

The Midwifery Act

CAROLYN FROST

I. INTRODUCTION

THE MIDWIFERY ACT¹ IS ENABLING LEGISLATION created to provide for the administration of the midwifery profession. The Act was introduced as Bill 7 in the Manitoba Legislature on 26 March 1997 and it made its way through first, second, and third readings, as well as committee hearings, without any amendments. *The Midwifery Act* received general support from all Members of the Legislature. It passed and received Royal Assent on 28 June 1997 but was not proclaimed into force until 12 June 2000. This delay was necessary to put required regulatory mechanisms in place and to set up appropriate educational programs and standards.

II. A BRIEF HISTORY OF MIDWIFERY

"FOR MOST OF HUMAN HISTORY THE MIDWIFE has been the primary, and in most cases, only, attendant available to birthing women."² Midwifery has been a respected and socially necessary profession throughout recorded history. The practice of midwifery was thoroughly documented in Greco-Roman times. Pliny the Elder, in his *Historia Naturalis*, and Soranus, a Greek physician, in his *Gynecology*, wrote of the role. Some of the practices, described by Pliny, would still be considered useful today.

In the Middle Ages, midwives continued to attend births of babies across the social spectrum, partially because of the taboo against men being present in the birthing room. By the 18th century, male midwives began to assist births. They soon began campaigning against midwifery in favour of obstetrics. The

¹ *The Midwifery Act*, S.M. 1997, c.9 (proclaimed 12 June 2000, Man. Gaz. June 24/00).

² J. Wood Catano, "Midwifery Fact Sheet" (year) CPHA Position Paper on Midwifery, online: Midwifery Coalition of Nova Scotia <<http://chebucto.ns.ca/Health/Midwifery/factsheet.htm>> (date accessed: July 2000).



male assistants argued women did not have the intellectual capacity to understand the “complicated science” of childbirth.³

North American physicians, in particular, campaigned vigorously to eradicate midwifery from the birthing experience. A physician in New York City, Dr. Garrigues, argued that the United States must “form the vanguard in the war of extermination against the pestiferous remnants of the pre-antiseptic days, midwives, and schools of midwifery.”⁴ By 1953, only three percent of births in the United States were attended by midwives.⁵

III. THE ROAD TO LEGALIZED MIDWIFERY IN MANITOBA

PRIOR TO THE DRAFTING OF BILL 7, MIDWIFERY was gaining profile in Manitoba as part of a resurgence movement in women’s health. Many women were calling for continuity of care through pregnancy and into the birthing process. Supporters argued that midwifery could provide this continuity. Midwives, generally, treat childbirth as a normal and natural event rather than a medical condition requiring intervention.

The midwifery debate in Manitoba stretches back to the late eighties when The Manitoba Council on the Status of Women, now the Advisory Committee on the Status of Women, released a midwifery report in 1987. Other reports, examining the issue, were released by the Health Advising Network, The College of Physicians and Surgeons, and the Manitoba Association of Registered Nurses. Developments were taking place in other provinces as well. Ontario, in particular, had developed its own enabling legislation that legalized midwifery in 1991.

In face of public debate surrounding midwifery in Manitoba, the then Minister of Health, Don Orchard, set up the Working Group on Midwifery in June 1991. The mandate of the Working Group was to recommend whether midwifery should be implemented in Manitoba, and if so to:

- develop a policy framework on how midwifery should be practiced in Manitoba;
- recommend how midwives should be educated, including requirements for entry to training and curriculum;
- recommend requirements for standards of practice of midwives and governance of midwifery;
- recommend methods of implementation with their attendant cost implications, including the cost of not implementing midwifery;

³ K. Jacobson, “A Short History of Midwifery in America” year source, online: <<http://frognet.net/~midwife/campaign.html>> (date accessed: July 2000).

⁴ *Ibid.*

⁵ *Ibid.*

recommend, if possible, a method of implementation, which does not result in any ongoing cost to the health care system.⁶

The Working Group made 44 recommendations dealing with all aspects of the midwifery profession. They noted, in their Report, that midwifery should be a self-regulated profession instead of a subsidiary of either nursing or medicine. Differences in underlying philosophies and clinical competencies were the basis of this finding.

The Report also argued that midwifery would likely result in cost savings to the public purse. For example, preventative techniques of midwives and less medical intervention in the birthing process would put less strain on hospital resources.

Another major benefit of midwifery, according to the report, would be the ability to provide care to women in remote and rural areas, without having the women relocate to an urban or tertiary health care facility weeks or months before the birth of their child. This would result in cost savings and provide psychological benefits to the mother and their family as a whole.

The Report also recommended that the Midwifery Implementation Council (“MIC”) be set up to oversee the implementation process of the acting profession, its students, and apprentices. The role of the MIC would be fourfold. First, a committee would be charged with helping to develop legislation and regulations, in conjunction with staff at Legislative Counsel. Second, they would be asked to develop guidelines for an educational program after inviting proposals to be submitted outlining a degree program to begin at a post-secondary institution in the province. Third, they would develop standards of practice for practicing midwives in Manitoba. And finally, they were required to work with interest groups, such as Aboriginal and Metis communities, immigrant women, and women with disabilities, to ensure equity in access to midwifery educational programs and services.

A. Midwifery Implementation Council Appointed

In May 1994, Health Minister, Jim McCrae, released the Working Group’s report and appointed twelve members to the MIC. Several issues needed to be resolved before the legislation could go ahead.

The Manitoba Association of Registered Nurses (“MARN”) strongly advocated for all midwives in the province to be registered nurse practitioners. They argued that nurse midwives were the safest option for women because of their capabilities gained through nursing training and experience.⁷ This position,

⁶ Manitoba, Minister of Health, *Report and Recommendations of the Working Group on Midwifery* (Manitoba: Legislative Assembly Press, 1993) at 1 [hereinafter Report].

⁷ A. Paul “Home-birth option touted Council urges multiple birthing choices” *Winnipeg Free Press* (13 January 1996).



however, meant that traditional midwives, already practicing or apprenticing within Manitoba, would be excluded from the newly legal profession. The Manitoba College of Physicians and Surgeons strongly opposed home births for safety concerns.⁸ Lastly, the level of insurance required and remuneration to be paid for acting midwives had to be determined.

These issues were eventually resolved. The chairperson of the Midwifery Implementation Council was Carol Scurfield. She was quoted in the *Winnipeg Free Press*, on the issue of traditional midwives saying, “[w]hat we are looking for is quality, not how they got ... their education.”⁹ The final draft legislation, in fact, reflected this policy choice in s. 12(1) by basing the licensing requirements of midwives on a set of competencies rather than upon formal education.¹⁰

Home births are not specifically mentioned in the legislation. The College of Physicians and Surgeons continued to argue against the possibility through the standing committee hearings. They noted that Quebec’s midwifery legislation prohibits home births and requires all births to take place in the hospital.¹¹

Despite this opposition to home births, the Manitoba regulations allow midwives to practice in the location of the expectant mother’s choice. When asked why no mention was made of home births in the legislation, Yvonne Peters, head of the legislation committee for the MIC, said that the decision was “political”; the committee knew that the issue was divisive and “would raise a red flag.”¹² She claimed the MIC wanted to pass the legislation and, therefore, chose to address the issue of home births in the accompanying regulations to the Act. She also mentioned that this decision was in keeping with midwifery legislation found in other provinces.

B. MIC’s Input in Drafting Bill 7

The issues of remuneration and insurance grew between the time the legislation was tabled and its proclamation in June 2000. According to Darren Praznik, the Minister of Health who walked the bill through the Legislature, the major issue was remuneration; whether midwives should be paid on the same scale as

⁸ Manitoba, Legislative Assembly *Debates*, Standing Committee on Law Amendments, written submission Vol. XLVII No. 2 (12 June 1997).

⁹ Paul, *supra* note 7.

¹⁰ *The Midwifery Act*, *supra* note 1.

¹¹ *Debates* (12 June 1997), *supra* note 8.

¹² Interview with Ms. Y. Peters, Head of the legislation committee for MIC (July 2000).

obstetricians.¹³ The decision, however, was made to *not* deal with this issue in the legislation. It too would be dealt with in subsequent regulations. Regulations are much easier to change, as they do not require comment or debate in the Assembly, thereby avoiding controversy.

Yvonne Peters' legislation committee for the MIC had a mandate to make recommendations to the legislative drafters. Originally, the committee was to make these recommendations by way of policy drafts, but later it began to make suggested drafts of the legislation itself.

Legislative counsel and the legislation committee worked together to create the final Bill 7. It took 21 drafts before the final bill was submitted to the Minister of Health for approval.¹⁴ The committee and drafters had to create a unique bill—not just a cut and paste version of legislation from other jurisdictions.

Originality was necessary from two perspectives. First, in most provinces there is a piece of legislation setting out standards of conduct that apply broadly to every health care profession. In Manitoba, these standards are variable and are set out in separate acts. Thus, the draft bill had to include standards of practice particular to midwives as well as a way to enforce the standards. Additionally, an acceptable phraseology had to be used because legislation in Manitoba must be written in both French and English.

According to Ms. Peters, the MIC tried to use language that would be considered both “plain English” (rather than legalese) and “woman friendly.” Some of the efforts at a plain language approach did not make it to the final draft. The committee, however, was satisfied that the finalized bill reflected the underlying philosophy espoused by the MIC.

Before the bill made its way to the Legislative Assembly it had to undergo yet one more step. At the time it was presented to the Assembly, Manitoba had a Conservative government. The practice of this government was to go through new legislation with the legislative review committee prior to its first reading. The purpose of the review was to highlight potential issues that could arise for debate or criticism. The party in power then had the opportunity to prepare to address issues before they became problems. The bill then underwent final scrutiny to determine if more clarification was needed in any area.

IV. THE CONSULTATION PROCESS

THE MIDWIFERY ACT IS THE ENABLING LEGISLATION, much of it recommended by the assigned working group. The Act was not introduced into the Assembly until 1997, four years after the working group's Report had been released.

¹³ Interview with Mr. D. Praznik (August 2000).

¹⁴ Interview with V. Perry, Legislative Counsel (August 2000).



Darren Praznik, the Minister of Health in 1997, spoke about the process Bill 7 went through to become *The Midwifery Act*. Enabling legislation for a newly recognized profession takes time. Not only must logistical and policy issues be settled, but according to Mr. Praznik, consultations with various groups must take place. These consultations are necessary to gain input from supporting groups and to allow those opposed to the legislation to come to grips with the fact that the legislation would, in fact, go through.¹⁵

Yvonne Peters said that the bill was actually ready to be submitted to the Legislature a full year earlier than the date of its arrival.¹⁶ The legislation committee, however, chose to delay its introduction in order to have proper consultations with Aboriginal and Metis women.

The purpose of the consultations was to determine whether aboriginal midwives should be regulated by the legislation or whether there should be separate legislation for their unique cultural needs. The consultations represent a divergence from legislative process in other jurisdictions. At the time Ontario's midwifery legislation was introduced, a clause had to be included that excluded aboriginal midwives from the application of the Act.

The Midwifery Act is quite different from other pieces of Manitoba legislation. It specifically states in s. 8(5) that there must be a standing committee to advise the Council on issues of care to aboriginal women. Section 8(5) was included as a result of the consultations.

According to Ms. Peters, the inclusion of this section was cause for debate amongst the drafters. When a clause is included in legislation it must be adhered to unless changed by later amendment in the Assembly. It is important, therefore, to include requirements that are capable of being met. On that basis, legislative counsel was concerned the Council position requirement might be difficult to meet every year. This solution was included in the final draft because the MIC had recommended that aboriginal women should always have a voice on the Council. Ms. Peters asserted that to date the Aboriginal advisory committee had no difficulty being established or contributing meaningfully to the College.

V. THE ACT

THE MIDWIFERY ACT ESTABLISHES MIDWIVES as a separate group of professionals; primary caregivers equal in status to both physicians and nurses. *The Pharmaceutical Act* is the model upon which all other Manitoba health professional acts are based. Looking at *The Midwifery Act* itself, it is clear that it is founded upon other legislation.

¹⁵ Praznik, *supra* note 13.

¹⁶ Peters, *supra* note 12.

Part One of the Act is the definition section. To maintain uniformity among the health care acts, many of the same words and phrases are used. For example, words are included in the new act that can be found in *The Medical Act* and *The Registered Nurses Act*.¹⁷

Part Two is entitled “Practice of Midwifery” and it closely mirrors Ontario’s midwifery legislation. The practice is defined in each act by near identical wording. The Ontario Act is very specific about what a midwife may or may not do. In contrast, the drafters in Manitoba, however, did not follow this example, preferring instead to define what midwives *may* do in a broad sense. Details were left to the regulations.

Additionally, the MIC felt it was important to include s. 2(3) in the Act, which stated that midwives are primary health care providers. This section is not taken from any other act but is included to ensure that midwifery be viewed on equal footing with other recognized health care professions.

Part Three establishes the College of Midwives and sets out the rules and regulations governing the College. This Part, although it does bear some resemblance to other acts, is original in terms of midwifery legislation.

Similarly, Part Four, which sets out the requirements for registration, is not copied from other legislation. These two parts, in particular, stand out because the rest of the Act clearly uses other legislation as precedents. It is not uncommon for parts dealing with the College and registration requirements to be unique to the profession because each profession has its own needs for who should be governed by or gain entry into the profession.

Part Five is the enforcement portion of the Act. It sets out how the College may enforce the included standards of practice. Part Five is a copied from *The Medical Act* (as it was in 1997) almost word for word. Only a few sections within Part Five differ from the precedent. One difference is found in s. 22(1)(e). It allows for mediation if the complaints committee decides that a matter is only a concern between the complainant and the midwife and both parties agree to the mediation. This section is a useful addition to the Act because it allows an alternative to the complaints procedure where it is clearly inappropriate for the conflict.

Part Six is an original piece of legislative drafting. It does not take its form or content from other legislation. Section 50(1) lists the powers of the MIC to make regulations with regard to every aspect of the profession. Section 52 is the only section in the Act that reflects the work of the Working Group Report from 1991.

The Report included core documents that were to be included to explain the underlying philosophy of midwifery in Manitoba. One of these documents, included as Appendix 5 in the Report, is a code of ethics for midwives in

¹⁷ R.S.M. 1987, c. M90; S.M. 1999, c.36.



Manitoba. The Act specifically provides that the College of Midwives may adopt the code.

Part Eight is, again, a close copy of the Ontario legislation. Clauses in each act create transitional councils with equivalent powers.

V. DEBATE IN THE LEGISLATURE

THE MIDWIFERY ACT WAS SUBJECT TO WIDE approval from all parties. The opposition, however, did bring up a few unresolved issues. They voiced concern over access to the service, as well as, sources of support for education and training. Their main issue of concern was the level and source of insurance for midwifery.

The opposition also argued in the Assembly and in the Standing Committee on Law Amendments that all women should be able to avail themselves of the services of a midwife. This they contended could happen only if midwives were fully insured by the provincial government. The opposition also argued that a home birth registry be established. This would allow the Health Department to assess how many women actually wanted this service and to calculate any cost savings relative to existing birth services.

VI. CONCLUSION

THE MIDWIFERY ACT COMBINES THE TRIED and true elements found in other pieces of professional regulating legislation with uniquely drafted sections to better serve Manitoba's women. It establishes midwifery as a profession on equal footing with other healthcare professions in Manitoba.

This establishment of status was essential to the profession's acceptance and success in the minds of many midwifery advocates. As a scheme for implementing a new profession, the legislation wisely leaves the structure of the College and regulation of the profession to a team of people picked by the minister for their expertise and interest in the area.

The most important achievement of this legislation is that neither the MIC, nor the drafters, nor the politicians were willing to sacrifice completeness for speed. This legislation addresses the eligibility of professional midwives by ensuring that the voices of all midwives are represented in the College.