Thank-you so much to Barbara Grandi and to ANDRIA for inviting me to Verona to speak at your very important conference. Barbara has asked that I put my talk into prose.

Midwifery in Ontario, Canada
Mary Sharpe

Definition

The definition of the word 'midwife' in English has a metaphorical meaning having to do with "transformation" and supporting "change". This definition acknowledges the great significance of this role in caring for women. The word itself comes from the Old English "mid wife" meaning "with woman". It is the midwife who accompanies the woman on this journey.

History

Neighbor women and lay midwives traditionally attended women's births in Canada at home; however, these caregivers were unregulated and not organized and there was no formal education system for midwives. Their numbers declined with the increasing number of doctors involved in maternity care. By 1960, most births occurred in hospital and midwives had almost disappeared.

The push for regulated midwifery came from an active consumer movement that resisted increasingly medicalized and instrumental births, where babies were separated from mothers after birth and where there was a strong government and obstetrical opposition to home birth. Women wanted choice of birth place, and regulated midwifery.

It wasn't until 1994, that the first province in Canada, Ontario, achieved regulated midwifery, and a midwifery education program funded by the provincial government.

Midwifery Model

The Midwifery Act of 1994 supported a Midwifery Model that was developed by learning from midwifery in other jurisdictions in the world and it is a model that currently is envied throughout the world.

The model places the woman and her baby at the centre of care and acknowledges that those family members and friends important to the woman are her chief supporters. She is cared for by midwives whom she knows, usually two but not more than four. The midwife is supported in her work by the Association of Ontario Midwives who advocates for her.

She is furthermore regulated by a College of Midwives designed to protect the public and which requires the midwife to uphold the demanding and important aspects of the model.

The midwife and the women are situated within the Ontario Health Care system, the women's care is paid for by the government. The midwife is a primary caregiver, is autonomous and not supervised by doctors. She has hospital privileges, is able to consult and transfer care.

Choice of Birth Place

The midwife must offer the woman choice of birth place: whether hospital, home or birth centre. Furthermore, the midwife must be competent and confident to provide care in all settings. Midwives are required to be annually updated and trained for emergencies in any settings.

Informed Choices

Midwives are required to discuss clinical options in all areas of care. The midwife is obligated to provide information so the woman can make choices about her care and to provide continuous care through pregnancy, interpartum and post partum care. All of this is done through her availability and time spent with the woman.

Continuity of Care

Women see no more than 4 (usually 2) midwives through the prenatal, intrapartum and postpartum periods. The woman's main midwife or back-up midwife is on call and accessible 24 hours a day, 7 days a week. Prenatal and postpartum visits are at least 40 minutes, sometimes longer, to leave time to explore any concerns and to develop a relationship with the woman, her family and her chosen supporters.

Midwifery Practice Groups

Midwives work in practice groups of about 6-12 midwives in settings within the community (outside of hospital) and are responsive to the particular needs of that community (for example, immigrant and refugee populations, inner city women). Family members and friends are always welcome. The midwife is privileged to be invited to care for the woman.

Prenatal Care

Women are seen on regular schedule: midwives do all care: tests, swabs, physical examinations, medical and obstetrical history, ordering ultrasounds, genetic testing and prescribing certain medications, for example. They provide childbirth classes and make at least one home visit.

The woman is the primary decision maker in all aspects of her care; the midwife must provide information in order that the woman can make evidence-informed decisions.

The time spent with women is important in order for a relationship of trust to develop between the midwife and woman so the woman can feel comfortable sharing her

concerns and so that the midwife can be responsive to what is important for the woman. (This is particularly important when working with women who have experienced sexual abuse in their past.) She is encouraged to contact her midwife with any concerns.

Intrapartum

The midwife must be competent and competent to offer choice of birth in hospital, home or birth centre. The woman pages or calls her midwife any time night or day to report signs of labour. (If the midwife is off-call, she must have arranged for a midwife known to the woman to be on-call). The midwife then often makes a home visit to the woman in early labour to assess labour and depending on the circumstances arranges to be with her when active labour begins. She provides monitoring and continuous labour support and arranges to have the second midwife arrive either to the home, hospital or birthing centre in second stage. The woman delivers her baby surrounded by her loved ones and with the watchful care and attention of her two midwives. Physicians and others are not in attendance unless there is a transfer of care for a cesarean birth or forceps or some other abnormal situation. If there is a transfer of care, the woman's midwife remains to provide support.

Women may wish to have their babies in bed, on their hands and knees, standing, sitting on a birthing stool, in a birthing pool or in any position they wish. They may wish to follow certain meditative or calming processes, or sing, or moan or vocalize. They may wish to be massaged or held or work quietly with the labour alone. They may wish to eat, drink or snack through labour. Much discussion around choice of birth occurs during the prenatal time; however, women are encouraged to have this choice be dynamic. A planned hospital birth could change to a home birth and a planned home birth to a hospital birth depending on the woman's needs, wishes and the circumstances.

The midwife's job is to follow the woman and support what she needs to do. We know that when women feel safe and supported, the important hormone oxytocin can do its work. Midwives take all necessary equipment to home births. In hospital births, they provide all care. Two midwifery-led birth centres have recently opened in Ontario.

Post partum Care

Right after the baby is born, the midwife supports skin-to-skin baby-mother connection, and when appropriate performs a newborn baby check, checks the mother and does any necessary breastfeeding support and suturing. She stays for at least 3 hours. If the baby is born outside of the hospital, she helps the family get ready to leave for home.

The midwife visits the baby and mother within 24 hours of the birth and then then does at least 3 more home visits over the next 10 days (sometimes as many as10 if there are breastfeeding or other concerns) and then visits continue in the midwife's clinic until 6 weeks postpartum.

Growth of Midwifery

Midwifery in Ontario is growing at a great rate, from 60 regulated midwives in 1994 to over 740 working in 97 clinics —about 14% of all births in Ontario. We hope that this number will grow to 80%! Since 1994, midwives have attended 180,000 births; 35,000 of these have been home births. Currently, 4/10 women in Ontario who wish a midwife cannot obtain one. Obstetricians still attend 82% of births. It is estimated that 60% of these are low risk and could be attended by midwives.

Midwifery Education Program

The growth of the number of midwives depends on the Midwifery Education Program (MEP) that takes in 30 students each year at 3 sites (Ryerson, McMaster and Laurentian Universities) in Ontario into its 4-year university bachelors of health sciences program. There is also a 6-9 month bridging program for foreign trained midwives run through the International Midwifery Pregistration Program at Ryerson.

The MEP was developed by and is taught by midwives; core midwifery as well as obstetrical texts are used. Of 9 semesters, 3 are pre-clinical and 6 are clinical where students are working in the field.

Preclinical courses.

Non science courses: required electives in the social sciences (including Birth and Its Meanings) and women's studies: two semesters of Working Across Difference; With Woman; Aboriginal Childbearing and Critical Appraisal of the Research Literature.

Science courses: Biology; Anatomy and Physiology; Reproductive Physiology; Pharmacotherapy and Life Sciences.

Clinical courses: for 4 semesters students work directly with midwives; for 2 semesters, they work with interprofessional partners, such as: lactation consultant, with an obstetrician, with high risk women, in the neonatal intensive care unit and electives, such as an international placement. During their midwifery placements, students perform clinical work under the supervision of a midwife 24/7 as well as attend weekly 3 hour tutorials at the university.

Reflections

The regulation of midwives, as primary health care professionals, was a social policy innovation that challenged the dominant medical authority and instituted new laws. Like physicians, midwives now had hospital privileges and were integrated into the health care system. Resisted dominant medical authority and challenged texts Changed laws (Ontario Healthcare Act). Profoundly entrepreneurial and cost-effective with Excellent outcomes: low cesarean birth/high breastfeeding rates.

Midwifery attempts to voice the needs of women so that their primary narratives can be heard, not the agenda of the caregiver.

Reflect on the difference in agency between these two statements: *"The midwife delivered the baby"* and *"The woman gave birth"* In the first the woman isn't mentioned. In the second, it is the woman who is in the nominative, active, present and acknowledged. Although birth is only one day in the life of a woman, it has an imprint on her for the rest of her life. And on the rest of the baby's life.

Midwifery is a profession where midwives can engage head, heart and hands, while keeping women at the centre. Midwives want to support women so that they can birth and care for their babies with relaxation, pleasure and joy.

A question some midwives in Ontario are struggling with:

The Ontario Midwifery model is highly satisfying but demanding. Some would say, Good for the woman, but difficult for the midwife. Can midwives sustain the on-call life and continuity of care?

Barbara Grandi asked that I might share some of my personal experiences with you as well.

Mary Sharpe: Personal History*

I believe that it was my mother's story of the caring and supportive relationship she had experienced with her midwife when my twin sister and I were born that set me thinking about a possible future career as a midwife. When we were about nine our mother began to tell us about our births in 1942, and about the care given by Jenny, her British-trained midwife. Jenny had inspired her by walking around the bed with her between contractions, declaring: "With every pain, the creator makes the opening a little bit bigger." In her opinion, medication should be avoided in order to protect the second twin. After our births, a doctor, who had been present in case Jenny needed help but had sat quietly in a corner, wound up a phonograph player sent to the hospital by my father and played Tchaikovsky's *First Symphony*.

However, "midwife" was a word that was rarely mentioned to a young woman growing up in Ontario, and there were no schools to support my ambition. Although I began university studies in the social sciences, I became discouraged by the behaviouristic and positivistic nature of these courses, and switched into English and philosophy, which seemed to have more heart and human interest. Upon graduation, I became a high school English teacher.

In the summer of 1964, when I was at university, I had the privilege of living for three months with an Aboriginal band in Northern Ontario. I was asked one afternoon to travel for 80 miles in a taxi with a woman in labour. I grabbed a bottle of disinfectant, a ball of string, and a pair of scissors and sat awkwardly beside Molly, a stranger to me, as she worked silently and bravely

with her strong contractions. This was her ninth baby. She delivered her baby with the assistance of an obstetrician minutes after we reached the hospital. I wondered why we had made the trip.

Later that week, I had a contrasting experience. I visited a young woman who had given birth at home to her first baby the day before in her log cabin with the help of a midwife on the reserve. She was nursing her baby by the light of an oil lamp and spoke of her special connection with her midwife. The scene I witnessed in the cabin had a kind of respectful simplicity about it compared to the alienating and disruptive experience for the woman who had been rushed to the hospital by taxi.

Throughout my youth, formal schooling often seemed irrelevant. Ideas and information floated around in a way that didn't relate to me. It wasn't until I gave birth to my oldest child, Jenny, whom I named after my mother's midwife, that I came in touch with intuitive knowing, the life of the practical, the connection with the organic or, as my mother would say, "the real thing." I found a knowing in myself that was clear, meaningful and powerful, arising from my body, unfolding in the primal acts of birthing and breastfeeding.

I began to network with other mothers; we formed a strong subculture exploring childbearing, breastfeeding and parenting practices. We began to read, write, research and share our learning with one another. As debutante midwives in the mid-1970s, we offered support to birthing women as friends. I discovered that direct experience and work in relationship with my children and other women were ways of knowing that had a valid place in the intellectual and academic world. These experiences put me on the path to becoming a midwife. I took an obstetrics nursing course in New York, and worked as a labour supporter at births in the Bronx. My work as a doula, or birth attendant, with women labouring in hospitals nurtured the social activist in me as I was astounded by unkind treatment and lack of choices for women. I became a childbirth educator and a lactation consultant, studied midwifery in the United States, practised as an assistant to homebirth doctors in Toronto, took on primary care for women having home births, and eventually in 1994 became an Ontario registered midwife, faculty member in the Ryerson Midwifery Education Programme and for five years its director. I have had the potent triple experience of practicing, teaching and researching midwifery. My masters degree explored midwives' impressions of the changes in their practices following midwifery regulation and my PhD explored woman-midwife relationships.

I have had the great privilege of developing relationships with over fifteen hundred parturient women, as a lay midwife and registered midwife. I have experienced profound changes in my midwifery practice over the years. The changes since midwifery regulation have been both joyful and puzzling. I noticed that something utilitarian involving shifts of feeling and attention began entering my practice. Why did I newly feel an impatience arising in me toward some women? Why did I feel less fear while working with women? To support the clinical needs of students in the midwifery baccalaureate programme, along with most other midwives, I usually had a student present in my practice. I was required to share my caring not only with other midwives but also with students. Although this had previously also been the case with apprentices, I was now stepping aside more to encourage the relationship between the woman and the student. I felt that I was moving away from relating directly to women and that this distance was affecting the care I was providing. I needed to continue to be alert and to try to sustain an approach to care that involved intention, attention and sincerity.

I brought my own birthing experiences to my research, as a woman who has received several forms of maternity care. These experiences alerted me personally to the importance of the caregiver-woman relationship. Between 1970 and 1982 I gave birth to six children. I birthed in five different settings with six different caregivers: for my three hospital births in the United States, the primary caregivers were, respectively, two obstetricians and a nurse-midwife; for two of my three home births I had family practitioners in Toronto and for the third a midwife in France. The midwives in the United States and France worked in jurisdictions where midwifery was legislated and institutionalized. The care provided me by midwives was not particularly special, personal or decidedly more positive than the physicians' care. I believe that my unpleasant experiences with the birth of my third child with the uncaring and cold service I received from the nurse-midwife in the United States led in part to my research questions with respect to the woman-midwife relationship. For the birth of my last child, I received care from a midwife in France who was very formal in her care and seemed not to be interested in developing a relationship with me. It is ironic that I gave birth to this child before the midwife arrived. The obstetricians and family physicians who attended me showed as much warmth, respect and quiet acceptance for my choices as did the midwives.

I have investigated birthing and midwifery practices in many countries around the world. I have engaged in professional dialogue with midwives, obstetricians and midwifery students, learned their models of care, observed births, presented research about Ontario midwifery care, and helped facilitate the exchange of information – and sometimes midwifery personnel – between these countries and Canada. This sharing has been a rich privilege.

*Partially excerpted from my PhD dissertation, Intimate Business: Woman-Midwife Relationships in Ontario, Canada. University of Toronto, 2004.