of the woman's membranes, releasing the amniotic fluid. The great majority of women attempting home birth experienced spontaneous rupture of membranes. Artificial rupture of membranes (ARM) may be employed to induce labour, or more commonly

as a procedure when the amniotic sac is bulging and ready to burst. According to 1980–81 data, ARM occurred in 8.6 per cent of all hospital births in Canada (Statistics Canada 1984, 34). In discussing the increased incidence of artificial rupture (in the attempted home birth sample) with several community midwives, they expressed surprise that ARM occurred in about 15 per cent of the sample. Walker et al. (1986) reported ARM in 15.6 per cent of the births they attended between 1980 and 1985. It may be that ARM is used to induce labour, or because a number of women about to give birth at home had intact amniotic sacs just prior to delivery and the sac had to be ruptured to permit delivery of the baby. The national rate of ARM may be lower, since all women giving birth are included. Table 7 indicates that approximately four-fifths of women planning home births had their membranes rupture spontaneously. About 15 per cent had their membranes ruptured artificially at home.

Meconium Staining

The presence of meconium (feces expelled by the infant) in amniotic fluid may indicate fetal distress. All obstetrical and midwifery sourcebooks recommend careful monitoring of the infant's heartbeat during labour if meconium is observed, with special attention to abnormal heartbeats (decelerations or accelerations). Meconium is not, however, an automatic indication of fetal distress. It is customary for the newborn infant to be suctioned with a DeLee catheter to remove meconium or mucus that may endanger the infant's respiratory system (Davis 1981, 104). It is significant that over one-tenth of these attempted home births involved some meconium show (see table 8). It is not always clear from the home birth records what procedures were taken to protect against fetal distress.

Oxytocin

The critique of obstetrical management of childbirth rests in part on what is seen as the unwarranted and routine use of drugs to influence the natural course of labour. The use of oxytocin to induce labour, to augment contractions, or as a routine procedure to assist delivery of the placenta is one case in point. The norm in attempted home deliveries was to avoid the use of oxytocin, although it is more prominent in the third stage of labour (between the birth of the child and expulsion of the placenta). As table 9 indicates, oxytocin was not used for nearly 82 per cent of the sample; it was used for 15 per cent of the women following the birth.

Table 7
Rupture of Membranes in Attempted Home Births

	N	%
Spontaneous	659	80.4
Artificial (home)	124	15.1
Artificial (hospital)	21	2.6
Born in caul	9	1.1
Trailing membranes	7	0.8
Total	820	100.0

Source: home birth records.

Table 8
Meconium in Waters

	N	%
Clear waters	610	83.7
Old meconium	13	1.8
Fresh meconium	30	4.1
Unspecified	76	10.4
Total	729	100.0

Source: home birth records.

Anaesthesia and Analgesia

Anaesthesia was not used in home births: epidurals and general anaesthetics are administered only in hospitals. Emotional support was often provided by the midwives and spouses during painful contractions. Other forms of pain relief included warm baths, massage, and ice packs. Again, this raises the issue of the community of women and how this level of support may reduce the conventional use of anaesthesia and drugs for pain relief. Certainly there have been statements concerning the reliance on technological solutions to birth events, particularly on the degree to which a technological approach to birthing may increase women's fear of labour and promote more instrumental deliveries and the use of pain relief, among other things. Close to 96 per cent of women attempting to give birth at home did not receive anaesthesia; it was used for women transferred to hospital, where an epidural or general anaesthesia might be used (see table 10).

Immobilization of women during labour and delivery has been challenged by some birth attendants and researchers. Walking during

Table 9
Use of Oxytocin in Attempted Home Births

	N	%
No oxytocin given	606	81.8
To induce labour	7	0.9
To augment labour	12	1.6
Post-partum (bleed)	109	14.7
Delivery of placenta	7	0.9
Total	741	99.9

Source: home birth records.

labour is thought to be beneficial for both the mother and the fetus. The duration of labour may be shortened, and blood supply to the fetus may be increased if the mother is not restricted to the lithotomy position. Table 11 shows that 56 per cent of women in the home birth sample walked at some point in their labours. This may be an underestimate, as not all records would record whether or not the woman was moving about during the labour. Records indicated that some women who intended to walk about did not do so because they were experiencing rapid, strong contractions. Others may simply have been more comfortable in a supine position.

Place of Delivery

Community midwives in Canada have made home birth their primary work, often supplemented with more conventional work, such as labour support for women in hospital. Birthing at home remains very controversial. Some view home birth as a perfectly healthy option for women. Michel Odent (1986, 132) has argued for a stronger appreciation of the benefits of birthing in "a familiar and feminine environment." Attempts to discredit home birth rest not simply on sober science, but on a lack of good will on the part of professionals seeking control in a technologically oriented society: "The subtlest way to discredit home births is to make it as dangerous as possible. It is made dangerous partly by creating an atmosphere of guilt. When a woman dares to think of having a home birth, the first thing she is asked is what she would do if there were complications. Professionals never think that it might be easier if women did not have to leave a familiar place" (Odent 1986, 133).

Categorical opposition to home births is commonplace within the North American medical profession and in many other associations.

Table 10
Anaesthesia in Attempted Home Births

	N	%
No anaesthesia	767	95.6
Epidural only	31	3.9
General only	3	0.4
Epidural and general	1	0.1
Total	802	100.0

Source: home birth records.

Table 11
Walking during Labour

	N	%
Walking	365	56.6
Not walking	280	43.4
Total	645	100.0

Source: home birth records.

Home births are seen not as inherently risky – some opponents concede that many if not most births will proceed well at home – but as hazardous, since complications of birth cannot be predicted with accuracy. The dictum is: "It is much easier to make a hospital birth homely than to make a home birth safe" (Beischer and Mackay 1986, 340). The authors add that complications such as neonatal distress, post-partum haemorrhage, and other potentially serious probems "can never be anticipated with certainty." A number of published studies of home birth demonstrate that most births can be completed successfully at home. A report by midwives practising in Alberta indicated that 7.3 per cent (n = 34) of women seeking a home birth were transferred to hospital and 1.7 per cent of home-born babies were transferred to hospital. Walker et al. (1986, 6) reported that babies were transferred for various problems: meconium aspiration, congenital heart abnormality, fever, spinal abnormalities, respiratory difficulties, and aspiration pneumonia.

Figure 5 indicates that approximately 86 per cent of mothers in the attempted home birth sample delivered at home. It appears that only 8 of these 885 women gave birth at the midwife's home or the home of a friend or relative. There was one case of a mother giving birth

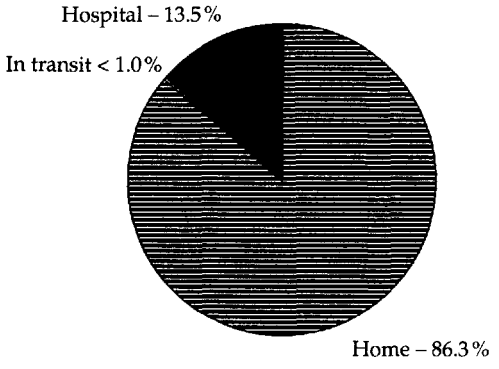

Figure 5
Place of Delivery

in a vehicle during a transfer to hospital. Over 13 per cent of mothers gave birth in hospital after transferring from home.

The commonplace emphasis on complications requiring transfer of home birth clients might be turned on its head. Very little attention is paid in the media to stillbirths in hospital. Of 43,911 live births in British Columbia in 1985, there were 193 stillbirths (of infants over 28 weeks' gestation). This converts to a rate of 4.4 stillbirths per 1,000 live births and specified fetal deaths (Statistics Canada 1986, 4–5). In contrast, stillbirths at home garner considerable media attention and are more likely to be followed by criminal charges against the birth attendants. It is clear, however, that congenital problems that cause the death of an infant are unlikely to result in criminal prosecution of birth attendants whether they are physicians or midwives, in hospital or at home. Linda Knox put the media focus in context: "You have to have a story before the media is involved. Unfortunately, they're quick to pick up on the negatives ... we don't read about the numerous infant deaths in hospitals over a year, but if there is one infant death out of hospital, or with a midwife involved, it's sensational news. There are hundreds of successful deliveries by midwives that aren't written about" (*Midwifery and the Law* 1991).

The next chapter provides more detail on the legal entanglements midwives have faced in Canada and elsewhere. At this juncture, however, it is important to note that the midwives I interviewed emphasized their vulnerability to criminal charges. Physicians and nurses practising in hospitals are shielded from criminal prosecution in practice, while midwives could face prosecution in spite of their record of attending births or even the merits of the case. This gap between formal equality before the law and patterns of prosecuting

midwives has often been highlighted in jurisdictions where midwives have an illegal or alegal (unclear) status.

Delivery Positions

The importance of matching birth management with the needs of the mother is clearly reflected in the variety of birthing positions adopted by women giving birth. The conventional position for spontaneous vaginal delivery and forceps delivery is the lithotomy position: the woman lies on her back, with flexed knees, and her abducted (drawn away from the mid-body) thighs drawn toward her chest (Jensen et al. 1979, 952). The conventional use of the lithotomy position in hospital deliveries has been criticized for prolonging labour since it does not utilize gravitational force, among other things. Enkin and his associates (1989, 187–8) question the usefulness of encouraging mothers to remain supine during labour. They suggest that "the supine position can adversely affect both the condition of the fetus and the progression of labour, by interference with the uterine blood supply and by compromising the efficiency of the uterine contractions. Frequent changes of maternal position may be a way of avoiding the adverse effects of fetal and maternal outcome."

Attempts by physicians to control delivery positions have prompted protest demonstrations, most notably at the Royal Free Hospital in Hampstead, England in 1982. There, the introduction of active delivery positions, such as delivering in an upright position, had been followed by measures to discourage any position other than on one's back. A protest rally was organized by the National Childbirth Trust. (For an account of this protest, see CSP editors 1982, 64.) Another instance of lobbying for improved maternity and infant services is reported by the Spastics Society (1981).

Results of a recent survey commissioned by the Canadian Medical Association indicate that only 26 per cent of women surveyed had their choices of delivery positions respected by the attending staff (Canadian Press 1987). A more recent survey of nine hundred women in greater Vancouver found that 92 per cent of the respondents agreed that "women should have as much choice as possible during labour and birth, and once the child is born." Specifically, 90 per cent believed that women "should be able to choose the most comfortable birth position for themselves" (Greater Vancouver Regional District 1993, 32).

Community midwives believe that a woman in labour should be able to choose from a variety of positions to find one that is most comfortable for her. Just over four-fifths of the birth records (for

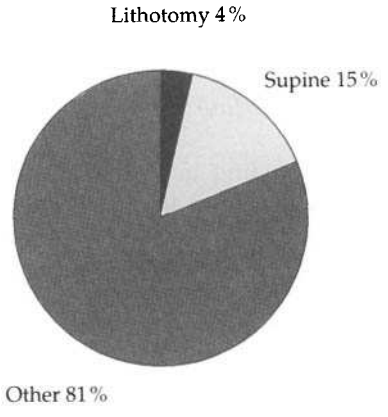

Figure 6
Delivery Positions in Attempted Home Births

which delivery position was indicated) mentioned other than lithotomy positions in home births. Women who were transferred to hospital very likely delivered in the lithotomy position or a supine position. It is difficult to establish the exact kinds of position in hospital because midwives' records tended to be weakest if the woman was transferred out of their supervision. Figure 6 compares the delivery positions taken by women attempting a home birth.

A variety of birthing positions were used by women in the home birth sample. The most frequently used position was on hands and knees; a squatting position also was frequently used. A key point is that midwives believe that there is no one delivery position that is suitable for all women. Most records indicated that women used a single delivery position. In about 10 per cent of the births, however, women reportedly used two positions – for example, squatting and then side lying – in delivering their babies.

Type of Delivery

Community midwives as well as nurse-midwives have indicated that through skill and emotional support for birthing women, rates of instrumental deliveries such as caesarean sections and forceps deliveries can be reduced. Indeed, community midwife attendance is accompanied by a dramatic reduction in the rates of instrumental deliveries. Caesarean deliveries accounted for 21.67 per cent of live births in British Columbia in 1991. The rates in Vancouver (21.70 per cent) and greater Victoria (22.77 per cent) closely match the provincial

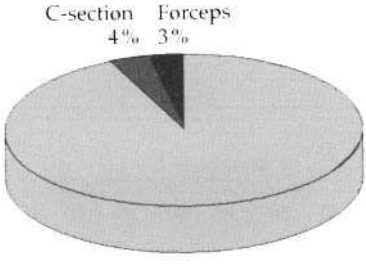

Figure 7
Type of Delivery in Attempted Home Births

average (British Columbia 1992, 46). In the United States, the caesarean section rate has increased from 4.5 per cent twenty-five years ago to 24.1 per cent in 1992 (Taffel et al., 1992, cited in Page 1993, 1479). The national rate for caesarean section was 15.9 per cent in 1980–81, compared with a rate of under 5 per cent for the attempted home births (see figure 7 below). Likewise, the percentage of forceps deliveries among the attempted home birth sample (2.9 per cent) is substantially lower than the nationwide rate of approximately 20 per cent (Statistics Canada 1984, 34).

Episiotomies

Community midwives contend that with perineal massage and support and skilful management of birth, most women can deliver babies without episiotomies (surgical enlargement of the vaginal opening). The episiotomy rate in Canada has been estimated at over 80 per cent for primiparas and between 50 and 60 per cent for multiparas (Klein 1993). While data on episiotomies are "best estimates" only, Statistics Canada (1992, 34) reported that 73,253 episiotomies were performed in Canada in 1989–90. The scale of episiotomy is thus striking, especially when scientific studies have challenged the routine use of the procedure (Klein et al., 1992, 1993). These figures may reflect the higher rate of caesarean sections nationwide, for those births do not require episiotomies. Figure 8 depicts the dramatic decrease in episiotomies among attempted home births relative to hospital statistics.

In their review of the available literature on episiotomies, Thacker and Banta (1983) concluded that there is no clear evidence of the benefits of routine use of episiotomies. They added that episiotomies

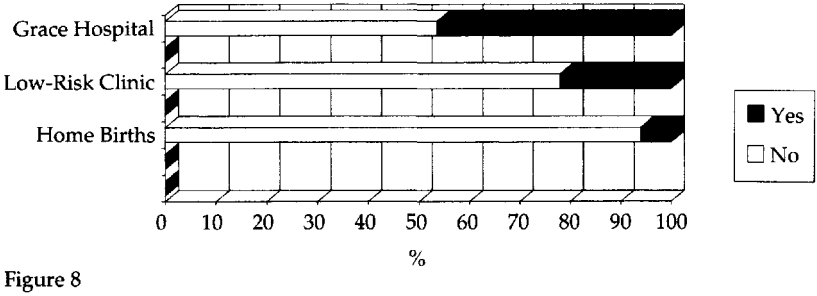

Figure 8
Episiotomy Rates in Home Births, at the Low-Risk Clinic, and at Grace Hospital
Source: home birth records, and Elaine Carty et al., *The Low-Risk Clinic* (1984: 20–1).

are associated with discomfort and pain for women during the post-partum period, and some maternal deaths have been attributed to infections following episiotomy. Midwives argue that the interventionist training of many physicians promotes the routine use of episiotomies. Moreover, perineal tears can often be avoided through perineal massage and support of the perineal area during crowning of the infant's head. Deliveries over an intact perineum are most common in the home birth sample. As noted in the previous table, the Low-Risk Clinic clients had a relatively low rate of episiotomy (22 per cent), compared with hospital-wide statistics collected at the Grace Hospital in March 1983.

The following table presents a comparison of perineal tear rates at Grace Hospital, at the Low-Risk Clinic, and among the community midwives. It should be noted that twenty unspecified tears were documented in the home birth records. Since the degree of the tear could not be assessed, they have been included as a separate row in table 12.

Post-Partum Measures

Suctioning of the newborn baby was undertaken in a considerable number of home births in the study. In some cases this is a precautionary measure; in others where the infant is in respiratory distress it may be a life-saving measure. Table 13 shows that suctioning is not routinely undertaken by the community midwives as a group. It can, however, be used as part of the midwives' repertoire, especially if the infant appears to have inhaled meconium or mucus during labour or delivery. Midwives seemed to regard suctioning as a relatively non-invasive procedure, and one that often assisted the newborn and served to check for substances that might obstruct breathing.

Table 12
Perineal Tears

	Home births		*Low-risk clinic*	
	N	%	*N*	%
Intact	362	41.8	7	14.3
First degree	308	35.6	20	40.8
Second degree	121	13.9	11	22.4
Third degree	13	1.5	0	0.0
Fourth degree	1	0.1	0	2.0
Unspecified	20	2.3	na	na
Episiotomy	40	4.7	11	22.5
Total	865	99.9	49	100.0

Source: home birth records, Elaine Carty et al., *The Low-Risk Clinic* (1984: 20–21).

Apgar Scores

The Apgar scoring method was developed in the 1950s by Dr. Virginia Apgar, an American anesthesiologist. The infant's health after delivery is conventionally assessed on five measures – heart rate, respiration, muscle tone, colour, and reflexes – at one minute and five minutes after birth. Thus, a child who is given a maximum rating of two points on each of these five measures would have an Apgar score of ten. A score of zero indicates that the child is stillborn. Intermediate scores indicate some deficits in the child's health at the time the measure is taken. Scores in the lower range can indicate serious difficulties in the newborn's health.

This composite measure of newborn health is usually recorded by community midwives. Table 14 shows the distribution of Apgar scores for infants delivered at home. Apgar scores are generally within the normal range for newborn infants. As table 14 indicates, there is a predictable increase in the Apgar scores over time for most infants. The small number of cases coded for ten minutes after birth ($n = 215$) occurs because midwives tended to not record Apgar scores at ten minutes unless there was infant distress.

Delivery of Placenta

The third stage of labour comprises the time between the delivery of the baby and the delivery of the placenta. Spontaneous delivery of the placenta occurs when it is expelled without partial (or complete) manual removal, and when oxcytocin is not used to hasten

Table 13
Suctioning Techniques in Attempted Home Births

	N	%
No suctioning	405	53.9
Bulb syringe	103	13.7
De Lee	117	15.6
Unspecified	126	16.8
Total	751	100.0

Source: home birth records.

delivery. Birth records often indicated "controlled cord traction" by the midwife; however, this procedure is classified as a spontaneous delivery provided that oxytocin or manual removal was not used. Table 15 indicates that over 90 per cent of placental removals were unassisted, or "spontaneous."

Delivery of the placenta was assisted in hospital for thirty-one cases (3.8 per cent of all cases). Manual removal of the placenta was undertaken in four cases (0.5 per cent of all cases). Walker et al. (1986, 5) reported that only a small minority (0.7 per cent) of births required manual removal of the placenta.

Neonatal, Perinatal, and Infant Mortality: A Review

The debate over whether community midwifery is dangerous or desirable is not simply ideological. There have been a number of research studies addressing the issue of safety in planned home deliveries compared with planned hospital deliveries and the nature of the attendants as correlated with birth outcome. Standard measures include perinatal mortality (deaths between 20 weeks' gestation and of neonates between birth and the following six days), neonatal mortality (deaths during the first 28 days after birth), and infant mortality (deaths between birth and the first year of life). In the discussion of the Canadian home birth study that follows, only the first two measures (perinatal and neonatal mortality) are used. The community midwives' records do not cover the full first year of a baby's life. Some exponents of midwifery argue that trained midwifery attendance is associated with better outcomes – lower rates of maternal and infant morbidity and mortality – than physician-managed births. An Illinois physician also concluded that home deliveries, if properly managed, could be safer than hospital deliv-

Table 14
Apgar Scores in Home Births

	1 minute		*5 minutes*		*10 minutes*	
	N	%	*N*	%	*N*	%
Zero	5	0.6	5	0.6	5	2.3
One	3	0.4	0	0.0	0	0.0
Two	3	0.4	1	0.1	0	0.0
Three	8	0.9	2	0.2	1	0.5
Four	21	2.4	0	0.0	1	0.5
Five	22	2.5	12	1.4	0	0.0
Six	49	5.7	6	0.7	0	0.0
Seven	86	9.9	13	1.5	1	0.5
Eight	207	23.8	40	4.6	3	1.5
Nine	331	38.1	230	26.5	13	6.0
Ten	133	15.3	558	64.4	191	89.0
Total	868	100.0	867	100.0	215	100.0

Source: home birth records.

Table 15
Delivery of Placenta

	N	%
Spontaneous	762	92.5
Assisted	62	7.5
Total	824	100.0

Source: home birth records.

eries. He believed that the home was generally bacteriologically safer, and that physicians assisting at home were more cautious (White 1977, 291–2).

Others have produced mixed findings regarding the home birth issue and the question of qualified attendants. A research team studying neonatal deaths in North Carolina reported that the neonatal mortality rate among the 242,245 babies delivered in hospital was 12 per 1,000 live births. For physicians attending a planned home delivery, there were no infant deaths among the 55 cases recorded. For trained lay midwives attending home deliveries the neontal mortality rate was 4 per 1,000 live births; moreover, the 3 deaths among the 768 babies delivered were related to congenital abnormalities. In one study of home births in North Carolina between 1974 and 1976, Burnett and his associates (1980) found that the rate of infant

mortality varied as a function of planning for such births and midwifery attendance. Specifically, planned home deliveries with lay midwives in attendance has a rate of 3 neonatal deaths per 1,000 live births. The corresponding rate for planned home deliveries without lay midwives was 30 per 1,000; for unplanned home deliveries the neonatal death rate increased dramatically to 120 deaths per 1,000 live births (Burnett et al. 1980).

One study of Hutterite midwives used physicians' records and birth certificates for Hutterite children born in Montana between 1961 and 1970. Converse, Buker, and Lee (1973) found that 63 per cent of deliveries of Hutterite children in their sample were attended by indigenous midwives. These Hutterite midwives were not trained in medicine or midwifery. The infant mortality rate for Hutterite children in these communities was not significantly different from that for Hutterite children delivered by physicians or for non-Hutterite Caucasian children delivered by physicians. Nevertheless, the neonatal mortality rate for Hutterite births managed by indigenous midwives was higher than Hutterite births attended by physicians; specifically, 16.4 versus 8.1 deaths per 1,000 live births. Additional problems included the midwives' lack of instruments to monitor fetal and maternal vital signs, infrequent and inadequate prenatal visits, reliance on the lithotomy position, and difficulties associated with managing uterine dystocia, cephalopelvic disproportion, and abnormal presentation of the fetus.

The best evidence, however, is that with proper screening procedures, timely transfer of mothers experiencing complications, and trained attendants, home birth does not result in higher rates of infant or maternal mortality. A large-scale study by Mehl and his associates (1977) in northern California studied 1,146 home births attended by midwives, physicians, or both. They found that birth outcomes and rates of complications compared favourably with average rates in California.

A variety of studies of home birth outcomes in Britain and Holland have been published (Campbell et al. 1979; Klein et al. 1983; Damstra-Wijmenga 1984; for a general review see Tew 1985, 390–4 and Flint 1986, 29–30). All confirm that home birth compares favourably with hospital deliveries in terms of neonatal and perinatal mortality. Home births have also been associated with lower rates of medical intervention in the birthing process.

Marjorie Tew's *Safer Childbirth* (1990) develops an argument against equating improved birth outcomes with physician attendance. Using statistics from Holland – where 36 per cent of births in 1986 occurred at home, and where midwives tend to manage births "according to

their own principles" – she found that the perinatal mortality rate (PNMR) was not lowered by hospital-based, physician attendance. Tew (1990, 267) reported that "the PNMR for all births was higher for doctors in hospital (18.9) than for doctors at home (4.5), which was in turn higher than for midwives in hospital (2.1), which was in turn higher than for midwives at home [1.0]." Tew (1990, 270) concludes not only that these findings question the advantages of obstetrical management of birth, "but even that [obstetrical management] actually provokes and adds to the dangers."

A study of 3,400 planned home births in Australia lends weight to these findings. Bastian and Lancaster's (1990) assessment (noted in Kitzinger 1991, 41) revealed that caesarean sections were rare (2.2 per cent), forceps and vacuum extraction deliveries accounted for only 3.1 per cent of births, and episiotomies (20.1 per cent) were substantially less frequent than the national rate of 39.9 per cent. Kitzinger (1991, 41) remarks that some women planning to give birth at home were classified as high-risk. Moreover, "30.8 percent were what doctors called 'untried pelvises,' because they were giving birth for the first time."

A recent review of the debate over place of birth, safety, and morbidity rates underscores the difficulties of establishing cause-and-effect relationships on the basis of existing studies. Campbell and Macfarlane (1987) nevertheless conclude that "there is no evidence to support the claim that the safest policy is for all women to give birth in hospital." The authors note that there is evidence, albeit inconclusive, that morbidity rates are higher for low-risk mothers giving birth in institutions than for other low-risk women giving birth at home. The authors add that "a majority of women who have experienced both home and hospital deliveries prefer to have their babies at home." They caution that this finding may reflect a "disproportionate number" of mothers who chose home birth after an unsatisfactory experience of birth in hospital (Campbell and Macfarlane 1987, 58). While the question whether women electing home birth are a healthier population in general than women delivering in hospital remains unanswered, there is clear support for the safety of home birth in some circumstances. It is important that women be screened for complications, that there be adequate prenatal care, that birth attendants be skilled in domiciliary mangement, and that back-up (emergency) services be in place. Attention has been drawn to ways in which diagnosis of risk, not actual risk, may contribute to increased caesarean section rates (Francome 1986).

With respect to this study, three essential dimensions in infant deaths are employed. First, the accurate measurement of such deaths; second, careful comparisons of time-frames; and finally, attribution

Table 16
Perinatal Mortality (per 1,000 births)

	British Columbia (home deliveries)		*British Columbia (provincial)*		*Canada*	
	N	*R*	*N*	*R*	*N*	*R*
Perinatal death	3	12.34	na	10.9	na	13.0

Source: home birth records. The B.C. perinatal mortality rate is taken from 1979 data, the Canada-wide rate from 1978 statistics. See Roger Tonkin, 1981.

of responsibility for the deaths. Since reports of infant deaths must be made under the Vital Statistics Act in Canada, difficulty does not usually arise with respect to infants who die at or near term. There are, however, various forms of fetal loss at earlier stages of pregnancy, including planned abortions (therapeutic abortions) and spontaneous abortions (miscarriages)

Two standard measures of fetal and infant death are used in this study. Perinatal mortality measures death of a fetus of 20 or more weeks' gestation or of a neonate between birth and the following six days. Neonatal mortality is a more specific measure, addressing neonatal deaths during the first 28 days after birth. Both measures are expressed as the number of deaths per 1,000 live births. The last dimension will be discussed at greater length after the following measures of mortality. It is important, however, to distinguish between unavoidable infant deaths that may be due to congenital malformations and those that may be attributable to caregivers' negligence. The latter are referred to as iatrogenic (physician-caused) deaths (Illich 1977). As it is used here, the term refers to negligence generally associated with caregivers, whether physicians, nurses, or midwives.

The perinatal mortality rates shown in table 16 were arrived at by dividing the number of stillbirths plus the number of early neonatal deaths (during the first week after birth) by the number of live births and the number of stillbirths, then multiplying the result by 1,000.

The perinatal mortality rate calculated above should be interpreted with caution. It is possible that the rate might have increased if all attempted home births in British Columbia and the other provinces had been analysed. I have not sought access to midwives who were not closely associated with the Midwives Association of British Columbia, nor have I referred to another community midwife who left British Columbia in 1981 after an infant death following an attempted home birth. It is arguable that exclusion of these records

may artificially lower the actual mortality rates of midwife-attended attempted home births.

There are other possibilities, however. One community midwife who attended hundreds of births in British Columbia provided a small sampling of records that included a few perinatal deaths, including a stillborn twin. She had not been the primary care midwife for the woman, and was reluctant to deliver twins out of hospital. Nevertheless, she agreed to assist the woman who was about to deliver the babies. The point here is that the sample of attempted home births is missing thousands of births that occurred between 1972 and 1986, and it is not possible to measure precisely the safety of hospital birthing alongside home births. It is generally agreed that existing studies – which are not randomized controlled studies – cannot conclusively establish whether or not home births are safer than hospital or clinic births (Tyson 1988, 39).

A second point is that community midwives did not always select the most healthy clients. There are cases of women who might have been screened out of home birth guidelines who later delivered at home. It should be kept in mind that many women delivering in hospital are healthy, and many have received good prenatal care. Community midwives indicate that perinatal mortality rates are not higher for populations intending to deliver at home. This issue does not necessarily revolve around a dichotomy of community midwifery versus hospital births. Penny Armstrong, an Ontario midwife who has practised midwifery with Amish women, provides a contemporary account of midwifery practice at home and in hospital (see Armstrong and Feldman 1986).

In his study of birth statistics in British Columbia, Tonkin (1981, 18) concluded that "the mortality rate for infants born at home is not markedly different from that of hospital born infants." A report on 465 home births in Alberta between 1980 and 1985 indicated that there were only 3 infant deaths and 1 stillbirth. This converts to a perinatal mortality rate of 8.68 per 1,000 live births (Walker et al. 1986, 1). The measure of neonatal deaths presented in table 17 shows a similarity between domiciliary midwifery outcomes and province-wide and Canada-wide comparisons.

These comparisons appear to support the community midwives' claims that planned home births are not necessarily more dangerous than hospital-based births. These findings are consistent with earlier published reports of low rates of perinatal and neonatal mortality among women seeking home births supervised by trained midwives. The corresponding figure for births managed by midwives on the Summertown Community Farm, Tennessee, a holistic birthing centre,

Table 17
Neonatal Mortality (per 1,000 births)

	British Columbia (home deliveries)		*British Columbia (provincial)*		*Canada*	
	N	*R*	*N*	*R*	*N*	*R*
Neonatal death	4	4.97	na	6.7	na	8.1

Sources: home birth records, Statistics Canada, *Births and Deaths*, vol. I (1984).

was 11.1 neonatal deaths per 1,000 live births (Gaskin 1978, 104). Holliday Tyson, in her research into 1,001 home births in Toronto, summarized her findings as follows: 93 per cent of the sample had spontaneous vaginal births; 3.5 per cent had caesarean sections; and 17 per cent of mothers and infants were transferred. Tyson (1988, 40) concludes that her data "show the Toronto home birth population to have a high rate of spontaneous vaginal birth, low rates of surgical interventions, low episiotomy rate, and relatively low rates of perineal lacerations requiring sutures."

Post-Partum Visits

The period following the birth of a child is critically important for mothers and infants. One midwife reported that while she gives attention to various measures of wellbeing of the mother and child, the intimate contact between herself and the client is also important. The midwife explained: "I have a post-partum flow sheet with everything categorized that should be checked. The post-partum care is every day for the first five days, sometimes twice a day depending on the situation. If the birth has been complicated in any way, then I will stay overnight, and usually for the first 18 hours. Every day for the first five days no matter who it is, no matter how normal the birth. That's partly because it takes time to wind down the relationship." She emphasized that the post-partum is not strictly a medical procedure: "Often, the post-partum will have nothing to do with checking what's happening physically, but everyone needs to talk about the birth ... The women really need that because so much is lost to them because they are so inside of themselves, labouring ... it depends, however, since some women don't need to be in such close contact post-partum."

There were exceptions to the norm of visiting, usually due to circumstances outside of the midwives' control. One midwife reported that a client disappeared from the area shortly after the

birth (and, incidentally, without paying the midwife for her services). In other cases where the birth took place some distance from the midwife's home, the midwife might stay for a few days after birth. Telephone calls might also be made in lieu of personal visits to the mother's home. There was considerable variation in the number of postnatal visits. Figure 9 shows that ordinarily a midwife made at least three post-partum visits to assess the mother and the newborn.

It may be that midwives did not document all home visits. If this is the case, it underscores the need for improved documentation of practice, including post-partum activities of community midwives. It is my impression that charting of births and midwifery practice has become more thorough since the early to mid-1970s. For example, the Midwives Association of North America (MANA) has devised a comprehensive statistics form (revised 1993) that charts demographic information, the woman's reproductive history, prenatal care, and so forth.

Safe Practice: Guidelines and Peer Review

The issue of infant and maternal safety is central to discussions of childbirth. Feminist critiques of conventional obstetrics often point to reduced freedoms for parturient women, erosion of community contacts, and the substantial power vested in the (predominantly male) medical profession (see Corea 1985; Cox 1991; Treichler 1990). It is also asserted that midwife attendance (at home or in hospital) can be as safe as or safer than physician-managed hospital deliveries. In British Columbia, many community midwives have devised collective standards and peer review procedures to assess what constitutes safe practice. Most practising community midwives are members of the Midwives Association of British Columbia (MABC) with several members founding a separate Midwives Collective.

The 1986 *Guidelines to Midwifery Practice* are taken from the experience of community midwives, the Board of Directors of the MABC, and general lists of contraindications to home birth. The MABC guidelines provide a comprehensive list of procedures for the community midwives. These procedures include initial and ongoing assessments of the client's social and family history, obstetrical and gynecological history, physical examination, and testing for urinalysis, blood pressure, pulse, and the like. The midwife may also refer the client to laboratory specialists for such work as Rh antibodies, hemoglobin, and rubella titre. The schedule for prenatal care is set out as follows: a monthly visit up to the twenty-eighth week of pregnancy; a biweekly visit thereafter until the thirty-sixth week; and weekly visits

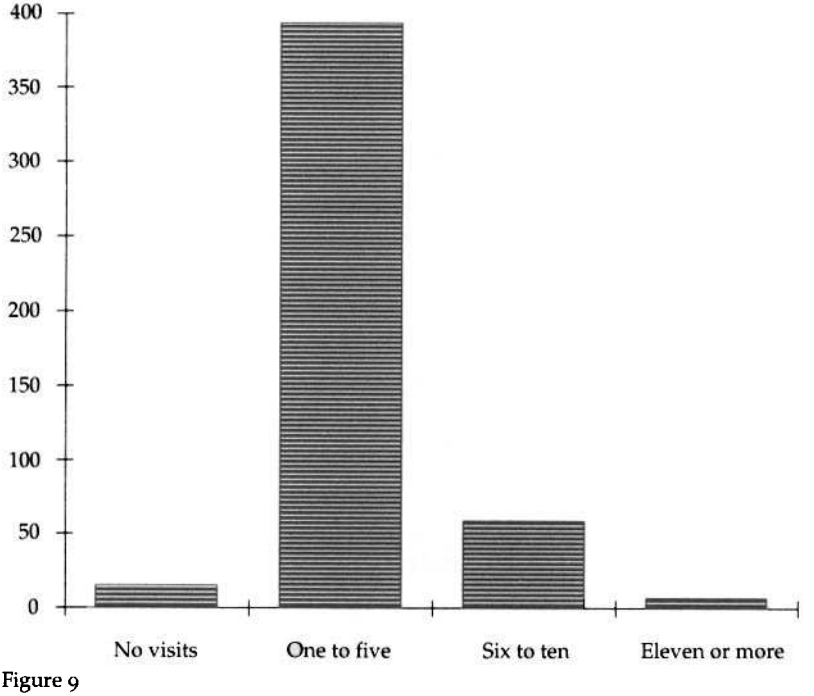

Figure 9
Post-Partum Visits by Community Midwives

from that point until the birth. Measures of blood pressure, weight gain, fetal heart tones, fundal height, and so on should be taken by the midwife. The midwife is expected to maintain accurate records of these visits and to monitor whether these measures are "within normal limits." There is an accompanying list of guidelines that are presented as "definite" indications for a hospital birth. Definite contraindications to a home birth include the following maternal factors: "cardiovascular disease, congenital heart disease, essential hypertension, vascular disease, achondroplasia, drug addiction or abuse, acute psychiatric problems, renal disease, endocrine disorders, thrombosis, emboli, Addison's disease, hypo/hyper thyroid, diabete[s] mellitus, neoplastic disease, immunocomplex disease, history of subarchnoid haemorrhage, TORCH infections, uterine infection, active tuberculosis, and asthma." Midwives disregarding these contraindications may be brought forward for peer review, which is not a formal disciplinary hearing.

Other contraindications to home birth are grouped under two headings. The first heading, "Obstetrical history," includes three or more successive spontaneous abortions, a previous unexplained still-

birth, and previous uterine surgery (which includes a previous caesarean section). The second heading, "Obstetrical Factors in the Current Pregnancy," includes intrauterine growth retardation, multiple pregnancy (such as twins), confirmed fetal heart abnormalities, and, inter alia, premature rupture of membranes (before thirty-seven weeks).

There is also an extensive list of possible indications for a hospital birth. The midwife is expected to consult with a physician when such situations occur as smoking during pregnancy, when the mother is more than 30 minutes away from the nearest hospital, when the mother is less than 17 or over 40, and when there is abnormal weight gain.

These guidelines, taken with subsequent guidelines for intrapartum care and postnatal care, appear to be a synthesis of international guidelines for midwifery and local debates over responsible midwifery practice. The key point here is whether midwives can be held accountable for ignoring guidelines, especially when some of them are not very specific. What constitutes "drug addiction or abuse"? Should the woman be automatically screened out for home delivery if her membranes rupture at just over thirty-six weeks but all other factors are well within guidelines?

The interpretation of the rules at present appears less formal, allowing the midwives some discretion in their work. Midwives are urged to not attend home births except for singletons; that is, multiple births should be managed in hospitals. One midwife recalled how one client, who was intent on a home delivery, had to be referred to another practitioner:

> I had a client who was going to have twins. The bottom line for her, after all the information, was that she would still choose to birth at home. My dilemma was, how to support her? In another climate, where midwifery is legal, there would be a process whereby that woman could still make that choice, and her caregiver would be protected from the consequences. [The midwife] would notify her superiors ... she would be able to continue to care for the woman with some kind of legal protection ... my personal choice in this case was to say "no," not only because of the legal consequences if anything was to go wrong, but also because I know what my skills are. I don't deliver twins; I don't do breeches, which are common in multiple pregnancies.

Some midwives indicated that they had adopted a more cautious approach to attending home births: "I don't do VBACs [vaginal birth after caesarean section] at home now, although I have managed some

VBACs at home over the years. [I may do it] for women who decided at the last moment that they wouldn't go into hospital. I think that VBAC can be done safely at home, but it is something that requires screening ... Politically, it is suicidal for midwives to do it, and I am very committed [to the legalization of autonomous midwifery]. I found there was a lot of pressure if I did a VBAC at home. Once, I was bombarded with telephone calls from physicians who were angry with me for attending a VBAC at home. Also, there is a risk factor. It is a high-stress birth and I am not really relaxed when I am there."

WORLDWIDE, there has been a clear shift to almost complete hospitalization of birth. Once established as a viable alternative to hospital-based obstetrics, the practice of domiciliary obstetrics in Britain, including the "flying squads" staffed by an anaesthetist, an obstetrician, and a midwife in the event of birth complications (da Cruz 1969) has given way to almost universal recourse to hospital obstetrics. It has been reported that approximately 97 per cent of births in Britain take place in hospitals (Kitzinger 1978, 51) and more recent statistics for England and Wales (1991) reveal that only 1.1 per cent of births are home births ("Home Birth Percentages" 1992). In Britain, the delivery of the Prince of Wales at home by Sir John Peel has been followed by the general recommendation by a commission headed by Dr. Peel that all deliveries in Britain occur in hospital (Kitzinger 1978a, vii). The official policy in Britain has thus discouraged domiciliary midwifery. Jean Donnison (1981, 9) remarks, "Despite the lip-service paid by successive Health Ministers to patient choice in the matter of home or hospital delivery under the Health Service (which, incidentally, means at no charge), any woman wanting a home birth on the National Health Service must possess the political skill of a Metternich, the patience of a Griselda and the persistence of a Pankhurst. If she is to succeed, she must begin to fight the Health Service bureaucracy as soon as possible in her pregnancy and be prepared to continue, perhaps for months, in order to overcome the almost insurmountable obstacles put in her way."

There have been a number of initiatives to estabish a more pluralistic maternity and infant care system. It is not at all difficult to establish the borders of debate over the appropriateness of home birth. Some support out-of-hospital birthing clinics and home birth; others decry home births as "the earliest form of child abuse" (Pearse 1977, 1979). Others encourage pregnant women to deliver at home and to lobby for the legal right for childbirth attendants to practise

domiciliary obstetrics and midwifery (Bittman and Zalk 1978; Brooks and Bennett 1976; Kitzinger 1978, 1991; Kitzinger and Davis 1978). Clearly, then, the struggle over birth attendance is in large measure a political and ideological debate over power and women's freedom of reproduction. The political and ideological dimensions of this debate are brought forward in the next section, with specific reference to the role of law in regulating birth practices.

Midwifery and the Law

An understanding of the community midwife movement in British Columbia is best located within the broad paradigm of conflict theory within sociology. Childbirth became a battleground between "lay" midwives, doctors, nurses, and scientists. Struggles over childbirth attendance in England reflected longstanding "inter-professional rivalries" (Donnison 1977, 1988). The nature of the conflict is complex, involving not only the economic interests of the established professions and the alternative practitioners, but disagreements among various groupings in the public over safety and standards and the gatekeeping functions of state officials. The conflict approach as applied in the case of midwifery invariably addresses the self-interest of the medical profession in presiding over childbirth and the premise that medical attendance is demonstrably superior to midwifery attendance (Hamowy 1984).

One point worth emphasizing is that the nature of the conflict is not static. Even powerless people can struggle against oppression, occasionally relying on the rule of law to secure their rights (Thompson 1977). This is also true of community midwives, since they reject unfavourable interpretations of their work, continue to practise midwifery, and lobby for the legalization of midwifery. Public education campaigns and media submissions – most notably, letters to newspaper editors – are the more visible lobbying techniques; workshops and educational initiatives, such as the British Columbia School of Midwifery, reflect less visible, collective initiatives to improve community midwifery services. As of 1993, the most successful of these initiatives was a partnership among three post-secondary institutions in Ontario. Laurentian University, McMaster University, and Ryerson Polytechnical University now offer a four-year baccalaureate program in midwifery (Williams 1993).

Other activities within the community midwifery movement include fundraising by means of dances, casinos, and mail solicitation. These activities are usually designed to benefit a group, such as the School of Midwifery, or to defray legal costs associated with

coroners' inquests or criminal prosecution following an infant's death. The resources of community midwives are paltry in comparison with the financial resources available to the state and through provincial and national medical associations. Midwives can innovate, however. Nine community midwives began a collective in which education is ongoing and in which each of the members has pledged to contribute up to a thousand dollars in the event that any one member of the collective faces legal costs.

As it evolves, community midwifery in Canada is a hybrid form of midwifery. With ties to a tradition of local self-help and some links with modern New Age spiritual philosophy, a number of practitioners also have formal instruction in nursing and midwifery. Guidelines for midwifery practice have been drafted (and redrafted), and peer review is one mechanism that mirrors a more professional approach to birth attendance by community midwives. The community midwives are not wholly united, however. Some midwives are not affiliated with the MABC, and express serious concerns about the co-option of midwifery as it becomes state-supported. There is disagreement over the appropriateness of attempting home birth without sufficient medical back-up, the availability of emergency services (ambulance transport), whether women who have had a caesarean section should attempt a vaginal birth at home, and so forth.

Community midwifery has faced troubles from without. State measures are taken against community midwives. Criminal prosecution of midwives and other birth attendants has been implemented in British Columbia (and elsewhere), as has prosecution under the provincial Medical Practitioners Act for practising medicine without a licence. The costs incurred in retaining a defence lawyer and the loss of income (if the midwife is forbidden to practice midwifery pending the outcome of a court case), along with the uncertainty of the eventual verdict, reflect some influences of the state on these midwives.

Other measures bear on our theoretical understanding of the state, the professions, and community initiatives. Despite years of lobbying for legal status for midwives and notwithstanding a substantial evaluation literature documenting the benefits of skilled midwifery practice, community midwives remain illegal practitioners under this provincial legislation. They cannot bill under the provincial medical insurance plan, and they lack a substantial defence fund in the event that they are charged with criminal or quasi-criminal offences. Nevertheless, this lack of resources is not always evident when midwives face legal actions. As discussed in chapter five, an Alberta midwife,

Noreen Walker had over $20,000 in her legal defence fund, as well as access to the pro bono services of an Edmonton lawyer.

Paradoxically, community midwives are relatively free to practise and even to advertise their home birth practices, to develop an academic curriculum and practical training, and to transfer women to hospital if a home birth is not successful. This freedom is circumscribed, however, by their complete exclusion from provincial health insurance plans. It is further constrained by the general powers of the medical associations through the state and the reluctance of state officials to further expand medical coverage. The preliminary evidence on the midwifery movement seems best suited to a "relative autonomy" perspective on the state. Liberal democratic states will vary in terms of the degree of their autonomy from civil society. The point remains that the state is not acting simply as an instrument of powerful interests, nor is it promoting the pluralistic principles often linked with liberalism.

In the wake of three coroners' inquests into baby deaths in Ontario, and following years of pressure by the Ontario Midwives' Association (composed of midwives and consumer advocates, among others) and other pro-midwife organizations, midwifery is now legally recognized in Ontario. The Ontario minister of health has proposed direct entry into midwifery (rather than mandatory nursing training in addition to or in place of midwifery training).

The task force on the implementation of midwifery in Ontario recommended a framework that would recognize and regulate midwifery practice. The task force recommended a separate Midwives Act, with the midwife's scope of practice corresponding to the international definition of the midwife. A system of consultations and referrals between midwives and physicians was favoured, although the profession would be self-regulating through a college of midwifery. Home births should be recorded in a central registry to assess mortality and morbidity more systematically. A four-year baccalaureate program was favoured, with a twelve- to eighteen-month program for applicants with nursing qualifications. One point of concern is that some community midwives would be effectively outlawed: the task force report (1987, 19) recommended that "no midwife be permitted to practise except in a practice, service, agency or other health facility approved by the Ministry of Health."

The arguments for legalized midwifery, centring on the safety of home births attended by trained midwives, the so-called soft measures of client satisfaction, and the fundamental democratic principle that the state should not interfere with private decisions of citizens,

are quite strong, as are the measures taken to stifle autonomous midwifery practice. The obstacles to the legalization of midwifery in Canadian jurisdictions seem to reflect professional resistance to autonomous midwifery practice and the reluctance of the state to permit community-based, decentralized initiatives at a time when state trajectories are moving toward greater control.

Nevertheless, it must be emphasized that the state in Canada is relatively autonomous, and the degree of autonomy is neither a static nor a permanent feature of the capitalist state. The administration of health is a provincial responsibility, and there have been varying degrees of response from the provinces toward recognizing midwifery in law and public policy. Ontario is in the forefront of legalizing midwifery, and Alberta has made provision for legal midwifery. British Columbia has reviewed a number of submissions proposing direct entry midwifery training and a legal status separate from the nursing and medical professions. In contrast, Quebec midwives have faced serious obstacles, including strong resistance from the medical profession. A recent memo from representatives of the Alliance Québécoise des Sages-Femmes Practiciennes (AQSFP) drew attention to some of these obstacles. Despite the passage in 1990 of a bill that provided for "a five year study of midwifery services within a framework of selected pilot projects," midwives have yet to achieve an established facility for midwifery practice. Moreover, currently they have no voting status on committees established to review these pilot projects, or to assess qualifications for midwifery practice. The authors of the memo protest this failure to implement a more visionary form of midwifery – along the lines followed by the Ontario task force and the Ontario government – and anticipate that midwifery initiatives will be co-opted: "The very real risk here is that midwifery positions in the pilot projects will be filled by midwives, nurses, or doctors who have very little actual experience providing continuous and complete midwifery care on their own responsibility in collaboration with other health care professionals ... The result will at best be a duplication of services and at worst a total mockery in terms of evaluation of competent and appropriate midwifery practice. In any event, an opportunity to create high quality, safe and innovative maternity services to women in this province has dissolved into a colossal waste of time, energy and money on the part of all concerned, including the Quebec taxpayers" (Stonier and Beauchemin 1993).

The dominant status of the medical and nursing professions is not likely to be set aside in maternity and infant care. Virtually all nation-

states actively promote medical and nursing education and practice, and there is a strong case for further developing the knowledge base and clinical practices associated with the medical and nursing professions. A related point concerns the artificiality of some constraints on birth attendants. As was set out in chapter three, the monopoly powers of the various provincial medical associations and their colleges have been achieved, in part, through the denunication and prosecution of the predecessors of today's midwives. The issues ahead will revolve around whether current midwifery initiatives are co-opted by the established health professions in Canada and who controls licensure, training, and peer review.

NURSING AND MIDWIFERY: "EVERYTHING THAT RISES MUST CONVERGE"

For the most part, midwifery has been seen as having a different role from that of nursing. As a calling or as a profession, midwifery usually stands alone and apart from nursing education and employment worldwide. There are signs, however, of a convergence and alliance-making between nursing associations and midwifery associations. In the United States nurse-midwifery was established as a combination of the two spheres. Chapter 1 described several differences between accredited nurse-midwives and community midwives in North America. As a rule, nurse-midwives work as salaried employees in hospital or clinic settings. They belong to professional nursing associations. Nurse-midwives are usually not responsible for intensive in-home prenatal care of clients, nor do they usually assume responsibility for the delivery stage of childbirth. Nurse-midwifery in Canada is usually associated with pilot projects such as the Low-Risk Clinic in Vancouver. In the United States, however, nurse-midwifery is more established.

Stereotyping nurse-midwives as a group is hazardous. There is great variation in the sphere of practice, especially in northern regions where midwives may be responsible for many decisions ordinarily assumed by medical personnel. In this chapter, the role of nurse-midwives is evaluated, with special attention to community midwifery practice. Significant initiatives are discussed: the attempt to establish an out-of-hospital birthing clinic in Vancouver, the Low-Risk Clinic, which allowed more independent practice and continuity of care by nurse-midwives, and the succeeding Midwives' Project at the Grace Hospital in Vancouver.

Central Problems in Nurse-Midwifery

Whatever the attempts to promote midwifery services, it is not uncommon for nurse-midwives to express resentment at the containment of their skills in attending women in childbirth. For some, the opportunity to apply these skills is truncated when they arrive in urban settings where physicians are dominant within the occupational hierarchy of hospitals. A midwife (and nurse) working in Canada but trained in England, remarked on the structure of obstetrical care and the limits placed on trained midwives: "I worked on the obstetrical unit (of a 55-bed hospital in the North). That was really interesting; I did quite a few deliveries because the medical coverage wasn't always that great. And basically I worked autonomously, with some limitations ... I was allowed a lot of freedom to practise in my own way. I think if I had not had that I would have found it very limiting. The physicians who were there were very inexperienced in obstetrics ... I realized why I was necessary, why they made a prerequisite of midwifery training for anyone who worked on the obstetrical unit ... they really needed my skills ... The most shocking experience I ever had in Canada was when I worked in a university hospital. Every woman had an obstetrician. It was a high-risk unit, but many of these women were not high risk. There were 18 obstetricians on staff. Women literally came in and had birth done to them."

The leitmotif of professionalism that appears throughout the definitions of nurse-midwifery has been criticized. A few community midwives have expressed their misgivings about what they see as the proprietary nature of some obstetrical nurses, managing the baby as their "property" while disciplining errant parents and community midwives. By contrast, some practitioners praise nurse-midwives for taking time with patients, for combining this rapport with clinical skills that are at least on a par with medical staff. Midwives' enthusiasm for continuity of care for expectant women may also clash with a medical model of birth in which labour and delivery may be disparaged as time-consuming, unexciting "handholding" (Scully 1980, 125–6). The movement for greater recognition of nurse-midwives as birth attendants has contributed to an expanded role in conventional obstetrical settings. The recent proliferation of nurse-midwifery programs in the United States (Scupholme 1982, 21). has often been interpreted in terms of consumer demand for alternatives to standard obstetrical attendance at birth. Midwives are active in tertiary care, and can collaborate with obstetricans and anaestheologists over decisions about pain relief in obstetrical care (Ghosh-Ray et al. 1980). A

survey of practising midwives in the United States in 1976, which gathered data on 1,213 nurse-midwives, confirmed that the collaboration between physicians and nurse-midwives permitted a degree of treatment of birth complications by nurse-midwives. This survey found that only 15 per cent of nurse-midwives working in the general area of deliveries managed multiple births. Only 12 per cent were responsible for breech deliveries. Nevertheless, 99 per cent of certified nurse-midwives (CNMS) performed and repaired episiotomies: "In general, the more invasive and risky the procedure, the less likely nurse-midwives are to perform it. However, nearly as many (89 per cent) reported they managed the care of prenatal patients with some complications. A number of minor complications occur quite commonly in otherwise normal pregnancies, creating a gray area between 'normal, well, uncomplicated patients' and 'high-risk' or 'complicated' patients. Most nurse-midwives providing prenatal care have developed collaborative relationships with physicians in which they can continue to care for patients who experience certain kinds of prenatal complications" (Rooks and Fischman 1980, 992–3).

One difference frequently suggested in the literature is that independent (community) midwives are more politicized than nurse-midwives. There appears to be a subcultural approach by some community midwives, including a resolve to respect the woman's wishes during labour and delivery and throughout the pregnancy and post-partum period. The community midwife, according to this portrait, is more likely to regard organized medicine as profit-oriented and male-dominated. In her practice she may contravene local or international practice guidelines on the basis of her judgment of the situation and out of respect for the women. This appears to be linked with two major themes: the historical takeover of birth by physicians from community midwives, and the perception that nurse-midwives are greatly constrained within the hospital hierarchy and unable to apply their skills fully to the women they serve. Cobb (1981, 75) indicates that nurse-midwives have been coopted by the dominant medical profession. One British Columbia community midwife observed that nurse-midwifery is less threatening to physicians' power than autonomous midwifery: "One reason why physicians want it to be nurse-midwifery is that they know how to control nurses, and they train nurses to be under their control. Physicians are terrified of the independent midwife who does a three-year program, and isn't a nurse. They are afraid of that woman because she doesen't do what they say ... If they have to have midwives, and it looks like they will, then they want to have nurse-midwives. They don't want to lose their piece of the pie to midwives. The only way

they can prevent that is to insist that every midwife have a physician present when she does a delivery."

The subcultural motif may be overdrawn with respect to many community midwives as well as nurse-midwives. My impression is that midwives tend to be oriented toward a community of clients and not toward a particular community or locality. In fact, the great majority of home births analysed in this study took place in over two hundred localities throughout Ontario, British Columbia, and Saskatchewan. It is also unsupportable to juxtapose community midwives against nurse-midwives as if the latter were not also serving a community or constituency. That constituency would tend to be disinclined to home birth and to be fairly positive toward conventional management of childbirth by physicians and nurses. There are instances of nurses taking action outside the conventional hospital network. There are of course exceptions; for example, an Ontario nurse published a favourable account of her decision to give birth at home with medical attendance (see Swedlo 1979, 307–53). Starr (1983, 223) holds that even in the seventeenth and eighteenth centuries in the United States, the lay midwife was regarded as a competitor by many medical men, while the nurse-midwife was not. Others are in agreement that nurse-midwifery in the United States is primarily a dependent occupation: "It is perhaps a mistake to refer to midwifery in the United States as an emerging profession. Midwifery as it was known in Europe and England never really existed; decisions, political and economic, were made which led to the elimination of midwifery. What is slowly emerging is a health worker called a nurse-midwife – an asssistant to the obstetrician and not an independent practitioner. Only 10 per cent of American nurse-midwives are presently employed in positions that offer full use of their training" (Anisef and Basson 1979, 368).

Another difference between modern community midwifery and nurse-midwifery involves the apprenticeship in birth attendance. Unlike the formal training in midwifery, usually in conjunction with completion of nursing training, community midwives tend to learn by practical experience unsupported by formal training: that is, through attending births and reading birth manuals. This differentiation between midwives trained in nursing and other midwives can in turn be linked to comments on the "proletarianization" of nursing (Wagner 1980) and the deflection of U.S. nurses' efforts to achieve greater autonomy. A related point is that solidarity among nurses in Canada is narrowly defined (Buckley 1979). Deference to medical authority is pronounced, although the emergence of provincial and national organizations and of collective bargaining status has

countered this historical situation. In Canada, the direction of legal lobbying and professional recognition has been toward an expanded role of certified nurse-midwives. It is estimated that there are at least one hundred certified nurse-midwives in British Columbia (Brook 1980, 6). Independent midwifery practice has generally been restricted to nurses working in remote regions with limited or non-existent access to physicians. A midwifery program at the master's level has been offered at Memorial University. An advanced obstetrical nursing course is continuing at the University of Alberta, and outpost nursing, with a midwifery component, is available at Dalhousie University in Halifax, Nova Scotia.

The movement toward a more independent practice for midwives in Canada was favoured by Louise Miner, past president of the Canadian Nurses' Association. She criticized general practitioners for simultaneously acknowledging their limitations while resisting midwifery practice. Normal pregnancies should be attended by midwives, and midwives should practice independently (see Korcok 1972, 45). In 1971 a survey of members of the Society of Obstetricians and Gynecologists of Canada found that the majority of members responding to the survey accepted the premise of trained midwives taking more responsibility in prenatal and antenatal care. Nevertheless, there was a general reluctance to give midwives the primary responsibility for managing the delivery of babies. Concern was also expressed about a possible lack of supervision by physicians of midwives in maternity practice (Korcok 1972a, 7). This reluctance to endorse nurse-midwives as birth attendants is also evident in the drafting of a document concerning the regionalization of maternity and newborn care in the United States. The American College of Nurse-Midwives (ACNM) was not invited to contribute to the drafting of this document (see Sugarman 1979, 69).

A statement in support of nurse-midwifery practice was adopted by the Registered Nurses Association of British Columbia in June 1979, following a ten-month investigation by a three-member committee. This statement included resolutions that the role of the nurse-practitioner should be established in British Columbia; that the practice of nurse-midwifery should be legally defined as "part of the ordinary calling of nursing," thereby securing an exemption from prosecution under section 71 of the Medical Practitioners Act; that standards of nurse-midwifery practice should be met; that various types of practice could be subsumed, including domiciliary (home) births and management of low-risk and high-risk births in hospitals or clinics; and that refresher courses be made available for nurse-midwives (RNABC, 1979). In 1993, certain representations made to

the Health Professions Council of British Columbia were hostile to the concept of home births and to the autonomy of midwives (that is, to their working without the direct supervision of physicians). The midwives' representatives countered that such supervision constituted a costly and unnecessary duplication of services.

Home Birth and Midwifery Policy

The issue of home birth has generated some consensus on the preferability of hospital settings for delivery. The Western Nurse-Midwives Association registered its preference for working with obstetricians in clinical settings (Canadian Press 1976). A spokeswoman for the Registered Nurses' Association of British Columbia stated the association's opposition to home deliveries as an alternative to hospital deliveries, adding that inadequate back-up services in British Columbia did not allow for safe home deliveries. The spokeswoman added that this policy position does not discredit home birth per se but instead emphasizes the importance of not undertaking domiciliary obstetrics without established access to emergency back-up services. The concept of nurse-midwives working in hospital settings, supervised by physicians, was recently endorsed by a joint committee of representatives from the Registered Nurses' Association of British Columbia and from the College of Physicians and Surgeons (Padmore 1983, A7).

Another potential area of conflict between midwives involves attempts to legitimize community midwifery practice. The Midwives Alliance of North America (MANA) comprises nurse-midwives and community midwives, and the Midwives' Association of British Columbia encourages membership of nurse-midwives and community midwives. Nevertheless, some certified nurse-midwife members have opposed the lack of clear standards of education and practice for community midwives (Campbell 1982). MANA representatives have sought to establish standards for "basic competency" for certified nurse-midwives and community midwives alike (Ventre and Leonard 1982, 23–4). The tension between certified midwives and other midwives is linked with a general trend toward professionalized health care, including nursing. Midwives may be concerned that the institutional structures of hospital-based births (with physicians and managers directing and assessing midwives' work) may undermine midwifery services (Kitzinger 1988, 10). There seems to be a tendency for certain tasks to be delegated to subordinates as organizations become more complex: for example, record-keeping and

scheduling, once deemed the bailiwick of doctors, have been delegated to nursing staff (see Hughes et al. 1958, 7; Growe 1991, 103).

Alternative Birth Centres

The introduction of alternative birth centres (ABCs) as a compromise between domiciliary birth settings and obstetrical wards is one example of innovation that results, in part, from consumer demands for the humanistic and flexible management of pregnancy and childbirth. For example, staff at a free-standing birth centre in Culver City, California, encourage families to remain together throughout labour. Women often choose a variety of delivery positions in these centres. Certified nurse-midwives are employed in the centre (Mittelbach 1986, 10). This apparently neat equation of birth innovations and public demands does not take into account the historic rivalry between various professional and non-professional associations (Freidson 1972). Nor does it address suggestions that ABCs do not significantly alter the incidence of obstetrical interventions.

With direct reference to alternative birth centres, DeVries (1980) contends that the apparent freedom accorded patients in ABCs is in fact used to consolidate the power of birth centre staff. Notwithstanding the homelike decor and espousal of unmedicated births, where possible, ABCs are characterized by unjustifiably high rates of invasive treatment, including analgesia, anaesthesia, episiotomy, and forceps delivery. DeVries (1984, 98) cites one study that documented a transfer rate of 46 per cent of patients from an alternative birth centre to a conventional labour and delivery suite. A televised documentary on home birth in the United States indicated that between 20 and 50 per cent of women entering an ABC will be transferred to operating rooms for forceps delivery, caesarean section, electronic fetal monitoring, and so forth (CBS News 1982). Establishment of birthing rooms within hospitals is another method of adapting settings to consumer demands, although it has been reported that in some hospitals the birthing rooms account for only a small proportion (in some cases as low as 3 per cent) of all births in hospital.

Some disagree that ABCs are in the best interest of pregnant women and infants. The growth of birth centres is tied to the professional interest of nurse-midwives, long subordinated to doctors' control through denial of hospital privileges and inadequate back-up services. The negative assessment of alternative birth centres (ABCs) is far from universal. Rothman (1983, 3–7) acknowledges that women giving birth in ABCs report satisfaction with their care.

Another point of concern arises from the failure to establish out-of-hospital birthing centres. An earlier proposal to develop an out-of-hospital clinic in Vancouver was not accepted by a federal funding agency. It was suggested by one person involved in the proposal that the lack of support among physicians was a factor in rejecting the clinic proposal.

Conclusion

Historically, midwifery programs in Newfoundland, Nova Scotia, Quebec, and Alberta "were designed to prepare nurses and others to care for mothers and babies in isolated areas" (Herbert 1993, 4; see also Field 1991, 5). With the decision to legalize midwifery in some Canadian provinces, midwifery training will provide a broader base of practice, such that qualified midwives will practise in urban as well as rural and northern settings. Broader access to midwifery training is also important. In Ontario the Bachelor of Health Science (Midwifery) program offered at McMaster University, Ryerson Polytechnical Institute, and Laurentian University provides for distance-education courses (in English or French at Laurentian). The program "will hold a number of spaces for aboriginal students" (Herbert 1993, 4). Such provisions are meant to increase access to training for prospective midwives. Relyea (1992, 168) favours midwifery programs that foster "the admittance of persons from a variety of backgrounds and educational preparation." In future, midwives will probably resemble Lesley Page's (1993, 1483–5) vision of the expert and "experienced clinician" who is aware of the available scientific literature and is able to act as a companion for expectant mothers.

MIDWIFERY DEMONSTRATION PROJECTS

The Low-Risk Clinic (originally called the "Hands-On Clinic for Nurse Instructors") was a pilot project that operated at the Grace Hospital in Vancouver from September 1981 until May 1984. The program remains in place in the new Grace Hospital in Vancouver, with six midwifery staff at the core of the project. It is now called the Midwifery Program. It is useful to look at the findings from one report published in the 1980s by those involved with this initiative.

In the Low-Risk Clinic, four nurse-midwives and four obstetricians worked together in caring for sixty-one women. This pilot project in a major hospital in Canada's third largest city was designed to provide safe deliveries of babies, to demonstrate the competency of

Table 18
Mode of Delivery

	Low-Risk Clinic		*Grace Hospital*	
Mode of delivery	*N*	%	*N*	%
Spontaneous	40	73.0	na	58.7
Forceps	9	16.0	na	19.8
Caesarean	6	11.0	na	21.5
Total	55	100.0	na	100.0

Source: Elaine Carty et al., *The Low-Risk Clinic* (1984: 25).

trained nurse-midwives in managing births with fewer interventions than occurred in conventional birth attendance. Continuity of care was sought. Extensive prenatal care was provided by the midwives, along with consultation with the physicians and nursing staff. It is important to note that the four women acting as midwives volunteered their time. In contrast, the current Midwifery Program involves one full-time staff member; another full-time position is split between two (part-time) staff. In addition, there is a director subsumed within the division of nursing at Grace Hospital.

The report on this project generally confirms the viability of more independent midwifery practice within a major hospital. A follow-up survey indicated that the clients were generally pleased with the project. One measure of the success of the project was the increased rate of spontaneous vaginal deliveries among the Low-Risk Clinic patients in comparison with hospital-wide statistics (see table 18). (As noted earlier, approximately 93 per cent of the attempted home births attended by the community midwives resulted in spontaneous vaginal deliveries.)

The report provides a useful description of specific policies and procedures for assessing the health of the woman and fetus throughout the pregnancy, as well as procedures for consultation with pediatricians, general practititoners, obstretricians, and nursing staff. An integral purpose of the clinic was to accommodate the wishes of the couple where possible and to ensure safe deliveries. The success of the Low-Risk Clinic led to the development of the subsequent Midwifery Project in the Grace Hospital. This ongoing project is an established part of the labour and delivery budget at the hospital. A midwife working in this service believed that such projects can be supported by physicians, and can benefit the obstetrical staff generally: "Exemplary nurse-physician relationships are alive in Vancouver. Our experience with one general practitioner in

the midwifery service at Grace Hospital is the best. Not only does this particular physician donate time and energy to the program, he supports and stands up for the midwifery cause, controversial as it is" (Robertson 1990, 5).

A pilot study of labour coaching by midwives in Toronto General Hospital supported the premise that midwife-assisted births provided fewer interventions than physician-managed births. The use of epidurals, forceps, and episiotomies was lower in the midwife-assisted sample (n = 51) than in the physician-managed sample (n = 58), although only the episiotomy rates (38 per cent and 18 per cent, respectively) achieved statistical significance. The pilot study supports findings from other studies in which intervention rates were found to be lowered through the involvement of midwives (Reid and Galbraith 1988, 1989–90). Although there is no systematic update of community midwives' work in British Columbia, the results described in this chapter correspond closely with birth statistics compiled by Carol-Anne Letty, a licensed midwife who has a home birth practice in Vancouver. Reviewing outcomes for home births (n = 30) and hospital births (n = 8) between July 1991 and June 1993, she noted that none of the thirty women who gave birth at home had had episiotomies. There were three caesarean sections, and the remainder delivered on their hands and knees (n = 18), semi-sitting (n = 10), side-lying (n = 4), and with a birthing stool (n = 3). No infant deaths occurred in this sample (Letty 1993).

A continuing difficulty in assessing the nature of contemporary birth attendance, including attendance in alternative birth centres, is the lack of information on particular centres. To some extent this lack has been overcome by recently published accounts of birth centres and nurse-midwifery practice in hospital settings in the United States. Several of these published accounts will be outlined here to indicate general themes and to underscore difficulties associated with evaluation studies from California, Arizona, Georgia, and Florida. These selected studies provide additional evidence in support of the safety of nurse-midwifery practice. More recent research has been interpreted very favourably with respect to birthing centres (see Lubic 1992). Perinatal mortality rates are lower than the average rate in the respective states and well within expected rates of perinatal mortality generally. There also tends to be a reduction in caesarean section rates, forceps deliveries, and the use of anaesthesia.

The incommensurability of these reports highlights a general difficulty of reportage (see also Wagner 1985, 114–15). Although reportage usually centres on conventional variables such as birth outcome, obstetrical interventions, and infant mortality and mor-

bidity, there is nevertheless a tendency toward unstandardized reportage wherein certain variables are presented and others omitted, without a clear statement of why some are deemed salient to the comparison of (nurse) midwifery practice with other birth attendants. This unstandardized method of reportage, along with missing data, impedes comparisons of findings pertaining to nurse-midwifery services.

The demonstration projects address a central tenet in the continuing debate over midwifery attendance: that midwifery attendance is uniquely suited to uncomplicated births. It has been asserted that "nurse-midwives are cost-effective because we can show improved neonatal and maternal outcomes with fewer medical interventions, because we provide safe births in less expensive out-of-hospital settings or for fewer hospital days, and because we can show that emotional support and education about nutrition, exercise, breastfeeding, and self-care are worthwhile" (Kraus 1984, 2). Haire (1981) contends that nurse-midwifery practice is superior to conventional medical attendance in many respects, particularly in promoting unmedicated births and reducing the incidence of episiotomies and instrumental deliveries. Haire combines her observations of maternity hospitals in Great Britain, Russia, western Europe, and elsewhere with more detailed observations of nurse-midwifery practice in the North Central Bronx Hospital, the Frontier Nursing Service in Kentucky, and the Su Clinica Familia in Texas. With specific reference to the North Central Bronx Hospital, of 2,608 midwife-assisted births in 1979, a relatively high percentage (88 per cent) delivered vaginally and spontaneously. Analgesia or anesthesia was resorted to in less than 30 per cent of all labours, while forceps and vacuum extraction together accounted for just over 2 per cent of deliveries. Over a third of women attempting a vaginal birth after a caesarean (VBAC) did so successfully. Nearly half (45 per cent) of births were done over an intact perineum, 26 per cent required episiotomies, and 29 per cent involved lacerations (a fourth-degree laceration occurred in 1 per cent of births studied). Haire's (1981) estimation of the importance of contemporary nurse-midwifery attendance is further reinforced by a study of a nurse-midwifery program in a county hospital in rural California. That study documented significant decreases in the rate of prematurity (from 11 per cent to 6.6 per cent) and the rate of neonatal mortality (from 23.9 per cent to 10.3 per cent) during the period (1961 to 1963) in which the nurse-midwives were active. Two additional points are of interest: first, such dramatic changes in these rates were not manifested in other regions of the county during the operation of the nurse-midwifery program; second, rates of

prematurity and neonatal mortality increased significantly after the program was discontinued. Among other factors, the researchers suggest that women receiving care during the three-year program were more likely to receive prenatal care and to begin prenatal contact earlier (Levy et al. 1971). This special status accorded nurse-midwives appears also in a recent discussion on malpractice liability of nurse-midwives. Certified nurse-midwives differ in terms of client satisfaction and participation, while the CNM's expertise and reputation for safety is retained. Nevertheless, litigation against American nurse-midwives increased in the 1980s, and is expected to continue as midwives widen their ambit of practice (Sinquefield 1983).

Nurse-midwifery practice in Canada, the United States, Britain, and elsewhere is characterized by the movement toward professionalized health care. The professional standard of care is achieved through specialized instruction (academic and practical), supervision by governing bodies such as nursing colleges and specialized associations, and the formulation of overarching standards of patient care. Just as midwives face contradictions in health structures (see Kitzinger 1988), so also are nurses subject to pressures of overwork and counter-pressures to recognize the value of their work and their ability to function more autonomously (Growe 1991). There are also pressures to develop feminist-based curricula in nursing, and to highlight the exclusion of some visible minorities from the profession (see Hedin and Donovan 1989; hooks 1989).

The current status of midwives with nursing accreditation may well be rising above the sometimes disparaged status of obstetrical nursing (see Hughes et al. 1958, 85). Nevertheless, in terms of prestige it is still conventionally ranked well below the medical specialties such as obstetrics (Lin 1976).

MIDWIFERY PRACTICE AND FORMAL AUTHORITY

The contradiction between professional training and the formally subordinate status of nurse-midwifery (whereby nurse-midwives may be supervised by doctors in order to practise) may lead to informal, covert tactics to circumvent legal and professional strictures on practice (see Hughes et al. 1958, 64–72, 172–3). These informal tactics may be quite effective in allowing midwives to practise their skills and in reducing interventions deemed unnecessary by the midwives. An important point, however, is that the circumvention of physicians' authority is substantively different from direct challenges to a physician's judgment. Concerns about professional prestige can

be linked with the manner in which formal authority impinges on, or threatens to impinge on, midwifery practice. Midwifery practice is subject to a variety of cultural, legal, and social rules in British Columbia and other provinces. It is important to remember, however, that midwives can circumvent some of the intrusions of technology and official gatekeeping. Direct challenges to official authority are sometimes avoided through appeals to orthodox authority, even fictional ones. A senior community midwife offered this vignette: "I did a birth up in Lund, near Powell River. I flew up there. The only problem I had, and this was something I hadn't considered, was that I had to fly from Vancouver International Airport and I had to go through the metal detector machine. And so the security officer said 'What's this?' when the birth kit was detected. I was quite embarrassed and I wasn't quite sure how to explain myself. I wound up saying that my husband was a doctor and that I was taking some equipment up there for him."

Passing through an airport checkpoint is one obstacle; the threat of prosecution for criminal or quasi-criminal offences is quite another. The following excerpt from an interview with a senior community midwife illustrates some dynamics of state measures of power and offsetting resources drawn upon by a midwife under official scrutiny.

The only time the legality issue came up for me was with a birth several years after I began doing primary care births. I had a really bad feeling about this birth and for the first time of all the births I attended I had three other primary care midwives assisting me with this birth. I still had this bad feeling but I couldn't pinpoint anything to screen her out (from attempting a home birth). Even her physician said I was being paranoid.

Anyway, the birth was fine and the baby was fine. Afterward I wondered why I had been so uptight about this birth. On the fifth day the mother called me to say that her baby had died in her sleep. I should have said that she shouldn't call anyone, the police, ambulance – until I arrived.

It was a 20-minute drive to her place and when I arrived the police and ambulance were already there. Now, the unfortunate thing is that my client was a single mother on welfare and the police officers treated her badly, suspiciously. It was completely out of the question that this woman would have injured her daughter. The police officers found out that the baby had been delivered at home, with a midwife present, and by the time I walked in the door they had been given my name. I took the mother to the morgue to see the child. When we returned the police wanted to question us in separate rooms.

I was asked a few questions off the record. The policeman didn't understand this situation. He said, "Who's illegal here? Is she (the mother) illegal?

Are you illegal?" "Who's in trouble?" is essentially what he was asking. I explained that midwifery is illegal and that if anyone was in trouble it would be me for practising midwifery without a licence. The police officer then asked me if I was a midwife. I said, "Do you think I should answer that, or do you think it would be really incriminating?" He said that I probably shouldn't answer, and he agreed with me that the mother probably shouldn't answer any more questions at this time.

The mother needed to talk. She wanted to settle these questions immediately. But when the officers said they wanted to take her to the station for questioning, I said "forget it." The mother was grieving, she was very shocky. The officers were angry with me for protecting her and said that they would get to me next, and that I would have to go to the police station. They asked the mom if she had beaten her baby – there were no marks on her body and I knew they didn't have any right to take her anywhere. I told them to get out. The mother wanted to be interviewed, however, in the house, so I told her not to answer any more questions. I glanced down at the officer's sheet. There were two questions: Was she your midwife? (she said yes) and did you pay her? (yes). The last question made me feel "Oh man, I'm in trouble."

That night I cleared out birth records, equipment, books from my house. It is frightening to think of having my records confiscated by the police: the records are invaluable to a midwife. I was informed by the police that I would be charged with criminal negligence causing death. They were awaiting the results of the autopsy report. It took 48 hours for the report to be completed and the conclusion was that the baby died of SIDS [sudden infant death syndrome]. Then I was threatened with a possible charge of practising medicine without a licence under the Medical Practitioners Act.

I was so relieved that the criminal charge had been dropped. The Midwives' Association of B.C. held an emergency meeting to discuss strategies if I was charged under the Medical Practitioners Act. I was enthusiastic about the trial. We decided that we would encourage consumer picketing of the trial, and that we should invite experts from Holland and the U.S.A. to speak to the issue of medical monopolization of birth in this province. However, my client contacted me after a visit from the police. She was told that the charge against me would be dropped. Now, they had plenty of evidence against me: her statement, for instance, and I had provided documentation of the birth (Apgar scores, and other details). My understanding was that the British Columbia Medical Association representatives were unwilling to launch a prosecution that would rally support for midwifery. I think that they wanted to make me sweat about it, but the charge never materialized.

This account draws together a few central themes in the control of deviance and legal measures. The first is that there are points of support that the midwife could call upon: careful documentation of

prenatal care, labour, delivery, and prenatal visits; her efforts to check on the mother's and infant's health (through the physician and the presence of three other midwives); and her cooperation with the authorities up to a point. It also dramatizes her suspicion of police activities. At another point in the interview she confided that she had destroyed numerous birth records after a (false) rumour that her house might be searched for evidence. In retrospect, she said she might have stored them safely away, but this would raise new problems, including confidentiality.

The broader point of support is the resources of the Midwives Association, and, beyond that, plans to involve other practitioners in a direct challenge to the illegal status of midwifery in British Columbia. It seems that this is a clear example of of the danger of assuming that midwives are defenceless against official powers of the state and the interests of the medical profession. Women do organize against some restrictions on reproductive rights, as evidenced a variety of associations that represent or support midwives. These include the Association of Ontario Midwives, the Midwives Association of British Columbia, the Alberta Association of Midwives, the Midwives Association of Saskatchewan, the Association of Nova Scotia Midwives, the Midwifery Coalition of Nova Scotia, the Association des Sages Femmes du Québec, the Alliance Québécoise des Sages-Femmes Practiciennes, Naissance-Renaissance, the Alliance of Nurse-Midwives, the Maternity and Neonatal Nurses of Newfoundland and Labrador, the Midwives Association of North America (MANA), the Canadian Confederation of Midwives, and so forth (Canadian Confederation of Midwives 1992).

The general principle that the state ought not interfere in private matters without good reason is also a check on state intrusion, especially in the ordinarily private sphere of reproduction and family relationships (Burtch et al. 1985). Parents may act as a resource for midwives by vouching for the midwife, protecting her, and threatening to embarrass officials. The following is extracted from an interview with a community midwife in the mid-1980s.

Q: Have you ever had pressure or interest expressed in your work by the police or the courts?

A: Every time the medical profession [in a city outside the Lower Mainland area] caught wind of my attending a home birth they reported it to the British Columbia Medical Association, the RCMP [Royal Canadian Mounted Police], or both. I had a situation with a very fast, a precipitate birth with a woman who was a VBAC [vaginal birth after caesarean section]. The couple was over an hour from a major hospital and while I didn't agree outright to

assist at a home birth, I said that I would respect the woman's wishes. I left their house while the woman was in labour, just to visit my children who were nearby, and I was called back because the woman was pushing.

By the time the other midwife and I returned, it was a precipitate birth, a good portion of the baby's head was showing. At birth, the baby was totally "shocky" [in shock]. We resuscitated the baby – which wasn't difficult to do in this case – and as a standard procedure in CPR we called for an ambulance. The paramedics took 20 minutes to get there and they were no help. I asked them to wait until the placenta had been delivered. (This was a precipitate delivery and there is a greater chance of hemorrhage with these deliveries). They asked "was this a planned birth?" and just snooped around the house. Then they said they couldn't stay in the house because they both had to listen to the radio (dispatches) in the ambulance.

What happened after that was that doctors, on reviewing the ambulance calls for that month, reported this incident to the police and the BCMA [British Columbia Medical Association]. The police visited the mother several times. Every time the mother referred to me as "her friend." [She would say] "It was lucky that my friend was there." She also promised to pull apart the ambulance service publicly. I got a real sense of persecution ... To be on the safe side I moved my supplies and birth records to a friend's house. This was the only real occasion that the police were involved: I am aware that the BCMA and the police were contacted on a couple of other occasions, but nothing happened.

This account underlines the ways in which prosecutorial power can be restricted. An autopsy report that would be ammunition for the defence is pertinent here, just as the lack of witnesses and other events can hinder prosecution efforts (Osborne 1983). On a far broader level, midwives have received out-and-out support from such groups as the International Childbirth Education Association and the Federation of University Women (Ontario 1992).

It is a mistake, however, to exaggerate the powers of community midwives. Action has been taken against practising midwives in British Columbia, Ontario, and Nova Scotia; charges were contemplated, then dropped, against midwives involved in the delivery of twins in Winnipeg in 1990. Community midwifery is primarily affiliated with home birth (although some community midwives also provide labour coaching in hospital and prenatal classes), and their clientele is quite limited in number. Only about 1 per cent of births in contemporary British Columbia occur out of hospital, and a number of these are not planned home births. There is thus a considerable difference between the situation of the community midwife in British Columbia and that of the village midwives in Third World

countries, where a great proportion of birthing in outlying areas is managed by traditional midwives (see Peng et al. 1972, 25–8).

The dominant cultural perspective on childbirth emphasizes risk to the mother and infant, the superiority of professional medical and nursing attendance, and the value of institutionalized birthing in hospital settings. Community midwives have drawn on a variety of evaluation studies of the place of birth and the issue of safety to argue against the assumption of greater safety in hospitals; they have also relied on their own experience in assisting thousands of Canadian women to give birth over the past two decades. This said, the cultural emphasis on hospital deliveries remains deeply rooted today and is unlikely to be substantially dislodged in the future.

The practice of midwifery is connected with legal rules surrounding childbirth, which are in turn closely aligned with the state authority. In a politically organized society, laws are ostensibly made in the public interest. This is quite clear with respect to the formulation of provincial medical acts in Canada. Such legislation affords medical practitioners a monopoly status over a variety of diagnostic and clinical activities; it also vests in physicians considerable powers of professional self-regulation through disciplinary hearings concerning professional misconduct and alleged incompetence. Time and again such monopolistic legislation is defended on the basis that it serves to protect the public interest. Professional monopoly status should ensure the highest level of training and peer scrutiny. Clearly, this presumption cuts across another cultural belief in the value of competition as it may affect standards, along with the freedom to choose one's occupation. It is evident that as work has become more professionalized and bureaucratized, the legal regulation of work has heightened. This regulation includes the attempt by occupational groupings to secure their market status by excluding rival groupings (Reasons and Chappell 1985; Giddens 1982, 188). Alternative groupings such as the Midwives' Association of British Columbia are more likely to be assessed in terms of their "integrative function" – that is, the intrinsic value of such groups as perceived by their members. These alternative groups nevertheless must contend with extrinsic factors that encouraged their members to become more professional, to establish standards, to be governed by other more established organizations such as a nurses' college (Light 1981).

There is an overt political dimension to some varieties of lay midwifery. A common theme is that obstetrical knowledge is deliberately restricted to medical (and nursing) personnel, that alternative practitioners continue to be outlawed while a medical monopoly is preserved, and that profit and male dominance in the structure of health

care are an integral part of current childbirth practices. This critique is accompanied by the advocacy of collective, non-hierarchical options for women seeking to practice health care and for their clients. It may also be extended to caution midwives about accepting the dominant methods of evaluating midwifery care. The danger, it is said, is that women giving birth, and their attendants, can have their experiences distorted by "scientific" studies of birth management (see generally Kirby and McKenna 1989).

SUMMARY

Studies of community midwifery practice and of the practices of "legal" midwives active in birthing centres and hospitals in the United States lend weight to the argument that midwifery care can be beneficial for women giving birth and their infants. In Canada, community midwives appear to be successful in reducing rates of instrumental delivery; similarly, they appear to achieve results comparable or superior to those of conventional hospital-based deliveries in terms of infant mortality and morbidity. Nonetheless, there are some deficiencies in the informal practice of midwifery, and instances of unsafe home birth practices have been reported.

For nurse-midwives, there is little to support past or present allegations that their work is inferior to physician-presided birth attendance. Indeed, there is decisive evidence that nurse-midwives can contribute in tertiary care as well as primary care settings. With respect to the community midwifery movement, however, there is concern that unregulated midwives may practise outside safety guidelines. Some infant deaths in Canada have been attributed, at least in part, to unsatisfactory midwifery. Community midwives operate without the protection of a Midwives Act and without the material resources and organizational structures available to their medical and nursing counterparts. Moreover, when they initiate midwifery practices or establish a midwifery school they face the threat of prosecution or the problem of limited funding.

The significance of the community midwifery movement can be linked with other attempts to decentralize institutionalized processes, including the management of death in hospices or at home, the victims' rights movement in criminal justice, and efforts to establish alternative (informal) dispute resolution through mediation (Christie 1978). The situation of nurse-midwives in many jurisdictions is complex, inasmuch as they are often highly trained and often assist fully in uncomplicated deliveries. In Canada, however, their presence has been and continues to be fairly restricted. The current

attempts to establish demonstration projects have been only partly successful. The proposal to staff a clinic outside a hospital setting was not accepted in 1979, and the Low-Risk Clinic in the Grace Hospital has been replaced by a different structure in which nurse-midwives do not provide the same continuity of care to expectant mothers. The clinic is nonetheless a recognition that the nurse-midwife's conventional role can be expanded in response to consumer demand and to lobbying for greater autonomy from within the nursing profession. Muzio (1991) favours a cooperative model whereby midwives define their own educational programs and work collaboratively with nurses.

While resistance to the hegemonic powers of the state and the professions is evident, the end result is not a marked diminution of those powers. The following chapter reconsiders legal regulation of midwifery practice in Canada; chapter 6 examines the future of world midwifery services.

CHAPTER FIVE

Midwives and the Law

INTRODUCTION

A trial of labour, in obstetrical terminology, refers to a situation where a woman may not be able to deliver vaginally because of suspected cephalopelvic disproportion, or where a woman has previously given birth by caesarean section and is being "allowed" to labour for a prescribed period of time before intervention (Cohen 1991). This terminology seems apropos for midwives in conflict with the law in Canada. Unproved, not yet established, and open to suspicion for their practices and motives, midwives in Canadian jurisdictions face an unsettled, tentative situation in law and in the health-care system. The medical profession and state authorities have become gatekeepers in the supervision and vetting of women's choices in reproduction.

This chapter provides a detailed look at key cases that have shaped the midwifery movement. While the focus is on Canadian cases heard in the past decade, it is important to consider the earlier discussion of how laws and medical ideology coincided so as to eliminate or vastly restrict midwifery practice in Canada and many other countries. According to the midwives themselves, what they are seeking is not an opportunity to prove themselves within the limits of pilot projects or short-term experiments, but recognition of their skills. By and large, their efforts have been bent toward respecting women's wishes – whether the women wish to give birth in a private setting or with a crowd, and whether they wish to give birth at home, in hospital, or in intermediate settings such as alternative birth centres.

A common denominator for midwives actively involved in the Midwifery Task Force of British Columbia and the Midwives Asso-

ciation of British Columbia is the desire for legalized, autonomous midwifery. Few midwives are willing to continue to practise without an assurance that the law will not be invoked against them. The threat of criminal prosecution, a coroner's investigation, or charges of practising medicine without a licence is ever-present for community midwives. This discouraging of midwives and their supporters is not peculiar to Canada. Odent (1986, 133) notes that in the western world doctors supportive of home birth often face professional criticism. He adds: "With the training of midwives as it is at the moment, not only are we not getting authentic midwives, but we are often stopping the careers at an early stage of those women who genuinely want to help other women at birth. This is done either by hassles with authority, or because it is hard to earn your living this way."

These threats are sometimes acted upon. In British Columbia two midwives were found guilty of criminal negligence following an infant's death at an attempted home birth. Other midwives have been subject to coroners' inquests or inquiries, and in at least one case serious consideration was given to criminal prosecution following an infant death. In Alberta an established community midwife, Noreen Walker, was charged in 1990 with practising medicine without a licence. In such cases, an infant usually dies or sustains serious injury before a complaint is made. In Walker's case, however, the delivery was successful, and no complaint was registered by the parents (Jiminez 1990). Such legal actions often have a devastating effect on attempts to develop midwifery practice.

Not surprisingly, many midwives have stopped attending home births, partly because of fear of legal action. Lacking legal protection for home birth attendance, and still unwelcome as bona fide practitioners in hospital settings, community midwives have dwindled as a force throughout British Columbia. In 1983 approximately twenty midwives were active in the Lower Mainland; in 1993 only fifteen midwives continued to attend home births. As the birthing population increases, midwives have fallen in numbers. Before discussing the current parodox of legal prohibition in the face of continuing support for women's options in birth, it will be useful to review some historical aspects of laws directed against midwives. Some statutes are quite specific in prohibiting midwifery practice, while at common law charges of criminal negligence are potentially applicable to any citizen. As noted below, however, midwives tend to be the scapegoats for criminal prosecution, unlike more established workers in medicine and nursing.

THE UNLAWFUL PRACTICE OF MEDICINE: QUASI-CRIMINAL LAW

Well into the nineteenth century, "midwifery" in North America meant folk or lay midwifery. Licensure was not required, and the extensive apparatus of licensure, legislation and litigation that now characterizes the health professions was very likely unanticipated by indigenous peoples or the early generations of settlers in Canada. With the growth of state authority, however, as well as increased populations and the burgeoning professions of nursing and medicine, childbirth became a site for struggles over who ought to attend births.

As indicated earlier in this book, women's customary assistance of women in childbirth has generally been replaced by a professional monopoly on birth attendance. The traditional birth culture of home remedies and neighbourly assistance – sometimes complemented by a call to a country doctor or local nurse – has been overtaken by modern, professionalized structures of care. These structures were not established without controversy, nor were they impeded by legal protection for many of the folk midwives. In nineteenth-century Ontario, for instance, the right to practise midwifery (independently of physic or surgery) was eventually restricted to medical practitioners (Biggs 1983). The takeover of birth attendance was not so one-dimensional. The right of women to practise midwifery without a licence was recognized in the first legislation passed in Upper Canada. Enforcement was problematic at this time, owing to the limited number of doctors in what was then a predominantly rural region. Nevertheless, section 49 of the Ontario Medical Act held that "it shall not be lawful for any person not registered to practise medicine, surgery or midwifery for hire, gain, or hope of reward, and if any person not registered pursuant to this Act, for hire, gain or hope of reward practises or professes to practise medicine, surgery or midwifery, or advertises to give advice in medicine, surgery, or midwifery, he shall, upon summary conviction thereof before any Justice of the Peace, for every such offence, pay a penalty not exceeding $100 nor less than $25" (see Biggs 1983).

An important qualification was that the alleged illegal practices must encroach on medical practice, and that isolated episodes would not sustain a conviction. Where prosecution under provincial legislation was anticipated, presumably complainants and prosecutors alike would have to contemplate whether these loopholes would affect the likelihood of conviction. As Mr. Justice Garrow indicated:

"The thing practised must, to be illegal, be an invasion of similar things taught and practised by the regular practitioner, otherwise it does not affect the monopoly, and is outside the statute. And it must be practised as the regular practitioner would do it – that is, for gain, and after diagnosis and advice. And it must be more than a mere isolated instance, which is sufficient to prove a 'practice'" (*Re: Medical Act [Ontario]* 1906, 513).

The obligation to prove more than a single act had been upheld in a number of precedents. The conviction of a Toronto midwife under section 49 of the Ontario Medical Act was reversed on appeal. The Appeal Court found that the Crown had not established that the midwife had practised medicine on more than one occasion, and further that she had not always received financial gain through her actions (*R. v. Whelan* 1900). The necessity to prove that financial gain was received and that the illegal practice of medicine occurred repeatedly was crucial in the acquittal of another accused person. The judge in *R. v. Armstrong* (1911) held: "Before an accused person can be convicted of falsely pretending to heal the sick, it is necessary that it be shown that the accused was in the habit of so pretending, or at least that there had been continuous treatment, the principle being the same as practising medicine for gain or hope of reward. An isolated case is not sufficient to secure a conviction." A subsequent decision by Mr. Justice Simmons in *R. v. Cruickshanks* (1914) confirmed that a single act does not constitute the practice of medicine or a trade.

As the state has deliberated over birth-related law, the criterion for an offence has been broadened. In Ontario, the common law rule that "practice" implied repetition of the offending act was altered. A single act was deemed sufficient to establish the practice of medicine. Nevertheless, the prosecution of midwives was not always successful. One criminal conviction of a midwife in the Northwest Territories was quashed on appeal. The court held in *R. v. Rondeau* (1903, 478–83) that section 60 of the Medical Profession Ordinance did not include "midwifery" as a form of practice to be covered along with "medicine" and "surgery." Since section 60 had been composed with reference to the earlier Ontario Medical Act, which prohibited midwifery, medical, and surgical practice by unregistered persons, the court reversed the conviction. The turn-of-the-century *Rondeau* decision was brought forward 90 years later, in the trial of Noreen Walker (discussed below).

Legal prohibitions on the practice of medicine thus served to protect unregistered practitioners, but only to a degree. Lawmakers and judges of the day seemed well aware of the need to facilitate medical

practices, and were undoubtedly influenced by the ostensibly progressive spirit of replacing untrained midwives with medical specialists and trained nurses. The courts were not always bloody-minded about who ought to be punished for infractions of the law. Technicalities seemed not to carry the day. In *R. v. Ornavowski* (1941), an orderly accused of practising midwifery and practising medicine, both for "hope of reward," was acquitted on both counts. The court held that the accused orderly had assisted a woman following delivery when no doctor was available to her; that is, he acted in emergency circumstances and did not attempt to charge for his attendance. On the second count, although the accused had on two occasions filled in blank prescription forms, taken patients' temperatures, and given instructions as to treatment, there was no proof of payment or a request for payment by the orderly.

The corollary was also true. Persons practising medicine on more than one occasion and seeking payment for their advice could be convicted (*Provincial Medical Board v. Bond* 1890). The County Court decided in favour of the defendant following a charge under the Medicine and Surgery Act of 1884. The defendant had treated people with plaster and given advice on the use of poultices for people suffering from tumours and cancer. On appeal, however, the initial judgment was reversed: a penalty of $20 for one day's practising and court costs were imposed on the defendant.

About two decades later, in a case heard in Saskatchewan, Mr. Justice Trant declared that the rights of unregistered practitioners are limited and sharply defined. They must not offer diagnosis, give advice, or prescribe medicines (see *R. v. Raffenberg* 1909, 419).

The practice of midwifery in British Columbia has generally been legally protected as the bailiwick of medical practitioners. Section 72 of the British Columbia Medical Practitioners Act stipulated that "(1) a person who practices or offers to practice medicine while not registered or while suspended from practice under this Act commits an offence. (2) For the purposes of and without restricting the generality of subsection (1), a person practices medicine who ... (d) prescribes or administers a treatment or performs surgery, midwifery or an operation or manipulation, or supplies or applies an apparatus or appliance for the cure, treatment or prevention of a human disease, ailment, deformity, defect or injury."

It is important to note that alternative practitioners may be acquitted on charges of the unregistered practice of medicine. In *R. v. Wong* (1979) the court held that the art of acupuncture was not recognized as a branch of medicine by the Alberta College of Physicians and Surgeons. Moreover, acupuncture was not taught in North American

medical education. A later conviction of an acupuncturist in British Columbia occurred despite the reasoning in *Wong*. It was held that the defendant had violated the provincial Medical Practitioners Act.

Under section 83 of the Medical Practitioners Act, the minimum penalty for a first offence of practising medicine or midwifery is $100 or imprisonment (section 87). The penalty is $300 or imprisonment for a second conviction, and imprisonment for a third or subsequent conviction. It must be kept in mind that the court has the power to dismiss charges against defendants when the information is insufficient. In one instance where a defendant was charged under the British Columbia Medical Act the information alleging the unlawful practice of medicine was quashed since it failed to set forth the act or acts constituting the alleged offences and failed to name the patients upon whom the defendant was alleged to have unlawfully practised medicine (*R. v. Kripps* 1977).

Under section 73 there are several exceptions to the broad ambit of medical practice set out under section 72. The following practitioners do not practise unlawfully while registered under their respective acts: chiropractors, dentists, naturopaths, optometrists, pharmacists, podiatrists, psychologists, nurses, and dental technicians. Orthotic technicians, physiotherapists, and dieticians may also be exempt from section 72. The legal standing of these practitioners and their self-regulation through professional associations qualifies the purely instrumentalist approach to medicine as an élite profession that is able to monopolize health services. Emergency procedures are permitted under the British Columbia Health Emergency Act. Domestic administration of family remedies is permitted, and religious practitioners "who practise the religious tenets of their church without pretending a knowledge of medicine or surgery" are exempted under section 74 of the act.

The common practice in Canada has been not to charge midwives with practising medicine without a licence unless there has been some tangible damage to the infant or mother in the course of a home birth or during a transfer to hospital following an attempted home birth. Thousands of births have been attended by midwives in Canada in recent years, with very few complaints registered by the parents concerned. In a sense, this testifies to the bond between midwives and their clients, a bond that is clearly not legally recognized. The discretionary power to prosecute midwives for unregistered practice, while rarely exercised, is dormant, and can be brought forward or at least considered.

As a rule, the prosecution of a midwife for unregistered practice would occur only if there was demonstrable harm to the mother or

infant. Even so, few such charges had been brought forward through the 1980s in Canada. The prosecution of Noreen Walker is one exception. Walker, a community midwife in Alberta, had practised for over a decade, attending over a thousand births. She was active in supporting women who desired to give birth at home, including those who wished to attempt vaginal birth after a caesarean section. The VBAC option in a home birth is one that is almost universally decried by medical and nursing bodies, but one that has not been proved less safe than hospital-based VBAC (Sufrin-Dusler 1990). Even though the mother, Katherine Charpentier, and the infant were not injured in a VBAC performed at home, Walker was charged as follows: "On or about the 4th day of May, A.D. 1990, at or near Castor, in the Province of Alberta, not being a registered practitioner, [the defendant] did practice or profess to practice medicine, contrary to s. 76 (1) (a) of the Medical Profession Act."

The case was heard before the Alberta provincial court. The Crown called its expert witnesses and other witnesses, ostensibly to call into question the legality of a midwife assisting with VBAC deliveries at home, and perhaps the nature of the defendant's midwifery practice in general. The defence lawyer arranged for expert witnesses to speak in support of the defendant. Moreover, the nature of the defence rested on attempts to challenge the constitutional validity of sections of the Alberta Medical Profession Act. The Notice of Constitutional Question (a notice pursuant to section 4 of the Alberta Bill of Rights) filed by the defence counsel challenges sections 76 and 77 of the act.

(a) Section 76(1) creates an absolute liability offence, or alternatively a strict liability offence, for which imprisonment is a possible sentence, thereby offending s. 7 of the Canadian Charter of Rights and Freedoms [hereinafter "the Charter"].

(b) To the extent that Section 76 creates an offence for the practise of midwifery by a person who is not a "registered practitioner," the section offends s. 7 of the Charter by limiting the life, liberty and security of the person of midwives who are not physicians and surgeons and by limiting the life, liberty and security of the person of women who wish to retain the services of midwives in preparation for and during childbirth.

(c) Section 77 offends s. 11(d) of the Charter by requiring a trier to find that an accused person "practices" contrary to s. 76 where such person does not "practice" but merely does any of the things mentioned in s. 77.

(d) Section 76 and s. 77 offend s. 2(b) of the Charter by purporting to create an offence for professing, or by way of advertising, sign or statement,

or by way of claim, makes [sic] certain statements without any requirement of proof of "practise."

(e) Section 76 offends s. 15 of the Charter by discriminating on the basis of sex in that midwives are predominantly women and the section is aimed in part at the suppression of midwifery; or alternatively, by discriminating on the basis of geographic location against midwives who practice midwifery within the limits of a city, town or village having a resident registered practitioner in midwifery therein [notice prepared by the defence lawyer, Simon Renouf].

The notice also alludes to possible violations of part of the Alberta Bill of Rights. The breadth of section 77 (persons who are deemed to practise medicine) is clearly open to interpretation, as is what is meant by the practice of medicine. In the Walker case, VBAC, especially in a home birth situation, was presented by the Crown as a medical procedure. The options of women to give birth in a preferred setting, limitations on doctors' skills or willingness to permit VBACs, and the failure to demonstrate statistically that VBAC women are at greater risk than other women in birth seemed to be part of the defence counsel's efforts to challenge the charge against Walker. Testimony at trial included statements by physicians concerning the inadvisability of attempting a VBAC at home. Other testimony pointed to evidence that VBAC risks have been exaggerated in medical training. Charpentier's obstetrician, Dr. William Young, was alleged to have stripped her membranes without her consent, a procedure not recommended for women seeking a VBAC. Professor Peggy Anne Field, then the president of the Alberta Association of Midwives and a professor of nursing at the University of Alberta, stated that while she would not attend a VBAC at home, "women's choice is paramount" (Williams 1991, 498.) On 5 June 1991, Judge Paul Adilman granted the defence's request for a "directed acquittal," meaning that Walker did not have to take the stand in her own defence, nor did her lawyer, Simon Renouf, need to call his expert witnesses. Judge Adilman noted that while Walker had clearly practised midwifery, "nowhere can I find evidence in this case that Ms. Walker was practising medicine. This was a normal, natural and uncomplicated birth" (see Moysa and Aikenhead 1991).

The legal issues surrounding childbirth become even more complex when one considers the liabilities of parents. In the United States the parents' duty of care has traditionally begun with the birth of the child: there has been no obligation on the part of the mother, for instance, to seek medical assistance prior to the birth. Nevertheless,

there appears to be a shift in legal opinion whereby a parent's failure to obtain medical care in circumstances where such care is clearly warranted ought to be culpable (Annas 1977, 180). Parental liability is also an issue with respect to responsibility surrounding midwifery attendance in jursidictions where it is illegal. Klein (1980) stated that the choice of a birth setting – and, by extension, the choice of birth attendants – is the responsibility of the expectant mother. I examined a number of documents (medical histories and midwives' notes made during prenatal visits) that also contained a waiver, signed by the mother (and father, where applicable), which purported to absolve the midwife from liability. Members of the Freemont Birth Collective (1977) linked their philosophy of parental responsibility and decision-making with a non-hierarchial approach to birth management:

> Working as a team throughout pregnancy and labor, prospective parents and workers all share in the responsibility for the situation. The woman who is pregnant or in labor, and her support people, are the ones who ultimately make the decisions about what to do, how to proceed. Especially because we're not certified in any way, we're concerned that people analyze their level of comfort working with us. We encourage people to educate themselves as much as possible, consult the statistics we have kept, ask us lots of questions, talk to others who have experienced obstetrical care in other settings, and to make conscious decisions to really think about what they want and to make intelligent judgements.

On another level, legal actions are conventionally brought against the birth attendant, not the expectant mother. This locus of responsibility avoids a direct confrontation with parental rights, and at the same time defines the legal conflict as essentially a dispute pertaining to occupational licensure. Legal protections for unborn children have also been strengthened. In Canada and in other industrialized countries the unborn child has been vested with certain rights. As discussed below, the *Marsh* case in British Columbia held that a child at term – but not yet expelled from the mother – was a person and entitled to protection. As the "human status" of the infant has been explored (Raphael 1975, 67), there appears to have been a rise in litigation in the event of injury or death to fetuses or infants.

The conjunction of medical knowledge and the legal protection of medical practice is best suited to the structural motif of power. The mechanics of touch, palpation, measuring, and viewing of the pregnant woman or fetus have become centred in hospital-based obstetrics, and other forms of practice have been largely excluded. Professional interests are thus protected, even though there has been

some erosion of the monopoly status of physicians under quasi-criminal statutes. A related point is that the various medical acts and health disciplines and professions acts serve to enable physicians to practise with little interference. They are enabling of medicine, and stand in stark contrast to their potential repressive application against non-physicians not covered specifically by such acts.

CRIMINAL PROSECUTION OF BIRTH ATTENDANTS

An examination of criminal prosecutions of midwives is crucial to understanding how legal encumbrances have affected midwifery practices, particularly in North America, where midwives' status at law is unsettled. Criminal sanctions can be severe; under Canadian criminal law, the maximum penalty for persons convicted of criminal negligence causing death is imprisonment for life (Bourque 1980). Criminal charges against midwives increased as home births attended by midwives became more prominent in the 1970s and 1980s. Two cases involving midwives charged following infant deaths are reviewed below. We begin, however, with the *Marsh* case, involving an ex-physician charged with criminal negligence in British Columbia.

R. v. Marsh (1979)

In *R. v. Marsh* a spiritual healer (and former doctor) was acquitted on a charge of criminal negligence causing death. The Canadian Criminal Code stipulates that criminal negligence occurs when a person, through commission or omission, shows wanton or reckless disregard for the lives or safety of other persons. The omission or commission must be associated with something that is his or her duty to do. Section 220 (formerly section 203) states that "every one who by criminal negligence causes death to another person is guilty of an indictable offence and is liable to imprisonment for life."

Midwives are quick to point out that Margaret Marsh was not a midwife as such. She had practised as a physician, had not completed a formal course or programme in midwifery, and had not had the benefit of continuity of care with the expectant couple. Marsh had agreed to attend the birth late in the pregnancy, when the couple's midwife was not available.

In the *Marsh* case, the infant's death was attributed to cerebral hemorrhage due to a tear in the tentorium of the skull. This tear was in turn associated with malpresentation of the fetus at term. The legal

actions that followed the infant's death were twofold. First, a charge of criminal negligence causing death was laid against Marsh, who had been dropped from the rolls of the College of Physicians and Surgeons of British Columbia. Second, following her acquittal on the above charge, a quasi-criminal charge of practising medicine without a licence in contravention of the British Columbia Medical Practitioners Act was successfully brought against her (McIntyre 1983).

In his reasons for judgment Judge Peter Millward concluded:

> Mrs. Marsh first became aware of the unusual and dangerous position of the child when the first foot appeared. By then, the evidence clearly shows it was too late to save the child from the injury that it suffered, or at least on the evidence, it is most unlikely, given the situation, that is a lack of skilled personnel present, the distance in time and space from the hospital, and the lack of any previous arrangements having been made ... On that finding, and with reference to the acts or omissions of Mrs. Marsh from the point in time when the foot first emerged, there cannot be a finding of criminal negligence causing death arising out of those acts or omissions, and accordingly, if any criminal liability is to be attached, it must be found in her acts or omissions prior to that point in time ... a most important point, in my view, is that there is no evidence whatever of any doubt, in the mind of Mrs. Marsh as to the position of the child at that point.
>
> Accordingly, while Mrs. Marsh may have been incompetent, yet I am faced with the evidence of eminent authorities called both by the Crown and by the Defence, to the effect that even the most expert and experienced practitioners do make mistakes from time to time in detecting the position of fetuses in circumstances similar to those which obtained here.
>
> I am faced with that clear evidence and a total lack of any positive evidence of a wanton or willful disregard. I am unable to conclude that any act or omission of Mrs. Marsh, prior to the emergence of the foot, was indeed negligent, and certainly I am unable to conclude that it was criminally negligent.

The *Marsh* case attracted wide media coverage and drew public attention to arguments for and against midwifery. Part of the defence strategy involved raising questions about women's birth experiences in hospital and in other settings. Even in the face of medical opposition to the idea of home births and independent midwifery practice, some medical practitioners are aware of the motivations of women seeking alternative birth care. Dr. Bernd Wittmann, an obstetrician familiar with the midwifery movement in Canada, made the following observations of birthing cultures: "When I arrived 20 years ago in Canada, coming from a European country where midwifery was fully accepted, where physicians were trained by midwives and where in case of an

emergency, the physician was forced by law to have a midwife present to help and support the woman. I realize that in North America ... [the situation] was quite opposite. There were deliveries done routinely in the Operating Room, in an OR [operating room]-like environment, on an operation table. The patient's arms and legs were strapped down ... there was a large amount of interference with forceps and episiotomies ... It was quite obvious that women had very negative experiences from their first deliveries. They knew about alternatives ... and decided they were unprepared to go back into this environment, and decided to go for home deliveries" (Interview transcript from *Midwifery and the Law* 1991).

A key point in *Marsh* involved the question whether an infant at term, but not yet expelled from the mother, could be deemed a "person" for the purposes of the Criminal Code. In *Lavoie* (1955), an award for the loss of a child not born alive was denied. In the judgment a human being was described as an entity that has proceeded completely out of the mother's body. Glanville Williams also spoke of the "conditional legal personality" of the unborn child, and said that claims of defendants for negligence injuring unborn children crystallize after the child-plaintiff is born alive (see Samuels 1974, 266).

In *Marsh*, Judge Millward held that a fetus at term, but not yet expelled, could be considered a person for the purposes of the Criminal Code.

> The essential nature of the organism, that is the fetus, is not changed by the fact of birth, and to hold that prebirth criminal negligence causing death of a fetus immediately after birth is an indictable offence, while similar negligence causing death immediately before delivery is not criminal, is not a conclusion that accords well with the concept that the state has a duty to protect unborn children and to preserve their opportunities to be born and to enjoy the rights and obligations normally incident to the status of human kind (at 14–15).

While *Marsh* did not directly involve midwives, it did set a modern precedent for the prosecution of an attendant at a home birth. Midwives were faced with the prospect of costly and protracted legal action in the event that an injury (fatal or non-fatal) was brought to the attention of authorities. Within a few years of the *Marsh* case, another prosecution was launched, this time in Halifax, Nova Scotia.

R. v. Carpenter et al. (1983)

In January 1983, Donna Carpenter and Linda Wheeldon, two lay midwives, and Charlene MacLellan, a nurse with postgraduate training in advanced practical obstetrics, were charged with criminal

negligence causing bodily harm. The charge followed the home birth of a baby girl and the transfer of the infant to hospital when she did not breathe despite efforts at resuscitation. After determining that the baby had suffered permanent brain damage, a doctor notified the police department and the charge was laid against the three attendants. The charge was amended to criminal negligence causing death in the summer of 1983, a few weeks after the infant's life support system was disconnected. The preliminary inquiry was held over four days in October and November 1983. Judge W.A.D. Gunn decided that the women would not be brought to trial owing to lack of evidence. The charge was dropped at the preliminary hearing prior to the trial. Witnesses at the preliminary inquiry made three key observations: first, the infant suffered a hemorrhage to the portion of her brain that governed breathing; second, the injury was not attributable to the midwives' care; and third, similar injuries had been noted among babies delivered in hospital settings under medical care (Alternative Birth Crisis Coalition 1984).

Cases such as *Carpenter et al.* may be used to highlight the vulnerability of midwives to criminal charges. Criminal cases against physicians and nurses who attend women in labour and delivery are virtually nonexistent in Canada. Peter Leask remarks on this disparity: "When babies die in hospital, sometimes thought is given to civil negligence suits against the hospital and the doctor, and that is of course traumatic for them, but to the best of my knowledge, there is never any thought given to criminal prosecution ... It's treated as a civil matter, as a regulation of the doctor's practice now. I'm completely confident that if midwifery were legalized in this province the same thing would be true about deaths involving midwives. It's the sort of aura of illegality surrounding midwifery that leads to police involvement and the sort of theory that there must be a crime here to prosecute" (*Midwifery and the Law* 1991).

Carpenter et al. was followed a few years later by a case involving two Vancouver midwives following an infant death in Vancouver's west end. This case was much more protracted, and raised many troubling issues concerning the status of the fetus (prior to expulsion) and the appropriateness of charging midwives.

R. v. Sullivan (1986–91)

Two Vancouver midwives were charged with assault, criminal negligence causing death, and other offences following the death of a baby girl on 8 May 1985 in Vancouver. These charges followed the transfer of a mother and unborn child to hospital following an

attempted delivery of a shoulder dystocia. This situation, in which the oblique diameter of the pelvic inlet is smaller than the bisacromial diameter, is regarded as an "obstetric emergency" along with other forms of dystocia (see Jensen et al. 1979, 492, 505).

The parents were reported to be supportive of the attending midwives (Sullivan-LeMay Legal Action Fund 1986). Over time, however, there have been reports of the suffering experienced by the mother during labour and after the stillbirth (see Women's Legal Education and Action Fund 1991, 8, 29). Mrs. Voth was later awarded $4,800 through the Criminal Injury Compensation program in British Columbia. The award was given on the basis of "the nature of the injuries sustained and the nature and degree of the pain, suffering, anxiety and inconvenience occasioned by the injuries" (see Workers' Compensation Board 1987, 12). In contrast to other cases involving infant death following transfer to hospital from home, the two midwife-defendants were originally found guilty on the charge of criminal negligence causing death. The midwives were ordered to perform community service and to refrain from attending births, and were placed on probation for two years. Expert witnesses called by the Crown were critical of their management of the birth.

At trial, Judge Godfrey encouraged greater regulation of midwifery practice in British Columbia. Judge Godfrey held that the accused, as childbirth attendants, "were under the legal duty imposed by s. 198 [of the Criminal Code] to use reasonable knowledge, skill and care." The trial judge was critical of the midwifery care, concluding that "the child would have lived had the mother and child been transported to a hospital earlier and had the accused possessed the skills of a medical intern." He concluded that the accuseds' management of the birth "showed a reckless disregard for the life and safety of the child." As discussed below, the judge made a controversial ruling that a child at term, while being born, "was a 'person' within the meaning of s. 203, nothwithstanding that it would not be a 'human being' within the meaning of s. 206." The midwives were also acquitted under section 204 (criminal negligence causing bodily harm), since the mother "had miraculously suffered only bruising."

In March 1987, the Coroner's Court of British Columbia completed a judgment of inquiry into the death of the baby. The coroner held that the death was due to perinatal asphyxia, and that this was an unnatural death. At the time of the judgment, the midwives had already been convicted of criminal negligence causing death. The criminal conviction was reviewed by the British Columbia Court of Appeal, and a conviction for criminal negligence causing bodily harm

(to the mother) was substituted for the original conviction of criminal negligence causing death. The decision in this case was controversial in terms of the ruling that for the purposes of section 203, a "full term child in the process of being born [is a] 'person'" until its birth, and also in the decision to substitute a conviction for criminal negligence causing bodily harm (to the mother) in lieu of the original conviction: "The accused had attended as midwives at the birth of a baby but there were complications during the birth and the baby died. (1) The trial judge had concluded that the baby in the circumstances was a 'person' within the meaning of s. 203 but the trial judge erred in that ruling as the baby had never been born alive [*Regina v. Marsh*, 2 CCC (3d) 1 (BC Co. Ct) overruled.] At common law the line of demarcation for a foetus to become a person was the requirement that it be completely extruded from its mother's body and be born alive, and no Parliamentary intention to change that requirement had been established here. The accused could therefore not be convicted under s. 203. (2) It necessarily followed that the child when in the birth canal remained a part of the mother as a matter of law. The trial judge had found that the accused were criminally negligent concerning the baby ... as the trial judge had already determined [that the accused were guilty of criminal negligence causing bodily harm, with respect to the mother], it was appropriate for the court of appeal here to enter that conviction now, and impose the same sentence imposed in respect of the offence under s. 203, [*R. v. Sullivan* (1988), 65 CR (3d) 256 (BCCA)].

The appellate course was not yet exhausted. The midwives launched an appeal to the Supreme Court of Canada. With leave to appeal granted, the midwives' lawyers, Thomas Berger and Peter Leask, were successful in having the conviction quashed.

This is undoubtedly the most prominent case involving Canadian midwives. The acquittal of LeMay and Sullivan, however, is not a clear victory for midwifery. The trial and appeals tended to focus on the evidence surrounding this particular birth-event, and in the appellate stages attention was redirected to the relatively narrow (in terms of midwifery's status) question of the status of the fetus.

The acquittal of Sullivan and LeMay, the decision in the *Walker* case in Alberta, and the general lack of a modern precedent for the successful prosecution of community midwives in Canada has undoubtedly prompted state authorities to regulate midwives in a less repressive fashion. A case that might have been regarded as a clear violation of midwifery guidelines in some jurisdictions – managing the delivery of twins at home – did not result in the criminal

prosecution of a midwife who attended a woman about to have twins. One of the twins was delivered stillborn on 12 April 1990 at the Winnipeg Health Sciences Centre. While it was reported that police were contemplating laying criminal charges against the midwife (Wiecek 1990), the case was instead investigated through the Office of the Chief Medical Examiner in the Manitoba Department of Justice. The cause of death was asphyxia due to compression of the umbilical cord. No judicial recommendations were made (Manitoba Office of the Chief Medical Examiner 1992, 17–18). The case highlighted the differences among the various advocates of midwifery; some favoured the licensing of nurse-midwives, others supported a wider definition of "midwife" that would include community midwives (Paul 1990, Larsen 1991).

INQUESTS INTO INFANT DEATHS

Although criminal charges are rarely brought against midwives in Canada, midwives who are charged are unlikely to be convicted. Another legal route, one not connected with the guilt-innocence dichotomy of adversarial criminal actions, is to proceed with a provincial coroner's hearing. Inquests involve recommendations by a jury of citizens; inquiries are conducted by the Coroner's Office without convening a jury.

The death of Daniel McLaughlin-Harris in October 1984 in Toronto, Ontario, was followed by a provincial inquest in 1985. Two midwives had attended the mother in labour at a Toronto Island residence. The baby was born asphyxiated, and was transported to the Hospital for Sick Children by one of the midwives. The inquest dealt with the causes of the infant's death and the viability of midwifery as an independent profession. The jury concluded that the death was attributable to oxygen deprivation, and that the death could have been prevented had the mother been transported to hospital at an earlier stage. The need for better monitoring of the infant's heartbeat and the importance of more "sophisticated" resuscitation equipment was also noted by the jury (Report of the Ontario Task Force 1987, 31).

The coroner's jury made several recommendations to alter the status of midwifery in Ontario. First, it recommended that the Ontario Health Disciplines Act be rewritten to specify what constitutes midwifery practice, and that strict penalties for illegal practice be imposed for practice outside the Act. Second, midwifery should

be undertaken as a specialty practice under the jurisdiction of the College of Nurses of Ontario; after five years, an independent college of midwives should be established. Third, midwifery training should conform to the international standards established by the International Federation of Obstetricians and Gynecologists and the International Confederation of Midwives (Burtch 1992, 168). To practise, a person would require at least two years' midwifery training and a year of general nursing. Fourth, licensed midwives should be given hospital privileges in maternity wards. Fifth, Ontario Health Insurance Plan coverage should be available for midwives' services and malpractice insurance should be compulsory. Sixth, birthing centres should be established in hospitals. Seventh, the option of home birth attendance should be available within the Ontario health care system. Finally, the College of Physicians and Surgeons should establish safety standards for home births, and doctors should be free from censure by their colleagues if they attend home births (Besheraw 1985, 11).

The Coroner's Office in Burnaby, British Columbia, has also been involved in cases involving midwife-assisted births. In addition to *Sullivan and LeMay* (discussed above), two other cases received considerable publicity. A coroner's inquiry in 1986 concluded that the responsibility for some infant deaths associated with midwives' attendance at attempted home births fell on the government for its failure to resolve a "state of uncertainty" surrounding midwifery and home birth. Chief Coroner Robert Galbraith (since retired) held that the midwife (Gale Gray) had contacted the back-up physician when she noted a drop in fetal heartrate. The midwife arranged for the mother to be transported to hospital. Despite rescuscitation efforts by hospital staff, the infant (baby McLean) was pronounced dead. It is significant that the parents of the stillborn baby supported and continue to support the midwife (see *Midwifery and the Law* 1991). Both parents also commented on the difficulties in actually making the transition from home to hospital, where the midwife was treated as an outsider rather than the person who "knew most about the birth" (*Midwifery and the Law* 1991). The parents also noted that the formal proceedings of the coroner's inquiry, with legal representation, publicity, and so forth, militated against their being able to maintain regular contact with the midwife after the death and before the inquiry.

The second case, which involved the death of an infant (baby Bellingrath) on 13 May 1985, was complicated by the parents' criticism of the attending midwife. As noted earlier, it is rare for parents not to support midwives even in tragedies associated with home

births. In this case, the British Columbia Coroner's Service ordered an autopsy when it was known that the midwife had been involved prior to the mother's caesarean section at Grace Hospital. The autopsy was ordered "in light of the current controversy surrounding the illegal practice of midwifery in the province of British Columbia" (*Verdict*, Coroner's Court of British Columbia 1988).

This case generated considerable activity in the Coroner's Office, the major crimes unit of the Vancouver City Police, and even in the Supreme Court of British Columbia. (In 1987 the court held that once the filing of the judgment of inquiry had been made, by law the coroner could not legitimately rehear the case or order an inquest.) In 1986 information was received that the attorney-general would not recommend criminal prosecution of the midwife or the back-up physician. Nevertheless, in February 1988, the attorney-general ordered an inquest.

Seventeen witnesses appeared at the inquest. They included the mother and father of the deceased child, the attending midwife, a consulting midwife, several physicians, and a nurse from Grace Hospital, among others. Twenty-two exhibits were filed. The verdict of the coroner's inquest was that the baby's death was accidental and due to asphyxia.

It was recommended that midwifery should be legalized and midwives granted "autonomous professional status" in cases of low-risk obstetrics. It was further recommended that a task force be set up to investigate the midwifery situation in British Columbia and that midwives have independent powers to admit women to hospital. The establishment of a college of midwives was also recommended to create and enforce standards of discipline, education, practice, and certification. It was also suggested that midwives be integrated into the provincial health care system.

Other recommendations were directed to the Midwives' Association of British Columbia, including that improvements be made in providing labour records and prenatal documentation when mothers are transferred to hospital. Concern was expressed over the need for guidelines for monitoring fetal heartbeat and vital signs, and the importance of the midwife alerting hospital staff to the impending arrival at hospital. Recommendations to Grace Hospital included synchronization of clocks throughout the hospital (to assist in the sequencing of events), a review of admission procedures, and a recommendation that staff "be receptive to incoming phone calls from midwives who are informing of pending arrival and condition of mother" (Coroner's Court of British Columbia 1988). Kaufman (1989)

viewed the inquest recommendations as demonstrating "clear and unequivocal support for recognition of midwifery."

The abstract notion that the state, through the law, acts in a neutral way to resolve disputes and to make recommendations seems quite distant from the effects of such hearings on the people concerned. Peter Leask has drawn attention to the emotional costs of legal proceedings; financial costs are also a major factor for midwives and their supporters: "I don't know any midwife who's making anything approaching a decent living from being a midwife, and any legal case instantly will cost the equivalent of years of income ... if we're talking about a prosecution, many, many years of income, [and] even for something like an inquiry or inquest, multiple years of income" (Peter Leask, quoted in *Midwifery and the Law* 1991).

There are cases, such as Noreen Walker's in Alberta, where former clients, other supporters, and even chiropractors contribute to a substantial defence fund (approximately $20,000, as of 1991) for the midwife. Lawyers may also represent the midwife at a reduced rate, or, as in Walker's case, on a pro bono basis. In fact, Walker's lawyer, Simon Renouf, had involved himself in earlier disputes, including the 1982 nurses' strike in Alberta, where he was the union director of the United Nurses of Alberta. The point remains, however, that most midwives (Growe 1991, 143) lack the legal expertise and financial resources to cope easily with formal proceedings. Another point arising from the coroner's hearings into midwifery is that all hearings have recommended the legalization of midwifery, and the individuals making recommendations have been attentive to the midwives' insistence on a sphere of practice distinct from medicine or nursing.

CRIMINAL NEGLIGENCE AND PHYSICIANS

Canadian case law reveals few instances in which charges of criminal negligence causing death have been brought against doctors attending births. (There are cases involving therapeutic abortions, most notably those involving Henry Morgentaler [Morton 1993].) In *Simard* (1964) the conviction of a physician for criminal negligence was quashed on appeal to the Quebec Court of Queen's Bench. A newborn child had died of a cerebral hemorrhage a few days following delivery by forceps. Nevertheless, the appeal judges clearly felt that the facts of the case did not warrant the jury's finding of guilt. Those facts included the mother's wish not to give birth in a hospital but rather at a clinic, her failure to follow Dr. Simard's suggestion of an X-ray for suspected cephalopelvic disproportion, and her departure from the birth setting against the doctor's advice.

The court also accepted expert testimony vindicating the use of chloroform and forceps and rejected contrary opinion on this point.

The *Rogers* (1968) case involved an ex-physician and practising naturopath, Dr. Everly Rogers. Dr. Rogers was charged with criminal negligence causing death. His patient, a two-year old boy, Leonidis Demosten, suffered from dermatitis and was put on a very low protein diet in April 1966. The boy lost weight and died in hospital in June 1966 as a result of gross malnutrition. In dismissing an appeal by the accused, the principle of competency required by law was reaffirmed: "In enacting s. 187 [of the Criminal Code] Parliament has imposed a legal duty upon every one who undertakes to administer medical treatment. Included in that legal duty is to have 'reasonable knowledge' in doing so. The essence of that 'reasonable knowledge' was that a physician (which Rogers was) should have foreseen the harmful consequences of depriving the child of proteins and calories in the circumstances. Regardless of his personal theories, Rogers was under a duty to have that foresight. It was, therefore, irrelevant for the jury to consider Rogers' own belief that his diet was a beneficial treatment" (at 299). Mr. Justice Nathan Nemetz concluded as follows: "It was open to the jury here, on the evidence before them, to consider whether Rogers, in knowing the deteriorating condition of this child, yet obstinately continuing the administration of a diet based on his personal theory of medical treatment, was criminally negligent within the meaning of the *Criminal Code* of Canada. Since, in my opinion, no error has been shown to exist in the charge, I would dismiss the appeal" (at 301).

Physicians are subject to malpractice actions and peer review, but are rarely brought into the criminal courts for childbirth-related practice. Community midwives are aware that they are vulnerable to possible criminal investigation and prosecution arising from home birth attendance, and many midwives indicated that this differential application of the criminal law is unjust. A community midwife interviewed in Vancouver in 1985 put this bluntly in 1985: "Hospital staff tend to perpetrate a number of offences against people, things that are negligent, even criminally negligent, against patients. But they get away with it because they are protected by the system." Despite the argument that up to a third of perinatal deaths in hospital are preventable, criminal actions do not ensue against established practitioners.

CIVIL SUITS AGAINST BIRTH ATTENDANTS

There are fewer malpractice suits against physicians (on a per capita basis) in Canada than in the United States. While 20,000 malpractice

suits were launched in the United States in one year, only 200 to 300 were initiated in Canada (Coburn 1980, 14). MacIsaac (1976, 204), using data from the Canadian Medical Protective Association, reported that between 1966 and 1970 the number of monetary settlements against its members averaged 18 per year; in 1971, 22 monetary settlements resulted from 131 writs against its members.

In a 1981 case concerning the death from hypoxia of an infant in a Vancouver hospital, the Supreme Court of British Columbia ordered payment of unspecified damages to the family. The nursing care afforded the mother was deemed to have fallen below the expected standard of care, and the attending physician failed to establish the progress of labour before prescribing painkillers. Lack of suctioning equipment in the emergency bundle and the absence of attending staff for thirty minutes while the plaintiff was in labour were other factors cited in the decision (Anonymous 1981).

Coburn (1980) suggests that judges in Canada are generally sympathetic to physicians because of a common status. This notion of class affinity is developed further with respect to the British judiciary and the Canadian judiciary (Miliband 1973; Olsen 1980). At the same time, there is little evidence of civil suits launched against community midwives by their clients. It is noteworthy, however, that as American nurse-midwives have become established as professionals in hospital and clinic settings, they are increasingly subject to malpractice actions (Sinquefield 1983).

RECONSIDERING LAW AND SOCIAL MOVEMENTS

There is ample evidence that dominant groups invoke their powers to exclude competing groups. While there are limits to its powers (Giddens 1982), the state is central to these exclusory attempts. It has the power to criminalize behaviour, to adjudicate civil matters, and to direct its financial resources to specific groups. Ursel (1988) regards the state as a central force in maintaining patriarchal relations and assisting in the transition from familial patriarchy to social patriarchy. At this point I turn to the patriarchal elements of obstetrical practice, and to an examination of how community midwifery presents a challenge to these practices. Hospital-based birth attendance is directed by physicians; less commonly, responsibility may be delegated to nursing personnel. Physicians' incomes remain well above the average incomes of other North Americans; midwives' incomes are markedly lower than average, especially community midwives. Concern has also been expressed over patriarchy in law. The term is

used here to mean "a specific organization of the family and society, in which heads of families [control] not only the reproductive labor, but also the production of all family members" (see Gordon and Hunter 1977–8, 12). Ursel (1988, 108) defines patriarchy as "a system or set of social relations that operates to control reproduction through the control of women both in their reproductive and productive labour."

Community midwifery in British Columbia and other regions is a concrete instance of resistance to medical dominance in the management of childbirth and the provision of prenatal and postnatal care. As noted above, attempts to use the courts to prosecute midwives under the Criminal Code have not always been successful. Even quasi-judicial hearings such as coroners' inquests do not automatically reinforce the authority of medical control over birth: two recent coroners' inquiries in Ontario recommended the legal recognition of midwives and the establishment of a provincial school of midwifery.

Legal struggles and the continuing dominance of physicians' authority in Canadian maternity care touch directly on the criticism of western legal ideology for the adherence to notions of a formal, abstract equality of citizens despite substantive inequalities before the law (Burtch 1992). Similarly, there have been serious criticisms of the ways in which pluralist theories of the state fall short, with policies of intolerance and repression evident in Canada and elsewhere (Knutilla 1992; McRae 1979). Some socialist writers, while acknowledging the role of law in perpetuating inequality, have favoured the *use* of law as a form of political struggle (Sumner 1981; Beirne and Sharlet 1980; Fine 1984). In the health-care sector, some have favoured "democratic relativism" as a means of protecting unorthodox forms of medicine and healing, thereby permitting comparisons of the various forms of health care (Feyerabend 1980). These struggles should not overshadow the continuing protection of professional attendance and medical dominance in Canada and elsewhere.

A key consideration is to determine when midwifery practice is demonstrably as safe as (or safer than) conventional physician-managed deliveries, and when it may be more hazardous. This issue is addressed directly in chapter five. A related point concerns the role of the state in promoting or containing midwifery initiatives. Laws that largely buttress the professional dominance of obstetricians and general practitioners are one case in point. By the state's vesting policing powers with the medical colleges, and through the occasional prosecution of alternative practitioners, the implementation of safe, pluralistic maternity care services remains greatly constrained.

Much of the literature concerning midwifery emphasises the role of parental choices in childbirth. This emphasis is seen as complementary to professional concerns about standards of care; well-informed parents should be able to choose from a variety of birth options without compromising their health or that of their children. For many, the existing law in Canada does not adequately recognize the issue of parental rights in childbirth. Peter Leask, a Vancouver-based lawyer, favours a legal model that parallels European systems, including respect for parents' choices: "There's no doubt in my mind that for those who want to change the law, the direction to go is the European model where written into the statutes that govern birth is a right of parents to choose, and a corresponding protection for birth attendants so that if parents make a choice which is not recommended, if the attendant has conscientiously given the safest advice and the parents choose something else, the attendant can still give as much help as possible in whatever birthing choice the parents have made. Here in B.C., in effect we have the opposite situation. The only situation where doctors can assist parents to give birth is a hospital, and any parent who doesen't choose that option has to have either no attendant or an illegal attendant, a situation *everyone* knows is unsafe" (quoted in *Midwifery and the Law* 1991).

The obstetrical system in Holland is frequently presented as an example of a system that promotes parental choices in birth, together with a record of maternal and infant safety. Anderson (1986, 13–14) attributes the success of the Dutch system to three factors: the establishment of highly trained midwives as "primary caregivers," clear guidelines for referral of clients seeking home births, and thorough post-partum care by maternity-aid nurses. This system of referral and training is coupled with a culture that promotes birthing choices. Lee Saxell, a community midwife who discontinued practice following a coroner's inquest, has remained active with the midwifery movement in Canada. She notes that Dutch women continue to use a variety of birthplaces, and that their culture supports childbirth. Birth is "accepted into the culture. Almost every child will be in a house where someone has given birth, or a neighbour who's just given birth and they can see a brand newborn baby. Children are very often at the births if they're family members ... [while some Canadian women are reluctant to go to hospital, for fear of unnecessary intervention] you don't see that so much in Holland where they're not afraid to go in; they would just prefer to be at home. It's more comfortable and it's perfectly normal. No one's told them that it's radical or dangerous. It's accepted into the culture. There are images of birth and pregnant women all over Holland ... it's just

more commonplace to see those sorts of images of pregnant women as being a normal part of the culture than it is here in North America" (*Midwifery and the Law* 1991). This coherent system contrasts with the malintegrated legal interventions that have characterized midwifery trials and inquiries in Canada. These interventions have to date imposed considerable costs on midwives, without building on recommendations that the legal practice of midwifery be established and promoted.

The net effect of the threat of criminal prosecution or a coroner's investigation has been that many senior community midwives have stopped attending home births. They cite costs, publicity, and uncertainty as factors that discourage their practice. Peter Leask notes that although community midwives manifest more caring for people and their income "does not approach a decent standard of living," they are faced with legal costs equivalent to "many, many years of income" if there is criminal prosecution (*Midwifery and the Law* 1991). In general, low incomes have been the standard for community midwives in Canada (Barrington, 1985).

In Lee Saxell's case, criminal charges were not laid, although a coroner's inquest was called following an infant's death after an attempted home birth: "Even though every midwife knows statistically that eventually it's going to happen, still it was devastating to me, and I was really emotionally distraught by the whole thing. I continued practising, and then when the death went to inquest three years later and I went through that whole process which was extremely lengthy because of the time that it took me to prepare and then recover, then I felt that I couldn't practice again because I couldn't risk that again. It's a sort of thing that you'd never want to do more than once. Anyone I know who has been through it, any other midwife in Canada feels the same way" (*Midwifery and the Law* 1991).

The lack of legal recognition has encouraged midwives to leave practice, and it has had a chilling effect on the recruitment of new midwives. This means that in contrast to other, more recognized professions, such as nursing and medicine, new cohorts of midwives are not being produced regularly in Canada. The "trials of labour" also serve to drain the limited funds of groups such as the Midwives Association of British Columbia; money that was raised in support of midwifery practice and education is diverted to legal costs. Legal defence funds are usually raised by soliciting former clients of midwives and by sponsoring gaming activities (such as casino benefits) in British Columbia (Burtch, 1987).

The "legalization of politics" (Mandel 1989) poses considerable costs for midwives, and deflects legal discourse away from issues

such as parental choice, and the integration of midwifery into Canadian health care. Midwives have lobbied for the power to regulate their profession. A College of Midwives could enable midwives to establish guidelines for the safe management of labour and birth and to review instances where such management was called into question. Not all midwives favour such a proposal. Self-regulated professions are rarely independent, and midwives would very likely be controlled to some extent by provincial health officials. It is also not clear if medical and nursing associations would support the proposal for a separate College of Midwives in any Canadian province. Midwives themselves have expressed concern over the ways in which midwifery practice could be restricted as guidelines became more conservative, and penalties (fines, suspensions, loss of a licence) became established.

Raymond DeVries (1985) examined how violations of regulatory law by American midwives raise serious questions about the value of legal regulation of practice. He noted cases in which "lay" midwives were arrested and required to post substantial bonds for bail ($25,000 in the case of a California midwife arrested in 1970; murder charges were dropped only after preliminary hearings) and cases in which other forms of disciplinary action were taken. Subject to a licensing law, midwives' practices are not reviewed by peers alone, but by "a legal code that defines acceptable and unacceptable behavior" (DeVries 1985, 120). Ironically, where midwives are not subject to regulatory laws, several factors can operate in their favour. These include the rarity of charges being brought by clients against midwives, the reluctance of clients to testify against midwives, the generation of positive publicity concerning alternative birth practices, the mobilization of financial and other support from other midwives, and a tradition of "hesitancy on the part of the courts to penalize unlicensed midwives" (DeVries 1985, 121).

The discipline of licensed midwives is another matter. Once licensed, midwives are subject to the scrutiny of medical personnel. In two cases in Arizona, midwives were either suspended from practice or had their licences revoked. One case involved assistance at a diagnosed breech birth, the other a decison to let the parents grieve the baby's death (when fetal heart tones could not be detected) instead of requesting medical assistance immediately. Both actions were in violation of the state law regulating midwifery practice. Midwives in Arizona are not only subject to complaints by physicians about conduct that may be inappropriate or illegal. They are also integrated into a health network, so that they must file detailed reports with the state Department of Health Services. These reports can be reviewed at any time. DeVries draws special attention to the

lack of media coverage of the Arizona cases. Significantly, "midwife organizations and alternative birth groups did not rally to the support of the accused" (DeVries 1985, 131).

DeVries takes a cautious approach to the value of licensing midwives. He points out that licensing schemes tend to remove opportunities for "consumer evaluation" of practitioners, while medical associations and state officials become more involved in reviewing and disciplining midwives for breaches of licensing regulations. Legalization may thus have an untoward effect on the very midwives who seek legal status, and on their clientele.

DeVries's work highlights the dilemma of recourse to state law in regulating parental choices and midwifery practice. As we have seen, the use of repressive law, such as criminal prosecution, has traditionally not resulted in conviction of unlicensed midwives, and legal costs are invariably high. The adversarial effect of such actions can widen the gulf between midwives and physicians. But DeVries (1985, 136–7) holds that where licensing is established, midwives subject to legal codes face loss of the right to practise midwifery and possibly the loss or suspension of a nursing licence. The once-blurred legal status of midwives practising outside the system is sharpened by legalization, but in a manner that retains an edge of punitiveness. Gaskin (1988, 56) reinforces DeVries's argument, noting that restrictions on certain practices – such as midwives' being prohibited from administering drugs to stop hemorrhaging – may lead midwives to conceal certain aspects of birth care.

It has also been pointed out that legalization in itself does not guarantee adequate midwifery services. Midwifery can be established, certainly, but it can also be whittled away or removed. Gaskin (1988, 56) cites the case of a Florida law allowing direct-entry midwifery. The law was passed following years of lobbying by the Florida Midwives Association; however, a counter-lobby of Florida physicians succeeded in reversing the direct-entry law. Midwives who had completed direct-entry training could continue practising, but to other aspirants the door was closed. Even in European countries where midwifery is well established, recent policies have led to fragmented obstetrical care. This fragmentation clearly undermines the continuity of care that midwives prize. Vicki Van Wagner (1984, 1991) notes that the role of the midwife as an advocate for women is compromised by greater recourse to technology ("machine-minding"), rising rates of caesarean sections, and other measures that erode the "close personal social support" traditionally provided by midwives.

The reappearance of community-based, independent midwifery practice in Canada in the mid-1970s challenged the medicalization of childbirth. As a countercultural movement in Canada and else-

where, midwifery offered an alternative to hospital-based, professionally directed birth management. The appropriation of childbirth by the (predominantly male) medical profession, and the cultural definition of women as incapable of managing birth, were strongly contested in theory and practice by midwives. Reversing the notion of midwives as anachronistic, midwives have sought to argue for midwifery as a highly skilled and sensitive role (Flint, 1986). This struggle focuses not only on the modern takeover of obstetrics by medical and nursing specialists, but on a legacy of repression of alternative healers in Europe and North America, including midwives and herbalists (Ben-Yehuda, 1980; Ehrenreich and English, 1973).

The nature of Canadian midwifery has been transformed in recent years. On the one hand, midwifery has been supported on the international level. The 1993 Congress of the International Confederation of Midwives was held in Vancouver (the first time the congress has been convened in Canada), and British Columbia midwives have completed clinical placements outside Canada (in Holland, Germany, the United States, Jamaica, and England). Community midwifery still exists in British Columbia and other Canadian provinces, but such community-based practice is not well integrated with the established health-care system of billing under medical insurance plans, hospital privileges for practising midwives, and malpractice insurance coverage. In British Columbia some community midwives fear prosecution and have abandoned their practices. The midwifery project at the Grace Hospital has not been expanded to match requests for such midwifery attendance. The midwifery debate in Canada may well founder on a co-opted version of midwifery that would place constraints on autonomous midwifery as it was practised in the 1970s and 1980s. These constraints include mandatory liability insurance, conservative guidelines for practice, no clear official commitment to encouraging out-of-hospital births, and mandatory supervision by physicians of midwives during patients' labour and delivery.

The development of midwifery policy in Canada has been largely arrested through government failure (aside from Ontario and Alberta) to implement midwifery services despite recommendations from numerous quarters, sensationalized media accounts of medical crises at home births, a pervasive ideology of physician dominance of childbirth, and the chilling effect of legal interventions. These trials of midwifery reflect deep contradictions in the construction of women's power (as workers and throughout pregnancy), and the power of criminal and quasi-criminal laws in securing social ordering.

The midwifery movement has implications for state theory: for example, it demonstrates ways in which social movements can gain greater access to resources and in some cases to achieve greater legal recognition. Midwifery may possess greater leverage than some other social movements in that it is potentially a source of legitimacy for existing governments. Implementation of midwifery would seem to vindicate the dominant ideology of liberalism, especially in terms of pluralistic choice of services and responsiveness of the legislature and health-related government services. Not surprisingly, midwifery has been mooted as a cost-saving initiative that would reduce unnecessary surgery, for instance, and in so doing would reduce morbidity (injury) to mothers and newborns (Ontario Task Force 1987, 2).

Midwifery nevertheless must face the consequences of cutbacks in certain services (Dobbin 1990). Further, midwives must resist the tendency to find a Machiavelli behind every government initiative. The provision of safe, secure environments for birth is arguably an initiative that is properly fostered by governments. The importance of infant safety is acknowledged by Canadian midwives. The Canadian midwifery movement is concerned not only with the implementation of safe maternity and infant services in Canada, but also with the reduction of infant and maternal mortality in the developing world. On the world scale, given that 99 per cent of women who die from childbirth-related complications are from the developing world, increased government support for safety worldwide would seem very valuable (see Hsia 1991, 85). The scale of maternal mortality in the developing world is evident in Dr. Malcolm Potts's vivid illustration: "Every four hours, day in, day out, a jumbo jet crashes and all on board are killed. The 250 passengers are all women, most in the prime of life, some still in their teens. They are all either pregnant or recently delivered of a baby. Most of them have growing children at home, and families that depend on them" (cited in Maine 1986, 175). The World Health Organization (WHO) estimated that nearly 13 million children aged five years and under died in 1990. One-third of those children died within a month of their births (Report of the Director General 1991, 2). The litmus test of the efficacy of such government roles, however, is whether actions by authorities take on a repressive, obstructive character, or whether they actively promote maternal and infant wellbeing in the developing world and elsewhere.

The midwifery movement also poses a challenge to the hegemonic status of medicine. The hegemonic ideology of woman and birth – the notion that birth is a medical event and that women and fetuses must be continually monitored by new technology, and the general