TERRITORIALITY AMONG HEALTH CARE WORKERS:
OPINIONS OF NURSES AND DOCTORS TOWARD MIDWIVES

BY

HILKKA ANNELI DAVIDSON

A Thesis submitted in conformity with the requirements
for the Degree of Doctor of Education
Department of Sociology in Education
Ontario Institute for Studies in Education of the
University of Toronto

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Territoriality Among Health Care Workers:  
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Doctor of Education, 1997  
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ABSTRACT

This study examines the opinions of doctors and nurses regarding the newly legalized profession of midwifery in Ontario. My study is based on conflict theory which examines the power differences in society. My thesis is that the move to legalize midwifery as an autonomous profession, independent of the two other professions of medicine and nursing has engendered and continues to engender resistance from doctors and nurses.

The legalization of midwifery in Ontario in 1993 was the result of the concerted effort of many women over approximately 20 years to create an independent and autonomous profession for the management of childbirth. Although the practice of midwifery has existed throughout history and was initially the role of older experienced women, in recent centuries it has come under the control of the medical profession. Both gender and professional forces have together conspired to wrest control of the childbearing from women, and in so doing has medicalized it into an activity that must occur only in hospitals, and almost without exception, be interrupted by some form of medical intervention.

Interviews with key individuals involved in the movement to legalize midwifery and a survey of doctors and nurses in Metro Toronto confirm the continued existence of ambivalence, resistance and even hostility to the 'new' profession. This continued opposition appears to be based on the 'disease theory' of the management of pregnancy and childbirth, loss of professional control, loss of territorial control and feared loss of income and job-security.
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Last, but not least, my heartfelt thanks go to my family, my children Mark, Karen and Scott, (Scott, your computer knowledge saved my life many times), and to my wonderful husband, Derek, who stayed by me through some hard times helping, advising and encouraging. Thank you for being proud of me.
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One day an elderly lady came to call on Surjeeto’s mother, Mohindro. She said she was a health visitor employed by the government and from now on would come once a month to the village to examine and advise all pregnant women. She asked Mohindro to send Surjeeto for a checkup. Mohindro looked surprised and said, 'what is wrong with my Surjeeto?'

She was told that pregnant women required a checkup now and then to see if all was well. They also needed advice about diet and had to be taught childcare. Mohindro looked at the health visitor in amazement and said 'but I can teach my child how to care for her children, and what advice about diet can you give? We have plenty of milk, butter, dal, atta. What more is needed? And, as for a checkup, why I have had five children and never had a checkup for any of them.

The village midwife, Akki, came when it was time for me to deliver. The health visitor said that Akki was alright, but she had no training. Mohindro was more amazed than ever, and asked how any person could be untrained if she had delivered babies all her life? (Oakley, 1986:17-18)
Chapter 1

INTRODUCTION

In November 1991 midwifery was legalized in Ontario, the first province to do so. The site for Ontario midwifery education was decided in December, 1992: MacMaster University in Hamilton with two satellite campuses, Laurentian University in Sudbury and Ryerson Polytechnical Institute in Toronto. The first four year program started in September 1993. The number of students admitted to the first year was 26. By 1996 there will be 122 midwifery students in Ontario.

Midwives who have practiced here illegally were evaluated during 1992-3 for their competency and eligibility to practice legally. The updating course and testing were done at the Michener Institute for Health Sciences. Approximately 75 midwives were admitted to the course which ended in September 1993. Of course many of these women have practiced midwifery for years, delivering hundreds of babies quite legally in other parts of the world. Many of these women are from other Commonwealth countries or Northern European countries where midwifery has been legalized for a long time, or was never considered to be illegal.

As a member of the health care profession and as a nurse educator I question why midwives have been denied the right to practice legally in Canada, and why this was a problem historically in Canadian health care. Midwives were never licensed here until now although many women practiced midwifery. One suspects that the medical profession had a part to play in preventing the legalization of
midwifery. In the United States, some states licensed midwives, others did not. In the State of Illinois midwifery practice is punishable by a 10,000 dollar fine and/or a prison term of several years (Hirsh, 1993).

However, midwifery is making a strong resurgence in Canada now, as a legal profession. A conference on midwifery at MacMaster University in November 1992 proved this. There were representatives from all provinces and territories, all stating the determination and intention of their own areas to have midwifery established there. Some parts of the country are more advanced than others but all seem very committed to the idea of midwifery. The question arises: are midwives now going to be accepted by the other health care workers, as part of the health care team or are they going to continue to face obstacles, especially from nurses and physicians?

The Catalyst for Change in Ontario

Problems with Births at Home and Hospital

The event that catalyzed the movement for the legalization of midwifery in Ontario was the baby death that occurred on Toronto Island in 1983, with midwives attending that home birth. The baby experienced breathing problems right after birth and although the baby was rushed to the neo-natal unit at the Hospital for Sick Children, he died 2 days later. The midwives were exonerated of any criminal wrongdoing at the subsequent inquest. Adverse media coverage of this case was extensive.
However, there are unfortunate events that occur in the hospital maternity units, under the care of physicians, that do not get media coverage. In the fall of 1992, while I was on a teaching assignment in a maternity unit of one of the Greater Metro area hospitals, my colleague’s daughter was admitted to the labour room. She had been in intermittent labour at home for over 24 hours. When her contractions were 5 minutes apart, she came to the hospital. The attending physician had told the expectant mother that her pelvic opening was very narrow and that 'the baby was a good size' thus anticipating perhaps some difficulties with the delivery. My colleague stayed with her daughter and said that when the obstetrician came in periodically to the room, he seemed distracted. The labour progressed sporadically on and off for another 10-11 hours. The patient was totally exhausted when she was taken to the delivery room. The obstetrician used mid-forceps to deliver the baby.¹

A few hours after birth the baby began to have convulsions. She was rushed to the Hospital for Sick Children where the diagnosis of brain hemorrhage was made. Tests showed she was bleeding from several locations of her brain. She had to have craniotomies to relieve the intracranial pressure. The baby lived. However, it has been clear from early on that the baby has definite motor function deficiencies, though it is too early to test her for mental capabilities. The baby had at least some sight and hearing at the age of six months.

One cannot but wonder if there was some negligence in the obstetrician’s care of this patient. He knew the birth might not be easy, yet the labour

¹When the head is higher in the pelvis but engaged and its diameter has passed the inlet, the operation is called midforceps” (Reeder & Martin, 1987:861).
was allowed to continue for a very long time, and then, midforceps were applied to the fragile head. Perhaps a Caesarean section would have been preferable in this situation.

One also hears from colleagues that sometimes an attending physician is in a hurry during and after delivery, endangering the life of a baby or a mother. One example is when a physician pulls on the umbilical cord trying to hasten the delivery of the placenta, by pulling it loose from the uterine wall, causing the uterus to invert and hemorrhage. Emergency surgery is necessary to save the mother's life. Mothers and babies are not necessarily always safer in the hospitals attended by physicians than they are in home births attended by midwives and thus the furor over the death of an infant delivered on Toronto island by midwives in 1983 did not prevent the legalization of midwifery in 1993. On the contrary, the controversy that it generated over the safety of home delivery by midwives vs. hospital delivery by physicians led to the recognition that home births were not universally or necessarily more hazardous than hospital births and that midwives had a legitimate role to play in pregnancy and delivery.

**Midwifery Policy**

Some women had "come to believe that maternity care was overly controlled by the predominantly male profession" (The Task Force Report on the Implementation of Midwifery in Ontario, [henceforth called Task Force Report, 1987]). These women believe that midwives could provide more holistic care, and would
regard the process of pregnancy and birth as healthy events, resorting to medical intervention much less frequently.

These women and Ontario midwives lobbied the provincial government in order to get midwifery established in Ontario. The lobbying started over a decade ago (in the early 1980s). "After the announcement in 1986 that the government would recognize them, an extensive planning period ensued" (Kaufman, 1991a:1).

Once the provincial government agreed to establish midwifery as a recognized part of the Ontario health care system, a task force was created in 1986 (Task Force Report, 1987). The Task Force extensively consulted physicians, nurses, hospitals, health science educators and midwives. They held hearings and received submissions "from more than 500 women's groups, consumer organizations, and individuals" (Task Force Report, 1987:11). They also heard 180 oral presentations (Reid, 1989:1205). The members also visited other countries where midwifery is legally practiced, e.g., Denmark, Holland, England, Scotland, Wales and the United States (ibid.).

The Task Force recommended that every pregnant woman make at least two visits to a physician during her pregnancy when cared for by a midwife. This would facilitate access to prescription medications and to tests and procedures that require a physician's authorization.
Outline for Practice of Midwifery

The Task Force believed that midwifery can be practiced effectively in a variety of settings, including hospitals, birthing centres, medical practices and private midwifery practices.

Bill 56 (An Act Respecting the Regulation of the Profession of Midwifery) was passed through the Ontario Parliament in November 1991. It deals with the scope of practice. Midwives' duties are to assess and monitor a woman during her pregnancy, labour, and post-partum period, and provide care to her and her baby. The Bill lists some of the 'authorized acts', that is, the procedures the registered midwives are allowed to perform in their practice. The list includes some minor operational procedures, cutting and suturing, administering drugs by injection or inhalation, performing internal examinations, taking blood samples from the mother by venipuncture or skin prick or from the baby by skin prick, and prescribing drugs designated in the regulations.

Midwifery will be a self-regulating profession. The college is established under the name "College of Midwives of Ontario" in English and "Ordre des Sages-Femmes de l'Ontario" in French.

On January 28th 1994, history was made in Ontario. In Markham/Stouffville hospital a baby was born with the help of two midwives. This was the first legally assisted birth by midwives in Canada. It was an important 'milestone' for midwives and the media brought it to the attention of everyone.
Research Plan

In this study I will research the attitudes and opinions of obstetricians, general practitioners who practice midwifery, obstetric nurses and nurse midwives toward the midwives who were part of the Ontario health care team since 1994.

There is evidence that "family physicians and Gynecologists are rapidly discontinuing obstetric practice. Infringement on lifestyle and threat of litigation are the two most important reasons for both family physicians and Gynecologists withdrawing from obstetric practice" (Rosser and Muggah, 1989:2419). Nevertheless, it appears that doctors feel threatened by midwifery. There may be many reasons for this. Midwives are very likely going to take away some patients from doctors. Thus there may be the fear of a loss of income. There may be perhaps also a more covert but more important reason why doctors object to midwifery, namely the issue of power. Pregnancy and childbirth are entirely female events. A male doctor must feel very powerful to be consulted by a woman on matters of which he has no personal experience. Pamela Abbott and Claire Wallace write: "Medical dominance in these areas of women's lives means that women are controlled to a large extent by the medical profession, and they rely on doctors for advice and information" (Abbott & Wallace, 1990:108). They state further that doctors have taken over total management of pregnant women, so that women are unable to make informed decisions about their own lives. Assuming that all or most midwives will be female, a large number of midwives will change the gender ratio somewhat.
Nurses may feel threatened by midwives because there will be yet another group of professionals giving them orders. Many nurse-midwives, for example from the United Kingdom, have had years of experience as midwives in their native countries and many years as registered nurses in Canada. In 1996 when the first group of midwives graduates from the university programs in Ontario, there are many young and inexperienced midwives who will perhaps admit patients to hospitals, write orders for them, deliver babies, while the experienced nurse-midwives can only assist.

To add to a situation that may be perceived as humiliating to nurses, the starting salary of a midwife will be approximately the same as the top salary of an experienced nurse. The midwives will be university graduates whereas the large majority of nurses do not have university education, but a three year community college diploma. Some of the older nurses were trained in hospital schools, most of which were three year programs. Nurses never had much power, but they may fear their power may even further decrease with the coming of midwives.

One very practical reason that nurses may object to midwifery is that midwives may cause lay-offs among nurses. When midwives do deliveries at hospitals, there are always two midwives present but when a doctor delivers a baby there are usually two or more nurses assisting.

In discussing health care issues in hospitals, both doctors and nurses are concerned about the diminishing funds for health care. Therefore, if another group of workers is coming to share the funds, the fear may be that there will be that much less for everyone.
Midwifery is now part of Ontario's health care system. Midwives will have an impact on the system and how maternity care is delivered. Small changes are occurring presently in the health care field, in the area of child bearing. Janice Turner reported in 1993 in the Toronto Star about Wellesley Hospital: "A team of construction and design experts are busy putting the finishing touches on a new maternity centre, set to open early in the new year" (Turner, 1993, p.E1). This new centre will be very much a 'woman centred' birthing place. A pregnant woman will be allowed to make informed choices, where she "will be able to labor, give birth, recover and rest up" (ibid.).

The physical changes are not the only ones taking place. Fundamental changes in attitudes, policies and procedures are necessary. "Nurses have had to be cross-trained to be full-service providers, while physicians have had to adjust to the idea of sharing power" (ibid.). However, not everyone can live with the changes. "Not everyone has been able to shed the traditional, doctor-driven approach, concudes Dr. Paul McCleary, chief of obstetrics and gynecology at Wellesley Hospital. Three of nine staff obstetricians have left to work elsewhere" (ibid.). (However, the issue of midwifery was not the only reason for the three doctors to resign.)

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2 The data were confirmed by a phone call to Wellesley hospital maternity unit.

3 The data were confirmed by a phone call to Dr. McCleary's office.
Lynn Sears Williams writes in a recent issue of Canadian Medical Association Journal: "A new generation of legalized midwives entered Ontario's health care mainstream in January and their arrival drew mixed responses from the province's physicians. Although some groups hailed their arrival, many doctors are upset about the change" (Williams, 1994:730).

If attitudes are negative, as hypothesized, this knowledge may assist the midwives to cope with and adjust to the health care world. If they are aware of possible problems, they can prepare themselves to face them. They can begin to problem-solve in advance. Blais et al. stated, in a study conducted in Quebec: "Identifying the areas of consensus and disagreement among the maternity care providers most concerned with the introduction of midwifery ... could help eliminate some misunderstanding and, eventually, define models of midwifery that would be acceptable in the current health care system" (Blais et al., 1991:6).

This study will reveal to some extent whether the power structure in the health care field is changing and whether women who make up a large majority of the para-medicals are making any gains in the medical hierarchy.
Chapter 2

HISTORY

"The practice of midwifery dates back to the beginning of human life. Its history parallels the history of the human race and its function antedates any record we have of medicine" (Task Force Report, 1987:197).

Classical Times

European History of Midwifery

From time immemorial women have helped each other in child birth. Midwives appear in the Bible: Genesis and Exodus (Donnison, 1977). They are also mentioned in Greek and Roman writings. The "mother of Socrates was a well-respected midwife" (Scott, 1989:14). Jean Donnison points out that in ancient times child birth was regarded as a female 'mystery' of which women alone had special knowledge and understanding. Child birth was presided over by female deities: Isis, Juno, Lucina, Diana.

Despite the contribution and importance of midwives to the human race, literature through the centuries has all but ignored them. However there was one important text written in the second century by a Roman named Soranus. It describes "the craft of midwifery so thoroughly and clearly that translations into the vernacular
of various European languages, and even into Japanese, through China, probably carried there by Marco Polo or other travellers appear by 1550" (Scott, 1989:14).

The book has a description of a birthing stool, and of various herbs with their uses and effects, and "even the technique for rupturing the bag of waters around the fetus to hasten labour is spelled out" (ibid.). According to Soranus "we call a person the best midwife if she is trained in all branches of therapy (for some cases must be treated by diet, others by surgery, while still others must be cured by drugs)" (Benedek, 1977:551).

According to Benedek, there is hardly any mention of midwives in literature after Soranus' book until the Renaissance. "They simply were ignored in medical writings until the end of the 16th century" (ibid.). Of course babies were born and midwives were there to help at all times. "The quality of the practice of midwifery during the Renaissance may have been generally inferior to the better class of Greek practice some 1300 years earlier if we assume that the qualifications of a midwife which were recommended by Soranus of Ephesus early in the 2nd century were commonly adhered to" (Benedek, 1977:550).

**Middle Ages**

When Christianity spread in Europe the church took control of all aspects of life. Healers came to be regulated by the priests. Priests, who were all male and had never even seen a birth, began to advise and regulate the midwives who were all female. "The paradox clearly resulted not only from a degree of occupational
prestige, but inextricably also from the relative prestige of men and women in the social order" (Benedek, 1977:551). Midwifery was woman's business, but male doctors (with the support of the priests) involved themselves with it in the Middle Ages (Donnison, 1977).

'Witches' and Their Contribution to the Healing Arts

No matter how well women treated illness or how knowledgeable they were, they were suspected of wrongdoing. Men found the mystery of female anatomy and physiology - that obviously only women had knowledge of - perplexing and somewhat frightening, as people are naturally afraid of the unknown. Women's knowledge in healing matters undoubtedly was greater than men's until modern times.

Women have always been healers. They were the unlicensed doctors and anatomists of Western history. They were abortionists, nurses and counsellors. They were pharmacists, cultivating healing herbs and exchanging the secrets of their uses. They were midwives travelling from home to home and village to village. For centuries women were doctors without degrees barred from books and lectures, learning from each other, and passing on experience from neighbour to neighbour. They were called 'wise women' by the people, witches and charlatans by the authorities" (Ehrenreich & English, 1973:1).

The French word for midwife is still sage-femme. The 'wise women' were very 'advanced' in their knowledge about herbs. In the Middle Ages these women used medications that are still in wide use today. They obtained ASA
(acetylsalicylic acid) from willow bark and of course aspirin is a very common drug today used as an analgesic and as an anti-coagulant (i.e. preventing blood clots - important medication sometimes for post partum mothers to prevent life-threatening thrombi and embolisms from forming). They also used Ergot from spoiled rye. This drug is widely used in obstetrics today to prevent post partum hemorrhage. It is also used in treatment of migraine headaches.

The wise woman, or witch, had a host of remedies which had been tested in years' use. Many herbal remedies developed by witches still have their place in modern pharmacology. They had pain-killers, digestive aids and anti-inflammatory agents ... Belladonna still used today as an anti-spasmodic was used by the witch healers to inhibit uterine contractions when miscarriage threatened (Ehrenreich and English, 1973:12).

Belladonna originally got its name from its dilating action on the pupils of the eye - a woman was perceived to be more beautiful if her eyes looked darker with dilated pupils. Belladonna drops are commonly used by present day ophthalmologists prior to eye examination. "Digitalis, still an important drug in treating heart ailments, is said to have been discovered by an old English woman in the 18th century" (Ehrenreich and English, 1973:12).

While women healers were using herbal remedies the learned doctors were still treating humours and bleeding their patients for every conceivable ailment. The church imposed strict controls on doctors, who seem to have obeyed the church dogma more willingly than the female healers did.

University-trained physicians were not permitted to practice without calling in a priest to aid and advise them, or to
treat a patient who refused confession ... Incantations, and quasi-religious rituals were thought to be effective. The physician to Edward II, who held a bachelor's degree in theology and a doctorate in medicine from Oxford, prescribed for toothache writing on the jaws of patients, 'In the name of the Father, the Son, and the Holy Ghost, Amen', or touching a needle to a caterpillar and then to the tooth. A frequent treatment for leprosy was a broth made of the flesh of a black snake caught in a dry land among stone ( Ehrenreich and English, 1973:15).

Male doctors had the edge because the church, which controlled everything, was operated and administered by men, and therefore favoured men as healers.

Universities would not admit women to study medicine, thereby allowing male dominance to occur and diffuse into all aspects of health care except midwifery. It took much longer for men to get into midwifery because of prevailing moral laws. Midwifery and child birth were considered dirty. A woman giving birth was 'contaminated' in the eyes of the church; therefore men were not too eager to break into this area initially. The attitude that proper doctors had no business in midwifery continued till the last century. It was partially due to this issue that the midwives were so maligned and equated with witches. If only women could do it, it must have been witchcraft.

In 1484 a book was published that was very damaging to the profession of midwives. It was called Malleus Maleficarum or Hammer of Witches. It was written by two German inquisitors, Heinrich Kramer and Jacob Spenger ('two beloved sons of Pope Innocent VIII'), (Benedek, 1977:560). Witches were accused of giving contraceptive aids and performing abortions and of eating unbaptised babies. The
most serious accusation of all was that "The witch is accused not only of murdering and poisoning, sex crimes and conspiracy - but of helping and healing" (Ehrenreich and English, 1973:10).

However, where were the poor people to get help with their illnesses? The male doctors directed their practice solely to the well-to-do in society; they were able to pay. The poor turned to the women healers because "on Sundays, after Mass, the sick came in scores, crying for help - and words were all they got, 'you have sinned, and God is afflicting you. Thank him: You will suffer so much the less torment in the life to come. Endure, suffer, die. Has not the church its prayers for the dead'"(Ehrenreich and English, 1973:11).

Malleus Malificarum also stated that "if anyone dares to cure without having studied, she is a witch and must die" (Benedek, 1977:560). Thus while male medicine gradually became fashionable, female medicine, especially midwifery, was stereotyped as evil magic.

**Midwifery Training**

Jacoba Felicie, who was a female physician in Paris in the fourteenth century, during her malpractice trial (in 1322) suggested higher learning for midwives so they could give better care to women, especially in the reproductive areas, since male doctors were forbidden by law to examine female patients' secret parts. Many women had perished of their illnesses because they could not let a male doctor examine their hidden parts and prescribe treatment. Felicie’s argument was that "in
the existing moral climate female physicians should be available to give women medical care, especially in regard to their reproductive organs" (Benedek, 1977:552). Women had little chance to study because they were considered inferior to men, therefore unable to learn as well; "women are more feeble" and most (but not all) women were illiterate and thus could not study. However, a century later "the predominantly obstetrical texts, which began to proliferate in the 16th century, were written in the vernacular more frequently than texts on other medical subjects because they were intended primarily for a readership which generally was ignorant of Latin, that is women" (ibid.).

Midwifery training and licensing did begin in the late Middle-Ages, first in Germany and then spreading to other parts of Europe. "The first known ordinance on this subject was enacted in Regensburg (Bavaria) in 1452. It did not specify any required training, but did require candidates to be examined publicly by 'honorable sworn women' who also were responsible for supervising them" (Benedek 1977:553).

If complications occurred during labour and delivery, a midwife was to consult a learned doctor (much like today). An elaborate midwifery ordinance enacted in 1573 in Frankfurt am Main stated "The midwives were not only instructed when to call a physician, but also in their responsibility if he failed to respond" (Benedek, 1977:556). In sixteenth century England, the midwives were regulated by the church, but "ecclesiastic instruction was to receive precedence over medical instruction" (Benedek, 1977:558).

Louyse Bourgeois (1563 - 1636) "was the first woman to write a book about midwifery" (Benedek, 1977:563). She was the wife of a physician and became
a royal midwife and served in that capacity for twenty-seven years. She delivered the future King Louis XIII (of France). But even such an important job was precarious. When one of her patients (Duchess d'Orleans) died following a delivery, Bourgeois was dismissed although no blame was placed on her for causing the death (ibid.). Bourgeois had objected to bleeding post-partum women, arguing that blood loss was substantial during delivery, therefore further bleeding would weaken a mother’s condition. She also advocated education for midwives and free consultation with doctors and surgeons.

Male Infiltration of Midwifery Begins

Male dominance increased in midwifery as the church continued its powerful presence. Mutual consultation and working together between male doctors and female midwives did not materialize. Doctors derided midwives more and more as they (doctors) invaded the field of midwifery. This was to bolster their image and attract more wealthy patients (Corea, 1978).

Some men went into midwifery to obtain a back door entrance to medical schools; that is, if they were not smart enough to get into medical school, they began to practice midwifery for a while (no one prevented them from that) and applied to medical school with practical experience behind them. Men also had to be wealthy to become doctors. The licensing laws favoured the rich. "The rich man's son is sent to your medical institution - he pays fees for lectures that he hears or does not hear - 'tis all the same - money buys him a diploma - he is licensed to draw blood, to
puke and purge mankind, at such price as he is pleased to demand" (Corea, 1978:28-29). On the other hand: "a poor man's son, no matter how capable, could not afford to become a physician ... (He might have added that women were excluded from medical schools just as the poor men were)" (ibid.).

**Delivery Forceps Developed**

Male prestige in midwifery also increased as a result of the invention of the delivery forceps. They were invented by members of the Chamberlain family. They were French Huguenots who had migrated to England. The Chamberlains managed to keep the forceps hidden and their use a secret for an incredible one hundred years. This was made possible by the fact that male midwives had to work by feel, not by sight. They had to have a sheet draping a woman in labour so they were unable to see the genitalia. For the same reason the patient was unable to see what was done under the sheets. Any female midwife in the room was ordered out before the forceps were used (Corea, 1978:251).

**Hygiene**

Hygiene, which in today's obstetrics is greatly emphasized, received little attention until the development of the 'germ theory' at the end of the 19th century. However, it was not totally ignored. As early as 1560 the first midwifery ordinance outside the German states was enacted in Paris. It required that "before they begin
they must take the rings, if they have any, off their fingers and wash their hands" (Benedek, 1977:557).

After the learned doctors began to deliver babies, the number of women contracting puerperal fever as patients of doctors far exceeded the number of women infected if they were looked after by female midwives.

In 1847 Semmelweiss observed in Vienna that the death rate of mothers in hospital wards attended by medical students was three times that in wards attended by midwives. The explanation, though unknown at the time, was rather simple. The medical students brought contagion from post-mortem rooms where they performed or assisted in autopsies on people who had died of various infections, such as puerperal fever. They might have washed their hands, but they did not change their clothes before going to assist in deliveries. Doctors, when presented with these statistics, were incensed (Corea, 1978:253-254). When Semmelweiss made his observations known, doctors retaliated and committed him to a mental hospital where he died of an infection in 1865. Doctors felt that they were gentlemen, who have clean hands; therefore, they could not possibly carry disease among their patients.

The year of Semmelweiss' death, Dr. James Edmunds enraged English doctors by reporting that fewer women died at the hands of female midwives than at their own. He had gathered statistics on puerperal deaths in London and at the Royal Maternity Charity. Poor patients delivered by midwives at the Charity expired from puerperal causes at the rate of one in every 556 births, he found, while private London patients, delivered mostly by medical men, died at the rate of one in every 204 (Corea, 1978:253).
The dreaded puerperal fever was only eradicated after Pasteur discovered microorganisms and developed his 'germ theory' in the latter half of the 19th century. He recognized that both lactic and alcohol fermentation were hastened by exposure to air.

He was able to declare with certainty in 1864 that the minute organisms causing fermentation were not spontaneously generated but came from similar organisms with which ordinary air was impregnated ... Lord Lister, who saw the applicability of these discoveries to surgery revolutionized surgical practice by utilizing carbolic acid in 1865 to exclude the atmospheric germs and thus prevent putrefaction in compound fractures. (Niven, 1970:439-440).

That was the birth of surgical asepsis and medical cleanliness.

**History of Midwifery in North America**

When doctors medicalized child birth, it meant they controlled the situation: "Men cannot give birth, nonetheless, they have taken control of childbearing and now they teach women how to do it properly" (Corea, 1978:249).

Before men took over midwifery in North America, "a woman used to sit upright, sometimes on a birthing stool, and deliver a child while the female midwife coaxed and encouraged her. When male doctors became the birth attendants, they adopted the lithotomy position for their own convenience and not for any medically valid reason" (Corea, 1978:235). The lithotomy position, where a woman lies on her back with her legs separated and elevated into stirrups for delivery of the baby, was
adopted purely for the convenience of the attending doctor, who could sit comfortably and extract the baby, while the woman giving birth would be in a very uncomfortable position having to push upward to give birth.

Some native women in North America either knelt or squatted while giving birth. Those positions are far more natural since the birth canal curves forward. Lying on her back, a woman has to push upwards to deliver her baby.

Although over 90 per cent of all births are normal, maternity care is routinely carried out in the hospitals.

The woman who is about to give birth is removed from her loved ones, taken to a cold and sterile room, strapped to a table, her legs apart and elevated, her knees in stirrups, her arms attached to an intravenous bottle, her belly to an oscilloscope...now strapped down and drugged, she is the object on which the doctors work and her unborn baby is the intra-uterine patient (Corea, 1978: 209).

Since doctors have taken over midwifery (obstetrics became a recognized specialty only decades ago), they must teach new doctors on 'how to instruct women to give birth'.

Doris Haire observed women in labour and delivery in the sixties. Time after time I saw women doing fine in their labour. They were pushing down and seemed to be fully in control. Then the doctors would lay the women down, let some guys practice their spinals on them, and then extract the babies with forceps. I finally asked the senior resident why they kept doing that and he said 'the thing you don't understand Mrs. Haire is that if every woman had natural childbirth, we wouldn't be able to practice techniques (Corea, 1978:232).
While doctors have always applied the medical model to child-birth, midwives have always regarded births as natural phenomena. They have allowed the women to be in control for the most part, just coaching and helping while nature takes its course. However, most midwives realize that there are exceptional cases where medical intervention is necessary and will consult a doctor in these situations.

**History of Midwifery in Ontario**

Before the white man arrived in North America, there were native midwives; however, there is no written history of their functions prior to the arrival of Europeans. "Native birth culture in its regional variations, presumably having endured for many centuries before the various native groups had contact with Europeans, has even yet not quite died out, despite drastic interventions by non-native medical workers whenever contact was made" (Task Force Report, p.201).

Among the white settlers, there was a 'neighbourhood network': "Helping out at births was something that neighbours did for one another" (ibid.). Birth attendants were women who very likely learned their trade from their own mothers. Some women had brought seeds with them from their home country and grew herbs in their gardens for medicinal purposes (ibid.). These women treated people where there were no doctors but even when there were doctors, women "continued to call in neighbouring women, friends, and relatives, until long after doctors were delivering most babies" (Scott, 1989:22).
In the pioneer days immigrant women in Canada were mainly European, most of them from France and the British Isles. Poor immigrant women were often assisted in birthing by midwives from their own culture and gave birth at home instead of in hospital. They often fared better than the middle class immigrant women who delivered at hospitals, where infections were common and women died of puerperal fever. "These midwives were, however, seen as not only siphoning the money that should be in doctors' pockets, but as also depriving the medical schools of poor patients on whom to practice" (Scott, 1989:24).

"The history of midwifery has generally been described in terms of a power struggle over the control of childbirth care between physicians and midwives" (Fynes, 1994:4). In 1795 it was made illegal in Upper Canada "to practice physic, surgery, or midwifery without a licence. According to Robert Gourley, the contemporary chronicler of those times, the Act was rather silly in the context of the scant population of most of Upper Canada" (Task Force Report, 1987:207). Gourley stated: "How absurd, how cruel, how meddling, that a poor woman in labour could not have assistance from a handy, sagacious neighbour, without this neighbour being liable to be informed upon and fined" (ibid.).

In 1869, orthodox medicine gained power and monopoly when the College of Physicians and Surgeons was founded. Education, licensing and registration for physicians were established. As licensed practitioners, physicians were then in a position to demand that unlicensed practitioners must not continue to work in the medical field, and objected to licensing those workers who had not been
educated in the same manner as they had been, such as midwives. Fynes cites a letter in the Canada Lancet in the latter half of 19th century.

I wish to oppose most strenuously [the licensing of midwives] as being totally uncalled for in a country which is flooded with doctors who have been thoroughly trained, and are therefore much more competent to deal with these cases than a midwife. I contend that as we have spent some of the most valuable years of our lives in the study of what is said to be a 'noble profession', as well as considerable money, that we should be protected most stringently against the meddlesome interference on the part of old women... who have never spent a farthing, nor lost an hour for the sake of becoming properly educated, to attend cases of confinement (Canada Lancet, 1873, 6:74).

There was no encouragement from physicians to establish midwifery education in Ontario to 'elevate' midwives to an acceptable level to practice. "The objections to licensing midwives under any conditions prevailed, and female midwifery continued to be illegal" (Task Force Report, 1987:207). Objections were often financially motivated. Midwives helped with deliveries for much less pay than the doctors; therefore it was easier for poor people to afford a midwife. One doctor complained that "where I am located I have to contend with two (midwives) ... they get about 60 cases a year, which would amount in my hands to a very decent living for my small family" (ibid.).

Twentieth Century

There were influential people early in this century, such as Lady Aberdeen, the wife of the Governor General of Canada, and Dr. Thomas Gibson, the
chairman of the Victorian Order of Nurses (VON), who advocated legalization of midwifery and training programs for them. However, objections were strong from nurses as well as doctors. "By 1935 over half the births in Canada occurred in hospital ... and by the end of the 1950s the medical profession successfully portrayed the image of birth as a medical event, requiring medical intervention in a hospital setting" (Fynes, 1994:13-14). Nonetheless, in remote areas of the country, midwives continued to practice. Mostly British-trained nurse midwives practiced in Northern communities because there were no doctors to help with deliveries.

**Revival of Midwifery**

Consumers, i.e. mothers giving birth, became disillusioned with the extensive use of technology in childbirth and the cold and impersonal atmosphere of the maternity wards in hospitals. They became instrumental in getting midwifery back into health care. Many women hired either a nurse midwife or a lay midwife to attend to their childbirths. These women wanted 'natural' childbirth again. This 'movement' began in the 1950s and gained momentum through the 1960s and 1970s.

Initially women who did not like the way they were treated in hospital maternity wards did not know how many others there were who felt the same. One incident brought this issue to public awareness. In 1957, the American magazine *Ladies' Home Journal* published a letter to the editor from a registered nurse who "asked the magazine to investigate the 'tortures that go on in modern delivery rooms'" (Task Force Report, 1987:223). *Ladies' Home Journal* had a wide circulation.
in Canada and the United States. The nurse mentioned some unpleasant things that women in the labour room have to put up with, such as being strapped to the delivery table, being isolated from their loved ones and often left alone. The response to the letter was so overwhelming that the magazine decided to publish a full article on the contents of the letters and titled it "Cruelty in Maternity Wards" (ibid.). Again a flood of letters resulted as women related their anger and frustration about their hospital experiences. Again the letters were published in an article, and "at the end of the article, the writer called for two major changes - that husbands be allowed into delivery rooms so that they could comfort and protect their wives, and that an immediate program of midwives' training begin" (The Task Force Report).

1960s

In 1961, the Medical Act of Ontario stated that "No person who is not registered shall practice medicine, surgery or midwifery for hire, gain or hope of reward" (cited in Fynes, 1994:55). The statement implies that only a licensed physician can practice midwifery. However, many communities, especially in some remote areas of the province, did not have doctors who could deliver babies. Often women were sent far away from home to have their babies in hospitals but quite frequently women were also assisted by nurse-midwives or lay-midwives in their own communities.
Although the midwives had no legal status they were not illegal according to Vicky Van Wagner, a registered midwife. They preferred to call their status illegal (conversation with van Wagner, Sept. 1994).

It was in the late 1960s, when the feminist movement began to gain momentum, that women began to pay more attention to their health issues and who controls these health issues. Some women began to question the medicalization of maternity care. They believed that pregnancy and childbirth were natural, not pathological, phenomena. Midwifery began to grow. "Feminism and midwifery cross-pollinated each other, though not without deep suspicion at first, as the midwives were seen to be celebrating the biological differences being repudiated by early feminists" (Scott, 1989:64). Opinions mellowed and the two groups found ways to support each other. The "women's movement created the confidence that allowed midwifery to flourish, and midwifery was for feminists a practical example of a woman-centred system" (ibid.) or as Burtch stated "the medical monopoly over childbirth has been challenged through consumer action and the women's movement in recent decades" (1994:23).

1970s

It is suggested that the Canadian state, including provincial governments, has in modern history become allied with powerful interests, not only in the private sector, but also in the growth of professions and social services. This alliance is dynamic, and allows for the exercise of discretionary powers by state officials (Burtch, 1994:23).
The medical profession had governmental support in its efforts to keep midwifery out of Canada. "Through their powers of law-making and law enforcement, as well as general fiscal policies, the provinces and the federal government were instrumental in promoting birthing care that has been dominated by medical and nursing services" (Burtch, 1994:37). Governments, however, do not have unlimited funds and in difficult economic times look for areas to cut back spending. In the 1970s provincial politicians began to look into maternity care when assessing the economic aspect of health care. Universal health insurance (OHIP) came into existence in the early 1970s. The committee that wrote the Frazer Report in 1970 (Selected Economic Aspects of the Health Care Sector in Ontario) dealt with the midwifery issue in a chapter entitled "Obstetrical Care: Midwife versus Obstetrician". The committee "considered whether the framework of licensing policy and educational requirements could be changed to allow for the training and use of midwives in such a way as to lower the current cost of maternity care, without compromising the quality of the care" (Fynes, 1994:58). The committee recommended the development of nurse-midwifery as a specialty in nursing. However, the Ontario Council of Health dismissed the recommendation as "unnecessary proliferation of specialties" (Fynes, 1994:61).

1980s

Midwives who continued to practice their trade did so without legal protection or recognition. Consumers wanted their services and were willing to pay
'out of pocket' costs to get midwifery care. Midwives "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" (Burtch, 1994:112). Midwives have adopted a more holistic approach to child birth. "There seems to be a general agreement among midwives that pregnancy is not synonymous with illness" (Burtch, 1994:55), but it is a natural part of life. Unlike physicians, who treat symptoms, midwives get to know the whole family and often assist the family with non-maternity issues (conversation with a retired midwife).

"As the 1980s began the midwifery movement was becoming more organized" (Fynes, 1994:72). There were strong objections from health care workers to the midwives' practice. The Ontario Association of Midwives was established in 1981. The ultimate goal of the Association was to achieve the status of legitimate health-care giver for midwives. Vicky Van Wagner writes: "We saw ourselves as sort of semi-legal - illegal practitioners. One of our goals was to see midwifery be legally recognized" (Van Wagner, 1993:115).

In the 1980s midwives received media attention due to the increasing number of home births: "Local TV talk shows featured midwives, and local newspapers focused on their activities" (Fynes, 1994:74).

There were some unfortunate incidents where babies died while mothers were attended by midwives. Inquests were held. The midwives involved hired a high profile lawyer, Clayton Ruby, to represent them. There was an outpouring of support from the public for midwives. Donations were sent to cover the legal costs. This
amounted to "$10000 in donations and sheaves of personal support letters" (Fynes, 1994:76). The jury recommendations in both the Kitchener, 1982, and Toronto Island, 1983, inquests were to legalize midwifery, setting standards for their education and practice.

Home births have raised one the strongest objection from physicians in connection with midwifery practice. Home births are seen as unsafe by physicians and physicians are not expected or encouraged to participate in them. However, it was the issue of home births that propelled the public and eventually the government to support midwifery. It was in January 1986 that the conservative government of Ontario announced that midwifery would be recognized and established in Ontario. The Honourable Murray Elston also "announced the creation of a Task Force on the Implementation of Midwifery in Ontario to make recommendations to him and to the Honourable Greg Sorbara, Minister of Colleges and Universities" (Task Force Report, 1987:11).

Summary

Midwifery seems to have been a respected profession in ancient times. Women cared for women in childbirth. When Christianity spread in Europe, the church gradually began to control all aspects of people's lives. Health issues, including child birth, were controlled by the priests, who supported men as caregivers. Respect for female midwifery declined and women healers were often labelled as 'witches'. Nevertheless, female midwifery survived in Europe and regained respect
until the mid 20th century. However, from the 1950s on women were encouraged to go to hospitals where male physicians 'delivered' babies, and the midwives' role was reduced to being a doctors' assistant in many English speaking countries. By contrast, in many countries in Northern Europe, midwives continued their work in hospitals as actual birth assistants, not doctors' assistants.

In Canada, however, midwives' status was very ambiguous until the 1990s when it was finally legalized in Ontario. (Ontario is still now, at the end of 1996, the only province that has implemented a midwifery program). The Task Force did a survey of practicing midwives in Ontario and found "approximately 50 midwives currently practicing in Ontario" (Task Force Report, 1987:72). They had very diverse training in midwifery; some were nurse midwives and others were lay midwives. Because of their small numbers, inconsistency in training and a legal status their existence was unknown to many people and they were vulnerable to criticism and were deemed unsafe by many of those who knew about them.

The feminist movement helped midwives to gain legal status. Women began to demand a say in their health care, wanting more control over what was being done to them. These women felt that the hospital environment, with the indiscriminate use of technology, was not the best place for such a normal healthy event as child birth. These women along with the midwives formed a strong lobby group and finally the Ontario government legalized midwifery.

In this province midwives are reclaiming their ancient role, demanding a reduction in the power differences that male sexist attitudes have created. It
remains to be seen what influence these developments will have in the rest of Canada.

The purpose of this study is to examine the extent to which these ancient attitudes and prejudices persist in modern nurses and doctors, despite legalization of midwifery.
Chapter 3

LITERATURE REVIEW

It is rather astonishing that as recently as 1992 we were told that "Canada is one of nine WHO member countries without an established profession of midwives. The others are Venezuela, Panama, New Hebrides, Honduras, El Salvador, Dominican Republic, Columbia and Burundi" (Kaufman, 1992:318). Canada was the only 'developed' country among the nine.

There is a plethora of literature dealing with midwifery in other countries, written by midwives, nurses, physicians, sociologists, feminists, academics, professional researchers, etc. Many countries have a long history of midwifery. The literature on Canadian midwifery is limited because midwifery has been an illegal occupation in Canada up until till the 1990s.

Now that midwifery is becoming legalized in this country, literature on midwifery is increasing rapidly. Ontario is still the only province to have implemented midwifery. There are three other provinces (Quebec, Alberta and British Columbia) that have legalized midwifery but they need to 'fine tune' their process and set down all the rules and regulations for midwifery, before implementing it, according to Margaret-Anne McHugh at the Ontario Ministry of Health (Personal telephone conversation, Feb. 1994. A follow-up phone conversation in November 1996 revealed that Ontario is still the only province that has implemented midwifery).
In preparation for my research I completed a computer search of the literature related to midwifery. A computer search with Medline and CD ROM - CINAHL (Cumulative Index of Nursing and Allied Health Literature) since 1984 revealed nearly 2000 sources in professional journals under the heading of midwifery. However, a large number of these articles (more than 25 percent) are not about midwifery but about nursing. The word midwifery appeared in them because the governing body in England for nurses is called 'United Kingdom Central Council for Nurses, Midwifery and Health Visiting.

Approximately another twenty five percent of the articles deal with various aspects of education in midwifery, such as curriculum development, midwifery models, clinical instruction, clinical placements, 'health teaching' mothers about their health and their babies' health. Since these articles are not related to the present topic they were excluded from the literature review. Excluded also were numerous articles which deal with midwifery in developing countries. Articles about medical procedures, and medical problems and complications in midwifery, and many other topics that are unrelated to the present topic were not included in this literature review. Only that portion of the literature that is germane to the topic of this study will be explored.

'Official' Opinions of Physicians and Nurses Toward Midwives

When the Task Force on the Implementation of Midwifery in Ontario began their work in 1986, they surveyed all the nursing and medical associations
about their opinions about the proposed 'new' health care group, the midwives. Representatives from various associations and governing bodies were interviewed. Their responses were quite different from each other. Much of the literature is oriented toward arguing for or against introducing midwifery into Ontario.

**Medical Associations' Opinions**

The Society of Obstetricians and Gynecologists, Ontario Chapter, accepted the idea of midwifery but with some reservations (Norman, 1989; Reid, 1988; Klein, 1991; Johnston, 1993; Kaufman, 1991a). They mainly opposed home births. The Ontario Family Physicians Association stated a similar official opinion (Klein, 1991; Reid, 1988; Johnston, 1993).

The Ontario Medical Association (OMA) initially opposed midwifery, particularly because of their opposition to home births (Kaufman, 1991a; McCourt, 1986; Neilans, 1992; Johnston, 1993). However, they have mellowed somewhat in their opposition as Ontario moved toward having legal midwives (Kaufman, 1991b; Klein, 1994; Stahl, 1991). The 1994 Health Policy Report from the Ontario Medical Association states, "A revised policy by the OMA Committee on Reproductive Care acknowledges the legal right of practitioners (physicians and midwives) to attend home births, but clarifies the fact that physicians are not obliged to do so" (Kidd, 1994).

The strongest opposition to midwives from medical associations came from the Canadian Medical Association (CMA) (Norman, 1989; LeBourdais, 1988;
Stahl, 1991; McCourt, 1986; Reid, 1988). The CMA initially stated that the present system of maternity care was adequate and no changes were needed. Then midwifery was legalized in Ontario. The CMA's Policy Summary, released in March 1994, still stated, "The CMA continues to support the obstetric care system in Canada the basic structure and organization of which have been successful and highly satisfactory to its users." They still would prefer midwives to be nurses with a specialty in midwifery and "physicians should remain an active part of the obstetric care team" (CMA Policy Summary, 1994).

Some health care workers expect 'turf battles' to occur with midwives (Fennell, 1991; Kinch, 1986). Dr. Claude Renaud, director of professional affairs for the College of Family Physicians of Canada states in regard to midwifery, "It is the family doctor who should be the primary caregiver, since it is the family doctor who has the means to offer the continuum of care that patients need" (Johnston, 1993:1005).

Nurses' Associations' Opinions

Nurses' associations, unlike doctors' associations, have not voiced strong opposition to midwives officially. The College of Nurses of Ontario, the Registered Nurses' Association of Ontario (RNAO) and the Ontario Nurses Association (ONA) did not object to midwifery; however, they all wanted midwives to be nurses with post-graduate midwifery diploma/degrees (Norman, 1989; McCourt, 1986; Kaufman, 1991a; VanWyck, 1992; College Communique, 1993). The argument
against nurse/midwifery, according to the advocates of a direct entry into midwifery training, is that they see nursing as 'illness' oriented "which would need to be unlearned before embracing the midwifery philosophy, and that their subservient relationship to physicians would interfere with the autonomous status as a midwife" (Steinmann, 1994:11).

**Lay-midwives' Opinions**

In addition to doctors and nurses there is also a group of midwives in North America who oppose the legalization of midwifery (Steinmann, 1994; Kreinberg & McSweeney, 1981; Burst, 90; Mason, 90). These are the 'lay midwives', 'counter-culture' or 'radical midwives', who have no official training in midwifery but have learned their trade through apprenticeship. They feel (some very strongly) that the legalized midwives have 'sold out to the doctors' and perform their duties too much like the physicians, using excessive technology.

 Doctors and nurses have voiced their opinions about midwives through their professional associations but very few studies have been published about individual health professionals' opinions.

**Ottawa/Carlton Study**

This opinion study (the only one in Ontario thus far) published in Ontario on midwifery was conducted in the Ottawa/Carlton area in 1988, by Doctors Stewart
and Beresford. Only physicians were questioned (N = 78). At that time "almost half thought that midwives should be licensed. Most felt that midwives should be trained as nurses first and should work under the supervision of a physician" (Stewart and Beresford, 1988:393). Midwifery, at the time of the study, of course, was still illegal in Ontario; however, 41% of the doctors had worked with midwives in other countries. "Female physicians were more likely than their male colleagues to feel that midwives should be licensed" (8/11 v. 27/65). Also, physicians who had worked with midwives were more likely to have this opinion than those who had not (20/30 v. 15/45) (ibid.:395).

Opinions Today

The issue of acceptance of midwives into the current health care team in Ontario is far from being solved. Lynne Sears Williams writes in the Canadian Medical Association Journal that many physicians are quite concerned about midwifery (Williams, 1994).

Dr. Rachel Edney, past president of the College of Physicians and Surgeons of Ontario and a long time promoter of midwifery, is quoted as stating that "there's more antagonism out there than I had realized, with some significant resentment ... some very distressed physicians think it is unfair that midwives will begin earning relatively large salaries during a time of health care cutbacks" (Williams, 1994). Costs of implementing midwifery at this time present a contentious issue, not only regarding midwifery salaries but also the cost of funding birthing centres, at the
time when hospital beds are being closed. Dr. Edney says "the concept has not been
greeted enthusiastically by doctors" (Williams, 1994:732).

Not only is there apparent resentment from doctors but also from
obstetrical nurses, especially because Ontario moved first to regulate midwives
working illegally outside the health care system. "In effect, it has rewarded the
renegades who didn't play by the rules" (ibid.).

Quebec Study

An extensive study on the opinions of nurses, midwives and physicians
about midwives was carried out in Quebec in 1991 by Regis Blais et al. at the
University of Montreal. A questionnaire was sent to 1744 health care workers (844
physicians, 808 nurses and 92 midwives). Their response rate was 80% (Blais et

Doctors did not object to legalization of midwifery but opposed home
births, although the definition of a midwife by the World Health Organization (WHO)
states that "she may practice in hospitals, health units or domiciliary services"
(ibid.:692). Other issues that the health care workers were concerned with were:
midwifery education, range of responsibilities, degree of autonomy and relationship
to other maternity care workers (ibid.).

The vast majority of those surveyed agreed that a university degree is
necessary for midwives. Most advocated a Bachelor degree (99% of the obstetricians
(Obs), 97% of the Family Physicians (FPs), 95% of the nurses and 86% of the
midwives) for entry into practice. The question 'Should midwives be nurses' received varying replies. 77 to 80 per cent of the physicians thought it necessary for midwives to be nurses first, 90 per cent of the hospital and 81 per cent of the community nurses agreed; however, only 20 per cent of the midwives agreed.

The Quebec team also found that opinions on responsibilities of midwives differed considerably. For example, 100% of the midwives and 92% - 98% of the nurses thought that midwives should provide prenatal care for normal pregnancies, perform normal deliveries and do post-partum care, whereas only 42% of the family physicians agreed on having midwives deliver babies. 75% of them agreed that midwives could monitor women during labour. The corresponding numbers for obstetricians were 53% and 80% respectively.

"Most of the physicians indicated that they would like midwives to work under their authority, but the nurses and, naturally, the midwives considered that midwives should be autonomous" (ibid.:695). However, the general consensus was that midwives should work in collaboration with current maternity staff.

Blais et al. state that their "results confirm to a certain extent opinions previously expressed by some physicians and a number of medical associations rejecting self-taught midwives, any midwifery practice that would be isolated from the regular health care system and out-of-hospital births" (ibid.:696).

Like the Stewart and Beresford study (1988 in the Ottawa area), the Quebec study was conducted before midwifery was legalized there. Blais et al.(1994) cautioned "since the recognition of midwives is a rapidly evolving issue in Canada,
the opinions of a number of the respondents may have changed since the survey was conducted" (ibid.:697).

Although the literature on opinion surveys of doctors and nurses in Canada toward midwives appears to be limited to the two studies cited above, there is considerable literature comparing and contrasting the delivery of infants by midwives and by physicians. This literature can be classified under the following major heading:

Differences in Philosophy (Midwifery vs. Medicine)
Woman Centred Pregnancy and Birthing
Pregnancy and Birth as Diseases
Medical Interventions in Pregnancy and Birth
Maternal and Infant Morbidity and Mortality
Control by Physicians
Autonomy of Midwives
Self Image of Para-professionals
Lack of Confidence of Midwives' Research
Education of Midwives

The attitudes of nurses and doctors toward midwives will be reflected in their opinions on these topics. Accordingly my research into the opinions of nurses and doctors about midwives must examine these issues as they appear in the literature and as they enhance our understanding of nurses' and doctors' opinions about midwives. These topics were used in developing the questionnaire for my study.
Different Philosophies (Midwifery vs. Medicine)

The literature shows that there are clear differences in midwives' and physicians' approaches to pregnancy and birth.

The major difference between a medical doctor's care and that of a midwife's is one of philosophy (Gray, 1987; Osadetz, 1993; Haas and Rooks, 1986; Norman, 1989; Hanley, 1993). "Although they are specialists, midwives do not approach their clients as experts. Rather they present themselves as colleagues, sharing responsibility with parents" (Hanley, 1993:14). Doctors want to manage labour and control pathology while midwives support a woman in labour, taking a more holistic approach.

Woman Centred Pregnancy and Birth

There is considerable literature on the shifting trends in birthing practices. In the 1950s it became 'fashionable' to have babies in hospitals. As with high heel shoes most women put up with inconveniences to be in style. They accepted the alienating and cold atmosphere of hospitals because that was what everyone did. However, starting in the 1970s and increasingly in the 1980s women began to demand comfort and more say in their maternity care, especially after some unpleasant hospital experiences, for example, being seen by the staff as passive participants in the birthing process (Reid, 1988; LeBourdais, 1988; Hanley, 1993;
Osadetz, 1993; Fleissig, 1993). Some women found communication with hospital staff difficult and impersonal (Fleissig, 1993; Jacoby, 1988). Women wanted a more holistic approach to childbirth where they have more control (Norman, 1989; Neilans, 1992; Sampson, 1992; Mason, 1990; MacKinnon & Mackenzie 1993; Kargar, 1992). They wanted to decide who cares for them during pregnancy and where they deliver their babies. In Britain the Ministry of Health commissioned an 'Expert Maternity Group' to research maternity care. The report, titled Changing Childbirth, was published in the summer of 1993. It strongly recommends woman centred care. "In much of the evidence received by the Group there was a strong emphasis on the need to ensure that care was designed around the needs of the individual woman and the choices she may wish to make" (Changing Childbirth, 1993:9).

Pregnancy and Birth as Diseases

Well over 90 per cent of all births in Canada now occur in hospitals. When a person is admitted to a hospital, it is for a medical reason; in most cases that person is sick. When a woman is admitted to a hospital to deliver a baby, she is a patient and therefore is considered by the staff to be sick. There are machines monitoring a mother and her baby, there are blinking lights and intravenous tubes. Pregnancy has been made into a disease (Roch, 1983; Norman, 1989; Abbott & Wallace 1990; Johnston, 1993; Klein, 1994; VanWyck, 1992; Rundell, 1992) and birth is seen as a normal event only in retrospect (Morrin, 1992). In Ontario eighty per cent of the births are attended by obstetricians (Norman, 1989).
Up till the beginning of 1994 an unlicensed midwife delivering a baby could be charged for practicing medicine without a licence in Ontario (McCourt, 1986).

**Medical Interventions**

As pregnancy and birth have been medicalized, medical interventions in them have increased. There is no question about the benefits of medical interventions in some situations (Abbott & Wallace, 1990; Roch, 1983; Rooks, 1983; Haas & Rooks, 1986; Sampson, 1992; Sullivan & Weitz, 1984; Neilans, 1992; Buhler et al. 1988). However, episiotomies, for example, are performed routinely with dubious benefit to mothers and babies (Graham et al., 1990; Weitz, 1987; Abbott & Wallace, 1990; Norman, 1989; Buhler et al., 1988). Some doctors insist that every primipara woman must have an episiotomy. Midwives claim that there is far less need for episiotomies if time is taken and skills are used to prevent tears.

Fetal monitoring that was initially used in high risk pregnancies is now used almost routinely. Because of occasional faulty readings of the monitors, further unnecessary interventions take place (Norman, 1989; Flint et al., 1985).

Another, almost routine, intervention is an artificial rupture of membranes (ARM) to hasten labour. "Many (British) midwives are unconvinced that women should have their membranes ruptured routinely ... Why are these midwives doing things they don’t agree with? ... they say, 'it's hospital policy'" (Flint et al.,
This evidence suggests that many British midwives have adopted the medical model.

The first recorded cesarean section, where the patient survived, was performed in England in 1793. (She lived to age 76.) It took approximately 100 years before this operation was performed with frequency (Frazer, 1987). Its use has increased in many countries (LeBourdais, 1988; Abbott & Wallace, 1990; Norman, 1989). According to Norman (1989) the Canadian cesarean section rate is double that in many European countries. One would suspect that there are some unnecessary 'sections' performed in Canada since the infant mortality rate is no higher in European countries than it is in Canada.

**Maternal and Infant Morbidity and Mortality**

Physicians are confident that due to their knowledge and care the maternal and infant morbidity and mortality has declined in the last century. This belief is disputed by many (Abbott & Wallace, 1990; Neilans, 1992; Klein, 1994; Fennell, 1991; Roch, 1983; Barrington, 1984). It is claimed that healthy mothers and babies are as much a result of better diet, better hygiene and better living standards than of improved medical care. "In Sweden, which consistently rates best in the world for birth outcomes, every woman is under the care of a midwife. In the Netherlands ... 96 percent of babies are delivered by midwives. Those countries with the highest proportion of midwives also have the lowest perinatal mortality rates" (Barrington, 1984).
Midwives and physicians seem to have very different, polarized ideas of pregnancy and birth. Both groups feel strongly about the rightness of their approach. The literature suggests that physicians have maintained predominance thus far (Barrington, 1984).

Physicians in Control

Doctors' training is geared toward diseases. Pregnancy and child birth are healthy events; therefore "general practitioners do not receive exhaustive training or clinical experience in obstetrics during medical school and internship" (Task Force, 1987:69), thus these natural, healthy events are medicalized. Home births virtually disappeared in the 1950s in North America (Sullivan & Weitz, 1984) and also in Britain (Morrin, 1992), and many other countries in the 50s and 60s. For example, in Finland, the Ministry of Health recommended in 1968 that there should be no more home births (Laiho, 1991).

Physicians are still opposed to home births. That is seen as one of the obstacles to midwifery, although midwifery does not necessarily mean a substantial increase in home births. Dr. Walter Hanna, then President of the Society of Obstetricians and Gynaecologists of Canada "believes that low risk pregnancies become high risk when a woman gives birth in her home as opposed to a hospital" (Norman, 1989:65). How high this risk is, is not known.

Studies show that physicians prefer to have midwives work under their supervision (Blais et.al. 1994; Stewart & Beresford, 1988; Sullivan & Weitz, 1984).
Since most doctors do not agree with home births this kind of supervision can only be achieved in a hospital setting.

On the other hand, it seems clear that women managed their pregnancies and deliveries well before the take-over by the physicians. Midwives performed their duties well. For example, this writer would not be here, had it not been for the skills of a midwife, over half a century ago, in a small village in Finland. There was no doctor to consult for the infant’s distress and mother’s severe post-partum hemorrhage. The midwife managed.

In today’s health care the medical model dominates. There is widespread faith in medical technology (Abbott & Wallace, 1990; Steinmann, 1994; Rothman, 1984; Ornstein, 1990; Norman, 1989; Smith & Jewell, 1991). The physicians have assumed the position of control and in their view no one is supposed to question that authority. Weitz relates how a doctor prescribed Syntocin to a woman in labour, although the labour was progressing well. A surprised midwife wondered why he had ordered it, but he retorted "What do you mean? Who are you to question?" (Weitz, 1987:82). Doctors decide what tasks they would like to delegate to other health care workers (Rothman, 1984). Prescribing medications or performing most of the medical interventions, even an emergency episiotomy (Sullivan & Weitz, 1984), are strictly physicians’ tasks.

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4Syntocin = Oxytocin is a hypothalamic hormone stored in and released from the posterior pituitary, or prepared synthetically. It acts as a powerful stimulant to the pregnant uterus, especially toward the end of gestation ... Injection of Oxytocin may be used to induce labor or strengthen the uterine contractions during labor (Miller&Keane, 1983:823).
Some writers (Johnson, 1972; Rooks, 1983; Rooks, 1984; Hicks, 1992; Haas & Rooks, 1986; Abbott & Wallace, 1990) feel that midwives' historically low status is maintained by their 'low status' clientele, that is all of their clients are either women or babies. The counter argument of course would be that the same clientele has not lowered the status of obstetricians and gynaecologists.

**Autonomy of Midwives**

Another strand of literature deals with the issue of autonomy. In Britain, midwives' autonomy has declined over the past 30 years with the medicalization of birth (Smith & Jewell, 1991; Weitz, 1987). In the USA, where many states have legalized midwives, Rothman states that often midwives feel they have autonomy, that they can make decisions about their work independently. However, they will quickly add that they have a very good relationship with their backup doctors. Therefore their autonomy is not true autonomy (Rothman, 1984).

When midwifery was in the planning stages in Ontario, nurses and doctors indicated that they would like midwifery to be a specialty of nursing, as it is in many of the states in the USA and in England and other countries. However, it was decided that midwifery training will allow direct entry into practice. The planners wanted midwifery to be an autonomous profession (Task Force, 1987; Kaufman, 1991 a; Kaufman, 1992; Neilans, 1992; Klein, 1994; Williams, 1994; College Communique, Dec.1993). It was decided that Ontario midwives will be a self-regulating profession.
Physicians are autonomous. No one dictates to doctors what they should or should not do, other than their own professional organizations. With midwives entering the health care field, some doctors fear loss of autonomy as well as loss of income (Rooks, 1983; Haas & Rooks, 1986). To become autonomous is to become professional (Klein, 1994; Roch, 1983).

**Poor Self Image of Para-Professionals**

When studying professions, sociologists "have focused attention on questions of attitude formation and socialisation into professional occupations" (Johnson, 1972:9). There is literature that deals with the socialization of health care workers.

"A key feature of health care is the dominance and control that doctors exercise over paramedical workers, including midwives and nurses, a position that is sustained through state support ... the process of professionalization is a process of male assumption of control over female tasks" (Abbott & Wallace, 1990, 114).

In the health care field the power differences have created a dichotomy that has reduced the self esteem of para-professionals (Hicks, 1992; Ho, 1989; Ornstein, 1990; Roch, 1983; Fennell, 1991; Stewart, 1988; Sullivan & Weitz, 1984; Jacoby, 1997; Weitz, 1987). Para-professionals are taught to be obedient and subservient through a hidden curriculum (Ho, 1989; Newson & Hallworth, 1984; Rothman, 1984).
A good example of the hidden curriculum in nursing is the attitude that the nurse is subservient to the doctor: at best she is an assistant and at worst a handmaiden. This carries into midwifery practice, since most midwives have a nursing background... This attitude is never formally expressed nor explicitly spoken, but the behaviour of some midwives may reinforce this 'subservient role' in the mind of the student midwife (Ho, 1989:291).

In Great Britain, where midwifery skills have been underused in the last three decades, midwives have lost much of their confidence (Roch, 1980; Hicks, 1992). Many women who have been examined by a midwife at a clinic are re-examined by a physician. "This is an example of nonsensical duplication of work by trained professionals which is expensive, unnecessary and frustrating for midwives, besides provoking unwarranted anxiety in pregnant women" (Roch, 1983:39).

Not only at the clinical level has the confidence of midwives been shaken, but also at the academic level, particularly in the area of research. The "overall research output for nursing and midwifery is low compared to the total populations involved (in research) and ... midwives produce considerably less published research than nurses" (Hicks, 1992:13).

Education of Midwives

In today's society much emphasis is placed on education. One of the reasons Ontario midwifery training was placed at the university level (RTFIM; Gazette, July 1993) was in order that midwives would be accepted as well educated professionals in the health care field (Rosser and Muggah, 1989; Osadetz, 1993).
In Britain most of the midwives are nurse midwives (3 years of nursing school and 1 year of midwifery training). In recent years a direct entry into three year midwifery course has been implemented (UKCC Annual Report 1991-1992; Winship, Jane, Personal interview in London, England, August, 1993).

In the United States there are both lay midwives and nurse midwives. Lay midwives have no formal training and although they may be skilful midwives do not have the same opportunities as nurse midwives do. There are many opportunities for post-diploma and post-graduate education (Fennell, 1991; Rooks, 1983, Haas & Rooks, 1986; Kreinberg & McSweeney, 1981) and many of the nurse midwives have taken advantage of this.

Because midwifery is a very current issue, the literature is growing constantly.

THEORY

In my research I was looking at these issues from the conflict theory viewpoint which emphasizes the power differences between groups and people and the power bases of professional organizations. Conflict theorists are interested in learning who in society possess power and who are subservient, since "harmony is rare; competition and struggle between groups for power and wealth are the normal situation. Society certainly does not automatically solve its problems, for the dominant social process is not a steady effort to restore harmony or equilibrium, but an endless struggle for advantage" (Spencer, 1990:17).
In our patriarchal society men hold the power in most aspects of our lives. However, women have not always accepted the lack of power. At the turn of the century "women struggled to secure equality as citizens. They sought higher education, access to the professions, an enlarged sphere of political influence, changes in the laws governing marriage which would enable them to own property independently of their husbands, and to control their earnings" (Smith, 1983:312). Smith goes on to say that the "resurgence of the women's movement in the 1960s raised more fundamental questions than previously" (ibid.:313). Among other issues the "personal subordination to men through work was also called into question ... for the wide range of subordinate but essential work which women perform directly for men was seen as part of a division of labour in society which subordinated women to men in a pervasive manner" (ibid.).

As stated earlier, the gender difference in health care is significant; the majority of physicians are male and most nurses and other para-professionals are female. However, gender is not the only factor that creates power differences and conflict in health care: physicians are usually from a higher socio-economic background than nurses are; they also have a higher education level than nurses do; therefore physicians assume a more dominant position in health care. Because the gender differences are so salient in health care (between male doctors and female para-professionals) it is the gender difference that is focussed on in this research.

In Ontario, midwives will complete four years of university training for entry into practice. Many of the students, entering the midwifery program, already have a university degree according to Karyn Kaufman at MacMaster University.
(personal interview); therefore their education is almost equivalent in length to a medical degree. Their salary is equivalent or arguably greater than that of family physicians. Nevertheless, it is highly probable that midwives will never attain the social standing and degree of power in society that physicians enjoy despite their professional status. It is difficult to avoid the conclusion that the gender difference between the two professions is the deciding factor. Although more women are entering medical schools today, of the practicing doctors, a large majority are men. One hears many complaints from women who are unable to find a female family doctor to care for them. Female obstetricians or gynecologists are even more difficult to find.

**Sociological Theories of Professions**

Emile Durkheim felt that professional organizations were a precondition of consensus in society (Johnson, 1972; Rueschemeyer, 1986), that is, professions would bring stability and balance to society. "While Durkheim viewed professional ethics as the fount of a new moral order, others have gone a step further ... and suggested that professions are to be distinguished from other occupations by their altruism which is expressed in the 'service' orientation of professional men" (Johnson, 1972:12-13).

Conflict theorists, on the other hand, disagree. "Rueschemeyer rejects the universality of such assumptions; in particular he questions that the 'central
values' alluded to are shared equally by all sections and interests in society" (Johnson, 1972:34).

Talcott Parsons viewed professions as having a collective-orientation rather than a self-orientation. According to this type of structural/functionalist approach, professions are the most stable element of society; they make up that force that protects steady and peaceful evolution. These theorists consider medical doctors professionals (ibid). C. Wright Mills, on the other hand, did not see "professions dedicated to service, stability and democracy, but as an explosion of experts and technocratsmen of narrow specialism and narrower vision" (Johnson, 1972:16).

Inconsistency is seen in the structural/functionalist view of professions. On the one hand professionals are viewed as altruistic and as having collective orientation; on the other hand theorists such as Robert Merton and T. Veblen argue that some professionals "suffer from a trained incapacity for social responsibility" (Johnson, 1972:17).

"The theoretical attempt to account for such diverse and inconsistent interpretations of professionalism has centred upon the concept of 'professionalization'" (Johnson, 1972:18). Some professions are still evolving toward professionalism e.g. social work, teaching and accounting, whereas others, such as law, medicine and architecture have reached the status of profession. (ibid.). "In attempting to reconcile the inconsistent interpretations of the social role of the professions, the theory of professionalization has excluded the one element which was constant in earlier approaches: the attempt to understand professional
occupations in terms of their power relations in society - their sources of power and authority and the ways in which they use them" (ibid.).

Parsons' structural/functionalist views attribute too much importance to the rational bases of professional practice and colleague and client relationships. This approach ignores the power relationships within professions which may result in the development of specialist groups and the promotion of specific racial and gender interests. The profession's dominance is thus maintained "at the expense of increasing the rational application of knowledge" (Johnson:35).

In Britain doctors have successfully restricted the role and scope of practice of para-medical professionals. The functionalists would argue that the stratification of para-medicals and the lesser rewards they receive are functionally related to the 'hierarchy of talent' that these professions display (ibid.:37). A conflict theorist, however, would argue that the difference in the reward structure is less related to talent than due to the success of historically powerful groups in society in maintaining their status and determining their rewards.

The structural/functionalist model, in emphasising the social value of professional activity for all of society and ignoring the power struggle, cannot account for variations in the control and organization of occupational activity evident in culturally and historically different societies.
Medical Profession

Medical doctors have built an incredibly strong power base in the health care field in most countries (Newson & Hallworth, 1984; Fennell, 1991; Rothman, 1984; Ho, 1989; Witz, 1987; Johnson, 1972). They have managed to subjugate other health care workers under their authority. "The medical profession maintains control over nurses, medical technicians and other new health practitioners and dominates the process of increasing division of labour in these 'auxiliary' health occupations" (Rueschemeyer, 1986:128). It is significant that these auxiliary health occupations are comprised mostly of women.

In addition, in the health care field, physicians hold the power over the patients. Doctors legitimize sickness. They decide who is sick. "It is through control of the diagnostic relationship that the physician has maintained his pre-eminence in medical services" (Johnson, 1972:58).

Medicine is known as a profession, whereas most other health care workers are para-professionals. "A profession is an occupation that has social power and, thereby, social control... In the health care, members of the medical profession have such control: the profession of medicine is dominant and it follows that 'the status of other occupations participating in a medical division of labor can only be subordinate'" (Rothman, 1984:300).

Even though all doctors are professionals there is some division within the medical profession regarding prestige.
Although primarily a technologist, the specialist's technology is defined purely in terms of the rationality of his profession. It can have no function outside of it. The general practitioner and the nursing staff enjoy lower status because firstly they must deal more directly with the profane (patients -not cases) and also because of many of their healing functions differ little from those practiced by non-professionals in the general domestic care of the sick. Their professional mystique is thus compromised by the contact they must make with the profane world (Jackson, 1970:10-11).

Ontario midwives are and will be a university educated, autonomous group of professionals. They may pose a threat to the doctors. "The power even of doctors is not unlimited... It is historically constructed, and it is contested by others. It is circumscribed by the effectively pursued interests of other - even if subordinate - health occupations, by patient interests expressed in the market, in health organizations and in politics" (Rueschemeyer, 1986, 129).

Nursing 'Profession'

Nurses have aspired for professional status for a long time. Nursing was established from the beginning of medical science as an auxiliary occupation, concerned primarily with "caring" rather than "curing" or "hygiene" rather than "medical treatment" (Gamarnikow, 1978). The mythology, propagated by Florence Nightingale, that only women can nurse and that women can only nurse under the control of doctors has been carried out historically.
Isabel Hampton Robb, one of the great nursing leaders of her time, observed that 'medicine has taken the decision out of our hands, and made trained nursing a profession, but how soon we shall attain to the full profession level depends upon ourselves entirely' ... It seems ironic, but if Robb were to evaluate the nursing scene over nine decades later, she might conclude that her observation is as pertinent today as in 1900 (Maloney, 1992:3).

Maloney goes on to state that "the true professionalism is not about being well paid or climbing the hierarchical tree ... [but] about controlling one's own practice and making one's own decisions" (ibid.:4). There are other criteria in the literature as to what defines professional status. Pavalko's 'continuum model' and Flexner's criteria of professionalism are cited by Bernhard and Walsh (1981:1-2). Carr-Saunders and Wilson (1933) categorized professions "by the amount of knowledge in which each laid claim to professional status. Those disciplines whose knowledge demanded rigorous *lengthy* study in the basic sciences and humanities were ranked as professions" (Maloney, 1992:5). Maloney also cites Friedson who "distinguished between profession and occupation by pointing out that the greatest distinction is in 'legitimate autonomy' as it gives the profession 'the right to control its own work'" (ibid.:6). Also "education elements have long been held to be among the most significant of the core traits of a profession" (Harris-Jenkins, 1970:69).

Issues such as control, theoretical knowledge, autonomy, techniques, commitment, altruism and high education level are related to professionalism. Nurses have moved toward professional status in some of these areas; however, they have not reached a full professional status yet.
Because the structural/functionalist viewpoint ignores the power struggles in society, this theory does not lend itself to this present study. Conflict theory that emphasizes the power differences is more appropriate and will be used in this study to research the nurses' and doctors' opinions of midwives.
Chapter 4

METHODOLOGY

My question is, will there be negative attitudes to some degree, toward midwives by health care professionals (i.e. doctors and nurses). Negative attitudes toward midwives may be present for the following reasons:

1) Because of increasing competition for clients when more midwives graduate and begin their practice, doctors and nurses will perhaps feel that midwives are moving into their 'territory' of work.

2) The autonomy that midwives have achieved in a relatively short time. Physicians have always been autonomous, whereas most nurses have not worked independently but have carried out doctors' orders.

3) The high starting salary of midwives. Midwives will have higher starting salaries than the mid-career or even end-career salaries of the most experienced nurses. Physicians, on the other hand, get a relatively small fee for the care of pregnancy, delivery and the post-partum check-up.

4) The philosophies are very different. Physicians and the majority of nurses aspire to follow the medical model when dealing with pregnancy and birth, whereas midwives take a more holistic approach and treat them as natural events.

This research had two parts to test the question. In part one the historical recognition of midwifery in Ontario was explored and how this is perceived as a loss or a victory or neither. Representatives from four different professional
organizations, the Ontario Medical Association, the College of Nurses of Ontario, the College of Midwives of Ontario and the Ontario Nurses’ Association (the union), who took part in the planning process of midwifery, were interviewed. Also, a representative from the Ministry of Health, who was part of the planning process, was interviewed.

In part two the attitudes toward midwives of obstetrical nurses, obstetricians and family physicians who practice midwifery were examined.

This study has components of both qualitative and quantitative research.

Data Collection

Part one of this research consisted of qualitative data collection. Qualitative research is "the study of broadly stated questions about human experiences. It is conducted in natural settings and uses descriptive data" (LoBiondo-Wood & Haber, 1990:509). Skodol-Wilson states that "the major purposes that can be served by using qualitative techniques are exploration and description, accounting for and illustrating quantitative findings, discovery and explanation, and extension of theory" (Skodol-Wilson, 1993:227). Bogdan and Biklen have described five general features of qualitative research: it is usually carried out in a particular setting under study; it is descriptive, quotations from the data (written results) are used to illustrate and substantiate the presentation. Qualitative research is concerned with process rather than outcomes. The data are analyzed inductively and are concerned with people's perspectives (Bogdan & Biklen, 1992: 29-32). For this study it was thought
to be useful to interview some of the individuals who were involved in the planning process of midwifery in Ontario, especially since these individuals represent those organizations whose members I would survey. The interviews were conducted to find out if the 'organizational' views differed from each other.

Interviews with Key Informants

Participants

This part of my research was done in the following five health care related institutions: the College of Nurses of Ontario [CNO]; the Ontario Nurses' Association [ONA]; the Ontario Medical Association [OMA]; St. Joseph's Hospital in Hamilton; and the Ministry of Health, involving interviews with six individuals in all. At one interview there were two interviewees present. The individuals interviewed were Margaret Risk, CEO at CNO; Leslie Bell, the President and Ina Caissey, an officer at ONA; John Krauser, Policy Advisor at OMA; Karyn Kaufman, a professor of midwifery at MacMaster university and a midwife on staff at St. Joseph's hospital; Margaret-Ann McHugh, an official at the Ministry of Health in charge of midwifery.

All the key informants except one [McHugh] were involved in the process of legalizing midwifery. They were contacted by telephone. I explained the purpose of the study and requested an interview. None refused. They all had held their present positions for several years. None of the interviewees requested anonymity but instead gave their permission to quote them and use their names. Each interviewee agreed to be contacted by telephone if clarifications were needed about the interviews. This
did not become necessary. Five of the interviewees were female and one (Krauser) was male. All were white and no other demographic data were obtained.

Instrument

The interviews were semi-structured. An interview guide was used. It provided some structure but allowed flexibility to deviate and allow new information to surface. Both open-ended and closed-ended questions were used. (See Appendix A for the interview guide)

Procedure

The interviews lasted approximately one hour and they took place in each interviewee's place of work. The interviews were taped and then each tape was transcribed word for word.

From the data various themes emerged. On the typed pages the themes were high-lighted in different colours to facilitate easier analysis. If the data dealt with more than one theme, all appropriate colours were used to high-light that area on the page. Most of the themes were basically answers to some of the common questions which were asked of all interviewees. Direct quotations from the interviews were used in the analysis.

The interview data are analyzed in chapter five.
Survey Data of Health Practitioners

Hospital Selection for the Survey

This study was limited to the Metro Toronto area. There are 37 hospitals in the Metropolitan Toronto area. According to the Ontario Hospital Association, 17 of the 37 hospitals have maternity units.

Of the 17 hospitals in Metro Toronto area that have maternity units, initially all six of the teaching hospitals and six randomly picked smaller hospitals were targeted for this research. All the doctors [targeted for the survey] were approached individually and all twelve hospitals were utilized for their responses.

The large teaching hospitals were selected for two reasons. First, teaching hospitals have medical students and residents training there who change annually, and the staff doctors are usually cross-appointed to the university faculty of medicine. Their attitudes toward the newcomers - midwives - could differ from the attitudes of the smaller hospital doctors who have no contact with students and whose colleagues remain the same.

The second reason for surveying all six of the teaching hospitals was that three of them were interested in having midwives and were in the process of setting up their maternity units to facilitate midwives working there. The other three teaching hospitals were not preparing to do so at this time. This could affect the attitudes of the staff toward midwives. Two of the teaching hospitals denied me permission to survey their nursing staff. In one of these two hospitals the director of nursing told me that the midwifery issue was 'too touchy' (at this time) and it would
not be appropriate for me to ask the nurses' opinions about it. In the other hospital the ethical review board rejected my request because the chief obstetrician was on the board and he felt my proposal was too biased. Both of those hospitals were in the process of setting up a midwifery program.

Although I was able to distribute my questionnaire to the physicians who practice obstetrics at all six teaching hospitals and six randomly selected non-teaching hospitals, I was not able to survey the nurses in two teaching hospitals. This resulted in reduction in my nursing population from approximately 116 to 96. It is not likely that this resulted in significant change in the survey results.

**Quota Sampling**

Initially a random selection of the nurse/doctor target population was planned. However, this was found to be very difficult especially because full-time staff was greatly reduced due to vacation times, (this research was carried out during the summer) therefore quota sampling was used of nurses and doctors. "Most attitudes, decisions and behaviours of people are derived from awareness of selected information ... to make generalizations about a wider class of phenomena" (Iverson Shelley, 1984:239).

The most common type of non-random sample is a quota sample. A quota sample is the non-random equivalent of a stratified random sample. The researcher determines which characteristics of the population are important to the study ... and then selects a sample with the proportions of these characteristics as are found in the population. However,
because the population is not explicitly defined, each individual does not have an equal chance of being selected, and therefore the sample is not random. Quota sampling has been found to be relatively inexpensive and relatively representative. It is used considerably in market research and public opinion polls (Hagedorn, 1990:553-554).

Quota sampling has its limitations, however. "The major biasing factor is that interviewers may take the path of least resistance when sampling ... tactics [that] will lend a false homogeneity to the data and keep them from being random" (Bailey, 1987:93). Furthermore, "although quota sampling relieves the interviewers of the burden of pursuing reluctant subjects ... it is not possible to calculate how likely one is to produce a precise estimate of true population. Moreover, lists of people with particular traits may not be accurate or readily available" (Spencer, 1985:36).

The criteria for the nurse respondents were: they should be registered nurses; they should be full time workers; and they should work in the maternity department of their hospital. The criterion for the family doctors was simply that they practice obstetrics. For the obstetricians there were no other criteria except their specialty.

Selection of Nurses for the Survey

There are approximately 756 registered nurses working in maternity care in the Metro area, according to the Ontario College of Nurses. 750 of these nurses
are employed in general hospitals. In her letter, M. Wang, at the College of Nurses, cautions that

Our statistical database is created from data collected from registrant renewal forms. This information is self-reported by registrants and there is minimal editing of the data. Therefore, please note this when analyzing the data and you should include a comment to this effect in any reports in which you quote this data in order that the readers can correctly interpret the numbers (Wang, 1994).

No statistics are available about the number of obstetrical nurses who are part-time workers or are 'job-sharing'.

Of the 750 registered nurses, approximately 24 per cent (180) were targeted for the survey. In large teaching hospitals, with a large nursing staff, 20 nurses were asked to complete the questionnaire, and in smaller hospitals with less staff 10 nurses were asked to complete the questionnaire.

In a quota sample one first decides which strata may be relevant for the study to be conducted. Then the investigator sets a quota for each stratum that is proportionate to its representation in the entire population ... After the quota is set, quota sampling consists merely of finding persons with the requisite characteristics (Bailey, 1987:93).

The nurse managers were approached for permission to carry out this survey, to distribute questionnaires among their nursing staff. They were given a letter of request which also assured them that the survey was completely anonymous, no name of a person or hospital would be revealed. The questionnaires were numbered only to keep track of returned questionnaires.
The unit managers or in some cases their 'second in charge' volunteered
to pass the questionnaires to their staff.

With the two teaching hospitals excluded (the ones that refused to
participate), 140 questionnaires were distributed to the maternity departments of the
ten participating hospitals.

Margaret Anne McHugh, at the Ministry of Health, stated⁵ that none of
the peripheral hospitals in the Metro area were setting up their maternity units to
facilitate midwifery at that time; therefore six smaller hospitals were selected
randomly. None of those refused to allow me to do my research.

In total, 96 completed questionnaires were returned by nurses, 68.5 per
cent of the (participating) target population of 140.

The nurse respondents (N = 96) were all full time maternity nurses. They
were all female. Only 76 nurses gave their age which ranged from 25 to 66 years, the
mean being 42 years. Ninety three gave their years of experience in nursing (3 did
not). The years of nursing experience ranged from 1 to 39 years, the mean was 19
years.

Nurses [and doctors] in the Toronto area are from many racial and ethnic
backgrounds. These demographic data were not obtained from the respondents. This
information could have been valuable in understanding and interpreting their
responses. Statistics Canada does not have detailed information about visible
minorities according to occupations. Health and social service industries are reported
together. The total population in these industries is 170,900, and of them, 49,260

⁵verbal communication
are members of visible minorities, slightly more than one fourth. The largest minority
groups among them are: 18,300 Blacks, 8,675 Chinese, 7,975 South Asians
(Statistics Canada, Profile of Visible Minorities, Ontario 1995: 156).

Of the nurse respondents, 44 per cent were trained midwives
themselves. They are not Ontario licensed midwives but graduates from other
countries. Among the nurse respondents there were 26 with Bachelor degrees and
three with Master’s degrees. There were 24 nurses who had taken at least one post
diploma maternity course, many (of these 24) had taken several courses either at the
college or university level.

Selection of Doctors for the Survey

According to the Ontario Medical Association, there are 183
obstetricians and 1800 general practitioners in Metro Toronto. A telephone survey of
the 17 hospitals that have maternity units revealed that there are approximately 156
obstetricians with admitting privileges to those hospitals and approximately 250
family physicians who practice in obstetrical areas. The discrepancy in the numbers
of obstetricians between the OMA and the figures given by the hospitals could be due
to the fact that there are retired obstetricians who are still registered with the OMA
but are no longer practicing.

The chief obstetricians in all twelve hospitals were approached, given a
letter explaining my study and asked for permission to survey the physicians in their
departments. All the chief obstetricians advised me to approach the doctors
individually and independently. This was carried out. Each questionnaire had a cover letter similar to the one accompanying the nurses' questionnaire. (Please, see Appendix C for cover letters) Although the doctors were assured of the confidentiality of their answers, a few (2 or 3) obliterated the numbers on the questionnaires.

For selecting the doctors in some hospitals a ward clerk or a nurse showed me the list of the obstetricians and family doctors on staff who practice obstetrics, and in other hospitals the secretary of the chief of obstetrics supplied the list. Names were selected from these lists. If a doctor was on vacation, another name was selected. The target quota was as follows: four obstetricians in the six teaching hospitals and three obstetricians in the six peripheral hospitals; five family physicians were asked in each of the hospitals (teaching and non-teaching).

Of the 156 obstetricians, 42 (approximately 26 per cent) were asked to participate in the study. Twenty eight completed questionnaires were returned by the obstetricians, 67 per cent of the target population.

There are approximately 250 family physicians who practice obstetrics in the Metro area. Sixty (24 per cent) were asked to participate in this study. Thirty physicians completed and returned the questionnaires. One half of the target population of the family physicians completed the questionnaire.

The doctors (N = 58) were obstetricians (N = 28) and family physicians who practice obstetrics (N = 30). The obstetricians ranged in age from 33 years to 68 years, the mean being 48 years. They had been in obstetrical practice from 1 year to 37 years; the mean was 16 years. Of the obstetricians only four were female and 24 were male.
The family physicians who participated in this survey were aged from 28 to 67 years old; the mean was 45 years. They had been practicing obstetrics from 1 year to 40 years, the mean being 16 years. The gender division among the family physicians was 16 males and 14 females.

Instrument (2)

Because midwifery is so new in the health care field in Canada, there are only two published studies before this present survey on attitudes of other health care workers toward midwives, Stewart and Beresford in 1988 and Blais et.al. 1994. The questionnaires from these above studies were not available for this study.

Based on the literature review and my experience as a nurse and nurse-educator, multiple-choice questionnaires were developed to obtain the opinions of nurses and doctors toward midwives. A small scale pilot study was conducted among medical personnel (3 nurses and 2 doctors) and the questionnaire was also submitted to two non-medical academics for feedback. Suggested changes were made to the questionnaires.

One of the major purposes of the questionnaires was to develop a scale to assess the opinions of doctors and nurses toward midwives. The intention was that this scale would demonstrate a high internal reliability as measured by Cronbach's Alpha of at least .80. The validity of the scale was assessed by face validity; i.e. the items in the scale are readily recognizable as asking for the respondents' opinions of midwives.
Procedure (2)

In most of the hospitals permission was granted immediately by the unit managers to carry out the study; however, in some of the teaching hospitals, permission had to be obtained from the research ethics committee. Each questionnaire had a cover letter explaining the purpose of the survey and assuring the participants of confidentiality.

All questionnaires were hand delivered to the maternity units, and the filled out ones were personally picked up. "Personal delivery and/or pick-up of questionnaires to individual respondents is another alternative (to mailing). The personal contact of the respondent with the research personnel seems to have a positive effect on the rate of questionnaires returned" (Polit & Hungler, 1983: 316). Although individual nurses were not approached, having personal contact with the unit manager probably increased the return rate of the completed questionnaires.

The questionnaires were also hand delivered to doctors' offices, and most of them were personally picked up when they were filled out; however, there were a few doctors who mailed the answers to me (I had left the questionnaire in each office in an envelope with my name and address on it). Only a few of the doctors were personally approached but the secretaries were very helpful in asking the doctors to fill out the questionnaires.

The results of the questionnaire data will be analyzed in chapters six and seven.
Chapter 5

ANALYSES OF THE INTERVIEWS with KEY INFORMANTS

This chapter describes the results of the interviews conducted with some of the participants in the process of legalization of midwifery in Ontario. The interviews were conducted in May 1994. The key informants were chosen from various institutions that were involved in the planning and implementing of midwifery. (see page 208, Bibliography) The interviews were taped and each lasted approximately one hour. The number of people interviewed was 6; one person representing the College of Midwives, one person from the Ministry of Health, one from the College of Nurses, one from the Ontario Medical Association and 2 people from the Ontario Nursing Association were present at the same interview. No attempt was made to include all professional institutions. The R.N.A.O (Registered Nurses' Association of Ontario) and the College of Physicians and Surgeons were not contacted. It was felt that the interviews with the officials from the College of Nurses of Ontario and the Ontario Medical Association sufficiently represented the official positions of these professions. Various issues regarding midwifery were discussed during the interviews, such as: entry into practice (i.e. nurse-midwifery or direct entry into midwifery training), midwifery education, autonomy and independence of midwives, anxiety about midwives among health care workers and cost and salaries of midwives. These were some of the issues that seemed to come up often in discussions about midwifery in hospitals prior to my research.
Five of these interviewees had participated early in the process of midwifery development which began in the early 1980s. They all agreed that it was the consumer group and midwives who began the process to get midwifery legalized in Ontario.

**Health Professions Legislation Review and Entry into Practice**

The Ontario nurse midwives had formed an association in 1973 in response to what they saw as a need for more family centred child-birth. Increased consumer demand encouraged lay-midwives in Ontario to form the Ontario Association of Midwives in 1981. These two organizations joined in 1984 to form the Association of Ontario Midwives (AOM).

It was the AOM and their customers and supporters who formed lobby groups who lobbied the provincial government to allow legalized midwifery in Ontario. These lobbyists were very articulate people and therefore able to argue well for their cause. "I think, in Ontario, the midwives themselves were the smartest group of women I have seen" (McHugh). This view was also echoed by the interviewees from the nursing organizations.

Due to widespread discontent in the regulatory system of health care, the conservative government created the Health Disciplines Legislation Review (HPLR) in 1982 (Fynes, 1990:83). With 75 other health professions, midwives "were invited to participate in the Review" (ibid.). They submitted briefs to the Review Board. Other
health care groups also submitted briefs and various groups were give copies of each others' briefs with requests to comment on them (Fynes, 1994:86). Nurses wanted midwifery to be a specialty of nursing. "All nursing generally was very supportive of midwifery as a profession, but supportive of it being based on nursing" (Risk). Bell and Caissey at the Ontario Nurses' Association also stated that "we were in support of midwives, on a contingency that they were nurses first". The Registered Nurses Association of Ontario recommended to the Midwifery Task Force "that the practice of midwifery be a specialty of nursing regulated by the College of Nurses of Ontario (Pamphlet, Registered Nurses' Association of Ontario, October 6, 1986:3).

Physicians also advocated nurse-midwifery. Krauser (OMA), related their early opinions on midwifery. "Our focus was less on midwives as the initial response to that and more on what's wrong with hospitals and what's wrong with physicians". Krauser said the doctors believed they were giving good maternity care. "They had really done a fair bit, regionalized peri-natal care... from an unorganized system, so they felt they really had accomplished something and then to be told that they had fallen far short of their mark in spite of their peri-natal statistics... very few women died in obstetrics... so they all thought they were doing pretty good".

However, when the doctors realized that women were not satisfied with hospital maternity care, physicians developed three options. "The first option was that the hospitals and the doctors could simply be more flexible. The second option was that the nurses already in the obstetrical units would be allowed to do deliveries" (Krauser). According to Krauser, the second option was "attractive because nurses were already part of the peri-natal system in the hospital and everybody knew each
other" (Krauser). The third option was to introduce a new professional. Physicians were not prepared to accept licensing those midwives practicing at the time because their qualifications varied so much. Their demand was that "the new professional must be of high standard" (Kaufman).

When doctors realized that changes were going to occur in maternity care, clearly, they preferred their second option, that of a nurse-midwife.

The members of the Association of Ontario Midwives represented both camps, nurse-midwives and lay-midwives. Kaufman who is a nurse-midwife and who was involved early with the development of Ontario midwifery and a member of the Midwifery Task Force, stated that "I think when we began the Task Force investigation I was not very decided one way or another [nurse-midwifery or direct entry]. I was certainly aware of the arguments on both sides". Kaufman elaborated on the Task Force debates on the topic of entry into practice. "I think the Task Force view became very much an understanding that there wasn't necessarily just one way of doing it. Our compromise, in a sense, was to say 'why be exclusive, why rule out the possibilities that those women that had not been nurses could become midwives? Therefore there was no particular reason to make it an exclusive entry with nursing as the prerequisite".

When the Health Profession Legislation Review was completed, midwifery was to be one of the (seven) newly Regulated Health Professions in Ontario (RHPA information, the College of Nurses of Ontario, April 1994:3). Those who had advocated direct entry into midwifery had won.
Midwifery Education

Prior to the Regulated Health Professions Act (RHPA) midwifery education did not exist anywhere in Canada. Those midwives who had practiced here prior to RHPA were either foreign trained or they were lay-midwives who had learned their trade through apprenticeship. However, many of the midwives had higher education. Caissey (ONA) stated, when discussing the midwives' lobbying for legal status, "the majority of them are very well educated. They are one of the most effective groups that I have ever met".

When Ontario physicians realized that it was inevitable that midwives would enter the health care scene, they focussed on midwifery education. According to Krauser, "we weren't prepared at the time to have current midwives just to be granted a licence to practice based on no evaluation, no certified standards. That would have been the worst possible scenario. There was no consistency of the product". He went on to say that "the fact that they had not gone through a formal professional training program, so they thought that you could just come out of the back woods and do a better job than doctors and nurses in the hospital was really quite offensive". OMA is satisfied that the education of midwives is satisfactory. "It's a B.Sc. program, so it's high level" (Krauser). However, the doubts expressed by Krauser about midwifery education had to do with home births. "It is not clear that the current training of midwives is adequate to screen women for home births. Unfortunately we'll find out by virtue of disasters at home".
The College of Nurses of Ontario also had advocated a baccalaureate level midwifery, albeit part of nursing. "This was discussed when we appeared before the Task Force with the RNAO. The baccalaureate preparation for midwives and RNAO particularly at that time had a strong lobby for baccalaureate as entry into nursing" (Risk).

The Ontario Nurses' Association had also wanted midwifery to be part of nursing. A degree is not a requirement for entry into practice for nurses. Bell (ONA) stated that there are 50,000 nurses in Ontario and "only 3 percent of them are at the degree level". Many nurses believe that ONA is opposed to a degree as an entry into practice; however, Bell denied this and stated: "No, we are not opposed to a degree. What we are concerned about is that it has never been accessible to all of our members". Because midwives are a small group, it is possible for them to have a baccalaureate entry level; "there are real logistical problems with the massive size of nursing" (Bell).

McHugh at the Ministry of Health also compared the size of nursing and midwifery. She commented on the vast differences of educational levels of nurses. They vary from hospital training to community college training to university educated, all the way to PhD level. Also the nurse practitioners are re-emerging. Yet all are called nurses. Midwifery on the other hand is a small group going through a four year university program. "The time they spend which is 4 year degree although they do it in 3 calender years, they are not learning nursing, so what they have in terms of education for specifically being midwives, I think is quite a lot, and they are talking
about adding maybe a supervisor practice or residency or internship or whatever at the end of this 3 years” (McHugh).

Kaufman thinks that a degree as an entry into practice “makes a difference. We had this argument that went on and on. There was a lot of sympathy … for it not to be a university program… Basically you can produce a competent midwife anywhere, but let’s face it, perception accounts for a lot. In North America the entry level requirement in many locations is at least a baccalaureate level if not beyond. For midwives to be the newest ‘kid on the block’ and come in with less than a university degree, I think just gave the wrong signals”.

All of the interviewees supported the idea of baccalaureate entry level for midwives. Nurses and doctors would have preferred them to be nurse-midwives. For their future autonomy and independence the midwives were able to foresee that nurse-midwifery would limit them.

Independence and Autonomy

Nurses have practiced in Ontario for centuries but their autonomy is debatable. Nurses are not allowed to give a patient in a hospital an aspirin or any other over-the-counter medication without a doctor’s prescription. Many simple procedures that nurses know how to do cannot legally be performed by nurses without doctors’ orders, such as discontinuing an intravenous or giving an enema, even if nurses often know better than doctors when to carry out these procedures,
for the simple reason that nurses give patient care 24 hours a day but doctors only make brief visits to the bedside.

The new Regulated Health Professions Act (RHPA) states the three controlled acts the nurses can perform. They are invasive procedures: "1. Performing a prescribed procedure below the dermis or a mucous membrane. 2. Administering a substance by injection or inhalation. 3. Putting an instrument, hand or finger, l) beyond the external ear canal,

ii) beyond the point in the nasal passages where they normally narrow,

iii) beyond the larynx

iv) beyond the opening of the urethra

v) beyond the labia majora

vi) beyond the anal verge, or

vii) into an artificial opening into the body" (RHPA information Sessions, the College of Nurses of Ontario, Apr. 1994)

However, the above procedures can be carried out by nurses only on physicians' orders. Other health care professionals who can write orders for nurses to carry out are dentists, chiropodists, and midwives.

The Registered Health Professions Act includes 23 health professions. There are 13 Controlled Acts included in the RHPA. Nurses can perform the three above mentioned acts. Physicians can perform all but one (dental care). Midwives can perform five controlled acts.
Midwives have the three controlled acts that nurses have and, in addition, they can prescribe some medications and look after a woman in labour and make decisions about her progress i.e. 'manage labour'. They independently carry out these procedures. Unlike nurses they do not require doctors' orders to perform their duties.

One of my questions to the interviewees was: Nurses have practiced legally here for a very long time but they never have attained the independence and autonomy that midwives have attained in a very short time, how do you think this happened?

Margaret Risk at the College of Nurses of Ontario believes that it has to do with the history of nursing. She says that although many nurses are very independent, "an awful lot have been trained and socialized to a model where they worked under the direction of doctors" (Risk). Because of the long history of a subservient relationship to doctors, nurses have not gained their independence.

Midwifery, on the other hand, is a new profession here and they are starting as a relatively small group. One reason they wanted to avoid being part of nursing was that they wanted to establish an independent profession. It is the newness and the small size of the profession that made it possible for midwives to become an autonomous profession. Most of the interviewees echoed this view (Krauser, Risk, McHugh, Kaufman).

I think because it was built from a clean slate, created de novo, and created in such a way that ultimately made sense in terms of how it was going to function. I think it would have been very difficult to create this as a specialty
of nursing ... autonomy is built into it because there isn't the same historical basis. Nurses are trying very hard to come out of that kind of dependent role... A lot of employment settings for nurses tend to be very hierarchical (Kaufman).

Margaret-Anne McHugh at the Ministry of Health stated that "midwifery was an overtly feminist movement but nursing has never been... Midwifery was started by women who were committed to independence and autonomy of women. She goes on to say that "there were about 3000 midwife attended births in Ontario without it being legal or recognized or controlled by anyone". Women were committed to it, "midwifery requires that kind of autonomy, otherwise you can't be an appropriate advocate for women". McHugh states that "nursing is buried in this history of handmaiden... I know this is not what nurses are but they are buried deep in this history".

Apprehension and Anxiety about Midwives

Some nurses are attempting to change their image by improving their education. Increasing numbers of nurses are getting university education or they are taking specialty courses. Nevertheless the new health profession (midwifery) has 'passed' them, and become an independent profession. Therefore it is understandable that there is some anxiety about midwives by nurses.

Leslie Bell at the Ontario Nurses' Association states "Yes, I truly believe there is resentment between nursing and midwifery. A lot of it stems from what they
[nurses] perceive to be power given to midwives that was not given to nurses... that is where a lot of the resentment lies". Ina Caissey at ONA stated that "I don’t think we are opposed to midwifery as a discipline but it’s very much where nursing is curtailed constantly, to have yet another group handed it [power]. Now, they [midwives] worked hard for it but still...". What nurses fear is that there is yet another group giving them orders. "It was bad enough when we had medicine and dentistry but now we have midwives and chiropodists" (Bell).

Caissey went on to say "We are still supportive of midwifery in that women should have the care of their choice. But ...I think a lot of it [resentment] is a fear of uncertainty. If I am in charge of a case-room [delivery room], what responsibility do I have to the midwife’s patient? Do I have any? Does she report to me? Who does what in any given situation? Everything is so vague".

In May 1994 The College Communique of the College of Nurses outlined the rules governing midwife assisted births in a hospital setting. According to the College of Midwives of Ontario (CMO) it is required that two midwives attend each birth. However, there are very few registered midwives now in Ontario, thus it might be impossible to have two midwives present at all births that they attend. CMO has agreed that "temporary practice arrangements permit midwife to work with a second attendant who is not a midwife. In the hospital setting, the most likely candidate for second attendant is a nurse" (College Communique, May 194).

Responsibilities of the second attendant include assisting the midwife, providing support to the woman, monitoring vital signs of both the woman and the newborn, and ensuring that supplies and equipment are readily available to the midwife. The CMO requires that a midwife obtain a
written signed agreement between the midwife and each individual second birth attendant outlining specific role definitions and responsibilities, and that the midwife provide a copy of the agreement to the second attendant (College Communique, May, 1994).

Nurses in maternity are also afraid for their jobs. With many cutbacks in health care, job security has diminished. According to Ina Caissey at the Ontario Nurses Association, nurses are finding "where there are midwives in some of the areas the registered nursing staff has been cut because some of the deliveries are now done by midwives, and midwives care for their own patients in the hospital".

Nurses have another concern due to midwifery deliveries in a hospital. If the staff has been reduced and an emergency occurs, delivery becomes a medical problem and more staff is required suddenly; thus there is a great risk that nurses might be short staffed (Caissey).

Nurses have 'managed' labour always because doctors do not stay with their patients during labour. A doctor only arrives in a delivery room when a nurse makes a judgment and calls him 'to catch the baby'. "Management of labour is a thorny issue. It was not given to nurses as a controlled act, but only if it is delegated. Nurses maintain they manage labour, but we have never been able to work that through" (Risk).

Krauser (OMA) stated that the initial reaction of the medical profession toward midwives was anger. "It was anger that in spite of all the developments that had been put into place in Ontario, (Ontario had the lowest peri-natal mortality rates, almost non-existent maternal mortality rates) the whole system and the doctors were
still subject to criticism. The system was in fact so bad that we had to have another practitioner to make it right so there was a period that anger was quite considerable”.

If there was resentment among physicians toward midwives in early 1980s, then what are their attitudes now? Krauser said "it's hard to say what is going on out there at the grass roots. Even in the 1980s there was quite a number of physicians who were very supportive of bringing in midwives”.

Margaret Risk (CNO) says that when "I am about the province to meetings there is a lot of rumblings, a lot of anxiety". However, she is positive about the relationship of nurses and midwives in the future. She says "I think a lot of the anxiety has been actually dissipated remarkably quickly. But there has been a lot of anxiety over the last couple of years that midwives will take over the role of the RN in the obstetrics, in the peri-natal area". Nurses see themselves as equals to midwives, not inferior to them, so the initial reaction to having to take orders from midwives was negative. "I think a lot of that has been dissipated, too" (Risk).

Karyn Kaufman, states that she, personally, has had positive experiences with other health care workers. However, she does concede that "There have been some testy meetings at times with various departments. I think family doctors have had the most uneasiness as to what this [midwifery] has meant".

Margaret Anne McHugh, of the Ministry of Health, thinks that "there is kind of fear of the unknown" (by physicians as well as nurses) and obstetrical nurses fear there is "yet another person I have to clean up after".
All interviewees except those at ONA attempt to minimize the anxiety of nurses and doctors about midwifery and believe that there is going to be an amicable relationship between midwives and other health care workers.

**Salaries and Cost Factors**

"One legitimate cause for resentment and anger" according to Leslie Bell at ONA is the issue of salaries. ONA's duty is to try to protect the jobs and salaries of nurses. The highest basic salary that an experienced nurse can make is $53,664 dollars per annum. The starting salary of midwives, on the other hand, is $55,000 dollars a year.

Health care costs are rising, jobs are lost in many areas of health care and hospital beds are permanently closed. The Social Contract has forced health care workers to take pay cuts. Leslie Bell at the ONA says that since nurses got their last raise the whole climate changed. Many people blamed nurses for lay-offs and cut backs because the nurses got a salary increase. "So for a new group to come in during that time and earning substantially more, probably is very hard for people to accept". Margaret Risk also at the College of Nurses stated that there has been "a lot of rumbling about the salary issue".

Krauser at the OMA voiced the same view. "The government is cutting back health care funding, education funding and welfare funding but they find money to put the infrastructure for midwifery".

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The OMA position is that midwifery is going to increase costs. "It appears to the physicians that the government is going to pay the midwives twice as much (as physicians) for deliveries. Whether that is true or not, I don't know first hand but...at the individual level many physicians are quite irritated by the perception that they are introducing a midwifery program that is going to cost twice as much" (Krauser). Krauser adds "that midwives agree with us that the reproductive care fees for family doctors and obstetricians are undervalued".

Both ONA and OMA interviewees believe that costs in maternity care are going to increase because of emergencies. They believe that, once a midwife's patient enters a hospital due to complications, the costs will increase. In addition to the midwife's salary now there is the extra cost of the hospital bed, and doctors' and nurses' salaries (Bell, Caissey, Krauser).

Margaret-Ann McHugh at the Ministry of Health agrees that there is a perception of increased costs and this could cause resentment of midwives. "At the time of cut-backs, people are losing their jobs, suffering from the Social Contract, feeling like money coming out of their pockets and...suddenly there is this other care provider and they have money in their pockets". Nevertheless, McHugh feels positive about midwives and thinks that once doctors know about them they will realize that these people are committed, very well educated and knowledgeable professionals. "I think that is why the doctors who work with midwives are less threatened by them".

McHugh also points out that with physician deliveries there are often more than one doctor present. "In the teaching hospitals there is often a resident, a
family doctor, and sometimes an obstetrician and a pediatrician present. And if we add the nursing care...if we add all of that...[the costs are high]."

**Summary**

Legalized midwifery came into existence in Ontario in January 1994 as a result of strong lobbying by those alegal midwives, who had practiced here prior to 1994, and their clients. The lobbying started in the early 1980s when a conservative government was in power. They initiated the Health Disciplines Legislation Review, thereby initiating the process to legalize midwifery.

The liberal government followed, 'created the legislation' and the NDP implemented it. "So everyone [all three parties] feels quite an ownership" (McHugh).

It was decided that midwifery training would be at the university level, an Honors' BA in Midwifery. It was not to be a specialty of nursing, although this was strongly recommended by both nurses and doctors.

Midwives wanted to be separate from nursing so they could develop an independent profession. Nurses have not been able to gain independence although they have worked here legally for centuries. The Regulated Health Professions Act has not increased the nurses' independence.

Doctors are and always have been an independent profession.

There is a certain amount of anxiety and apprehension among health care workers about midwives, albeit for different reasons. Doctors fear that costs will increase when midwives deliver babies. Nurses are anxious about possible loss of jobs.
in maternity area. They also resent taking orders from health care workers whom they consider their equals. The nurses' union is displeased about the high starting salary of midwives which is higher than the top salary of a nurse.

Midwives practicing in Hamilton have had no difficulty in being accepted into the system (Kaufman). However, in some other areas such as Sudbury, the physicians especially have strongly resisted midwifery and have tried to bar midwives from hospitals (Kaufman).

It seems rather remarkable that a small group of women has taken on governments and strong professional organizations who resisted them, and managed to enter the health care system as legal, independent professionals.
Chapter 6

ANALYSES OF THE SURVEY DATA OF NURSES

This chapter presents and analyses the findings of the research among maternity nurses (N=96). These nurses were full time workers in ten hospitals in Metro Toronto area. Four of the hospitals were teaching hospitals and six were non-teaching ones.

Type of Questionnaire Used in This Study

Presented in this section are data on nurses' opinions toward midwives. The respondents indicated their opinions on a questionnaire that consisted of 31 items. There were three 'yes' or 'no' answer items, 18 items were on a four point Likert-type scale format (strongly agree, mildly agree, mildly disagree, strongly disagree). The respondents were also given an option of 'I don't know'. Seven items had other kind of multiple choice answers and three items asked for demographic data.

Restating of the Question

My hypothesis is that the doctors and nurses working in obstetrics will not welcome midwives with enthusiasm, even though midwifery now is a legal
profession. Furthermore I hypothesized that the antagonism against midwives is due to various causes. Nurses resent the high starting salary of midwives and the considerable autonomy that midwives have attained in a very short time. There is also a fear of job loss among nurses as more midwives enter the health care field and nursing jobs are disappearing.

Doctors on the other hand resent midwives because they (midwives) might take patients away from doctors, thus reducing their income. Doctors, especially the family physicians, who do not earn large sums of money from obstetrics, feel that midwives earn too much for the number of deliveries they do annually. There is also the difference in philosophy among these health care workers. Doctors follow the medical model. Nurses have in the past followed the medical model but are slowly moving away from it and are adopting a more holistic model. Midwives are using the holistic model in their practice.

**Development of an Attitudinal Scale**

pay, [26] midwives equal co-workers, [27] would use/recommend midwifery services). Values were assigned to the answers (strongly agree 1, mildly agree 2, mildly disagree 3 and strongly disagree 4). Three items were reverse coded to guard against "aye sayers". (10,16,20). Eight of 96 nurse respondents answered "I don't know" on the Likert type questions and were therefore categorized as missing data and not assigned a value. The mean value of the 88 respondents was 33.318. The median was 32.500. The standard deviation was 7.987. Examination of the internal reliability of the scale composed of the 14 items, using the nursing data only, resulted in Cronbach's Alpha of 0.80. "One of the most widely used measures of the reliability of an index composed of several items is Cronbach's Alpha" (Bainbridge, 1992:473). Cronbach's Alpha is "a measure of reliability of items in an index equivalent to the average of all the possible split-halves reliability coefficients" (ibid:566).

The median of the attitudinal scale was used as the index, so that values below 32.500 indicate 'a more positive attitude' toward midwives and values above the median indicate 'a more negative attitude' toward midwives.

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6"The mean is equal to the sum of all scores divided by the number of scores. The mean is the index of central tendency that is usually referred to as an average" (Polit & Hungler, 1989:265).

7"Median is the 50 percent quartile, or the 50th percentile ... the median is a value such that 50 percent of all observations in the data set fall above it and 50 percent fall below it" (Iverson-Shelley, 1984:124).

8"Standard deviation is a measure of variability; measure of average deviation of scores from the mean" (LoBiondo and Haber, 1994:512).
The Main Question (Item Number 31)

Item number 31 asked "In summary, do you object to or approve of midwifery practice in Ontario?" Although the item no. 31 was a Likert type question it was not included in the development of the attitudinal scale because it is the 'main' question and the intention was to test it by the attitudinal scale.

The tabulation of question 31 showed that 70/96 (73%) nurse respondents indicated approval of midwifery, 10/96 (10%) objected to midwifery and a rather substantial number, 16/96 (17%) said 'I don't know'. On initial reading of these results one would conclude that a large majority of the nurse respondents approve of midwifery. However, closer investigation seems to indicate less favourable attitudes.

When the attitudinal scale that was developed for the analysis of the data is applied to this item (N=31), the approval of midwifery among the respondents is not as great as it appears at a first glance.

Answers to item 31 are classified according to whether the respondent scored less than 32.500 or more than 32.500. Categories 1 and 2 indicate a more favourable attitude, categories 3 and 4 indicate more negative attitude toward midwives. Of the two respondents who strongly objected to midwifery one was placed in category 3 (more negative), quite consistent with her strong objection, the other in category 2 (more positive). Eight respondents objected mildly to midwifery.
and six out of eight equally consistently achieved scores on the attitudinal scale which place them in category 3.

However, it is noteworthy that 11 (28%) of the respondents who mildly approved of midwifery achieved scores on the attitudinal scale that place them in category 3 (more negative). Of the 31 respondents who strongly approved midwifery 18 achieved scores on the attitudinal scale that placed them in category 2 (i.e. somewhat positive). These eighteen respondents (in category 2) achieved less favouring scores on the scale than what their answers on the questionnaire would indicate. (Table 1)

Table 1. Question # 31 Related to the Attitudinal Scale

Category: 1&2 'more positive view', 3&4 'more negative view'

1 = stronger positive, 2 = somewhat positive
3 = somewhat negative, 4 = stronger negative

<table>
<thead>
<tr>
<th>Categories</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Row total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly appr.</td>
<td>13</td>
<td>18</td>
<td></td>
<td></td>
<td>31(39%)</td>
</tr>
<tr>
<td>Mildly approve</td>
<td>1</td>
<td>27</td>
<td>10</td>
<td>1</td>
<td>39(49%)</td>
</tr>
<tr>
<td>Mildly object</td>
<td></td>
<td>2</td>
<td>6</td>
<td></td>
<td>8(10%)</td>
</tr>
<tr>
<td>Strongly object</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>2(2%)</td>
</tr>
<tr>
<td>Column total</td>
<td>14</td>
<td>48</td>
<td>17</td>
<td>1</td>
<td>80(100%)</td>
</tr>
</tbody>
</table>

Missing observations 16
When other questions were examined in relation to the attitudinal scale, collectively 75/96 (78%) of the nurse respondents had a more positive attitude toward midwifery, (18 in category 1 and 57 in category 2) and 21/96 (22%) placed in categories 3 (20) and 4 (1) (Figure 1).

The nurse respondents were divided into two groups: registered nurses (N = 54); and nurse midwives (N = 42) who are registered nurses as well as trained midwives from outside of Canada. It should be noted that only 7% of the registered nurses had a stronger positive view of midwives and 70% had a somewhat positive view, whereas of the nurse midwives 33% had a stronger positive view and 45% had a somewhat positive view of midwives. Twenty four per cent of the registered nurses and 22% of the nurse midwives had more negative attitudes toward midwifery (Figure 2).

When the responses are examined collectively in relation to the attitudinal scale, they tend to be slightly more positive than negative toward midwifery. It should be pointed out that a large majority of the answers, whether positive or negative, were clustered in the "mild" categories, i.e. most of the nurses displayed mild rather than strong attitudes toward midwives. Some possible reasons for this phenomenon could be:

1. Midwifery is still in its infancy in Ontario and nurses do not wish to either praise it or condemn it at this early stage and have adopted a 'wait and see' attitude.
2. They could have responded on the basis of social desirability which means that people answer questionnaires in a way they believe they are expected to rather than expressing their true beliefs. Nevertheless, the added comments (209 comments) on
the questionnaires expressed strong opinions of midwifery and a large majority of them (about 140) were rather negative (55 comments were seen as neutral and only 14 were truly positive comments toward midwives).

COMPETITION and UNCERTAINTY

There seems to be a certain amount of competition and uncertainty among the respondents about many aspects of midwifery. First there is the issue of the need for midwifery. Is there a shortage of doctors practicing obstetrics? Undoubtedly many nurses feel that this new profession is somewhat threatening to them and this concern creates feelings of uncertainty. This was expressed to me by many nurses with whom I have worked prior to the start of the study. These concerns became apparent in the data particularly when juxtaposing the answers to the multiple choice questions and the added comments.

Of the 96 respondents 37% agreed (either strongly or mildly) that there is a doctor shortage in maternity, whereas 41% disagreed and 22% answered 'I don't know' (Table 2). Since only 36 per cent agreed that there is a doctor shortage in maternity care, perhaps this can be interpreted that the majority of nurses (63%) feel there is no need for midwives.
Figure 1. General Attitude of Nurses on the Attitudinal Scale

Category 1 = More Positive toward midwives
Category 2 = Somewhat Positive
Category 3 = Somewhat Negative
Category 4 = More Negative
Figure 2. Attitudes of RNs vs. RNMWs on the Attitudinal Scale

Category of Attitudinal Scale

Category 1 = More Positive Toward Midwives
Category 2 = Somewhat Positive
Category 3 = Somewhat Negative
Category 4 = More Negative

RN = Registered Nurse
RNMW = Nurse Midwife

Percentage of Responses

Categ. 1 Categ. 2 Categ. 3 Categ. 4

Category of Attitudinal Scale

RNs RNMWs
Table 2.  Is There a Shortage of Doctors in Obstetrics?

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>Mildly disagree</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>Do not know</td>
<td>21</td>
<td>22</td>
</tr>
</tbody>
</table>

Total 96

Three respondents who mildly agreed qualified their answers by stating that there is no doctor shortage in large centres such as Toronto, but rural and northern communities do have problems with attracting and keeping doctors in obstetrics. However, the shortage does seem to exist and is not restricted to certain areas of the province only. Rosser and Muggah wrote "Family physicians and obstetricians are rapidly discontinuing obstetric practice ... Only 20% of all newly graduated family physicians are starting obstetric practice" (1989:2419), and Chance stated "There just are not that many obstetricians in Ontario to look after the women having babies" (Renaud, 1993:1005).

When asked how to solve the problem of doctor shortage, forty-eight percent of the respondents (46/96) said it is not a problem (Table 3). Of those 52% (50/96) who perceived there to be problem of doctor shortage, (19/96) 20% advocated midwifery, 17% (16/96) would like to see more doctors go into obstetrics (e.g. "create incentives to encourage them - MDs - not to migrate"), and 15% (15/96)
suggested both. In this group of respondents therefore there was only a slight
preponderance of respondents advocating midwives rather than doctors.

Table 3. How to Solve the Doctor Shortage Problem

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Problem</td>
<td>46</td>
<td>48</td>
</tr>
<tr>
<td>More Doctors</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>More Midwives</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>96</strong></td>
<td></td>
</tr>
</tbody>
</table>

These figures could be interpreted that only one half of the respondents
feel there is some competition from midwives (in the hospitals nurses care for the
patients admitted by doctors only, not by midwives, therefore if there are fewer
doctors admitting patients, nurses may lose their jobs) and perhaps they would prefer
the status quo, i.e. if there is no problem, why 'fix it'. By the same kind of reasoning,
one would expect that one half of the respondents would say that there is no demand
for midwifery. That was not the case.
Demand for Midwifery

That there is a demand for midwifery in society was supported either strongly or mildly by 73% of the respondents, 17% disagreed and 10% said they did not know (Table 4).

Table 4. Is There a Demand for Midwifery?

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>47</td>
<td>49</td>
</tr>
<tr>
<td>Mildly disagree</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Do not know</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>96</strong></td>
<td></td>
</tr>
</tbody>
</table>

This majority view is supported in the literature. "Canadian women are increasingly demanding an alternative to the 'medicalization' of childbirth and to hospital deliveries by obstetricians" (Baker, 1989:24).

The respondents saw the need, particularly in rural areas and the north as stated in the comments to this question. Although 73 per cent agreed that there was a demand for midwifery, their comments considerably qualified the scope of practice of midwives. This revealed uncertainty of the respondents toward midwives.
Approximately one quarter of the respondents pointed out in their comments that normal, low risk pregnancy does not always mean that no complications occur at birth and they agreed that an emergency back-up system should be in place. As Walker has pointed out, "Normality with respect to pregnancy, especially first pregnancy, is a retrospective diagnosis" (Walker, 1995:36).

Supporters of "hospital, physician-attended births claim that birth is a naturally risky physiologic process that entails grave risks for mother and fetus if not overseen in a medically managed, physician controlled setting" (Hafner-Eaton & Pearce, 1994:817).

One individual who advocated doctor care said "uncomplicated pregnancy is unpredictable at delivery" and another stated "I feel that 'primips' [first time mothers] should have to deliver in the hospital, if uncomplicated, then other pregnancies could be followed by midwife right through to delivery".

Even midwifery supporters made comments such as "with doctors in the background [available] - in rural areas doctor can be at home on call, if in large cities doctor should be in the same building - midwives could deliver babies". Some respondents advocated that midwives should have lots of practical experience, and be well trained. Nurse midwives and experienced labour and delivery room nurses were also suggested as alternative health care personnel to attend uncomplicated pregnancies.

Forty-two per cent of the respondents felt that uncomplicated, low risk pregnancies should be looked after either by midwives or by both midwives and doctors jointly (43%). Ten per cent said doctors should care for uncomplicated
pregnancies, i.e. 53% of the respondents feel that a doctor should be involved in all births (Table 5).

Table 5. Who Should Care for Normal Pregnancies?

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Midwives</td>
<td>40</td>
<td>42</td>
</tr>
<tr>
<td>Both</td>
<td>41</td>
<td>43</td>
</tr>
<tr>
<td>Do not know</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

The respondents' generally rather restrictive view of the scope of practice of midwives in Ontario (e.g. midwives 'are not capable' to manage home births) contrasts with the experience in other jurisdictions. For instance, today "75 per cent of births in European countries are attended principally by midwives ... All of these nations have lower infant mortality rates than does the United States" (Hafner-Eaton, 1994:815). Baker states that "several European countries (most notably the Netherlands, Britain, Sweden and Finland) rely extensively on midwives in hospital and home births" (Baker, 1989:9). The uncertainty here, in Ontario, perhaps stems from the unfamiliarity of midwifery by health care workers.

Another area of competition and uncertainty was shown in replies to the question about sharing patients with midwives.
What Will It Be Like to Share Patient Care with Midwives?

Approximately one quarter (26%) of the respondents predict it will be easy. Twenty nine per cent say it will be difficult and 4 per cent stated it will be impossible. A fairly large number (41%) stated they 'don't know' (Table 6). This perhaps reflects the fact that midwifery is still not widely implemented in Ontario. That 29% will find it difficult and 4% impossible to work with midwives and 41% 'do not know', suggests that 74% of the respondents feel less than positive about the issue.

Table 6. What Will It Be Like to Share Patient Care?

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy</td>
<td>25</td>
<td>26</td>
</tr>
<tr>
<td>Difficult</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>Impossible</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Do not know</td>
<td>39</td>
<td>41</td>
</tr>
</tbody>
</table>

Total 96

Respondents who predict it will be easy to share patients added comments such as "I was advised that the care would not be shared that midwives would be responsible for their patients", and "it will be fun and enjoyable". Some of the comments by respondents who predict difficulties were: "Initially there maybe difficulties", or
Inapplicable, nursing is not involved unless handover of care to a doctor [takes place]. If handover, then midwife's role is purely as a labour coach and I am perfectly willing to work with the midwife in that situation in the interest and wellbeing of the mother and unborn child.

This sounds as if she will only work with a midwife if a doctor is involved. In studying the comments and in reflecting on the fact that only 26% predict an easy working relationship while 31% predict difficult or impossible working relationships and as many as 41% are undecided it becomes apparent that there is still considerable confusion and suspicion among maternity nurses as to what role the midwives will play and what the role of the nurse will be in relation to midwives. This uncertainty is perhaps based on the fact that midwifery is so new as a profession here. It is the "fear of the unknown" (McHugh). Until there are more midwives and nurses have more contact with them, the uncertainty will persist.

COOPERATION (1)

The issue of nurses' co-operation with midwives was studied. Again the multiple choice answers were much more positive than the added comments.

Assisting a Midwife on Request

A substantial number of respondents (77%) said they would assist a licensed midwife, but 20% said they would not. (In actuality it has now been decided
that nurses do not have a choice. They are required to assist a midwife when requested. Of the nurse-midwives 36/42 (86%) agreed to assist, 5/42 (12%) said they would not assist a midwife (Table 7). Since they are midwives themselves one would expect that they all would assist a colleague because of professional solidarity, but on the other hand those six who disagreed perhaps feel that since they are not allowed to practice midwifery themselves they should not get involved.

Of the registered nurses 38/54 (70%) agreed and 14/54 (26%) disagreed with assisting midwives.

Table 7. Bivariate Registered Nurse vs. Nurse Midwife

Would Assist a Midwife

<table>
<thead>
<tr>
<th>Opinion</th>
<th>yes</th>
<th>no</th>
<th>don't know</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwives</td>
<td>36</td>
<td>5</td>
<td>1</td>
<td>42</td>
</tr>
<tr>
<td>Regist. nurse</td>
<td>38</td>
<td>14</td>
<td>2</td>
<td>54</td>
</tr>
<tr>
<td>Column Total</td>
<td>74</td>
<td>19</td>
<td>3</td>
<td>96</td>
</tr>
</tbody>
</table>

Some respondents quite accurately stated that health care is a collaborative effort and no one works truly independently. One nurse midwife who agreed that she would help a registered midwife added that "midwives are responsible for their own actions. We cannot have a health care system where midwives are

---

9) Personal conversation with the obstetrical unit managers at one of the teaching hospitals
competing with doctors. Animosity will arise. The long term goal should be to provide the best care for individual patients".

**Carrying Out Midwives' Orders**

Although 77% of the respondents stated that they would assist midwives, only 48% of the respondents agreed (either strongly or mildly) that they would have no problems carrying out orders from midwives, 37% stated they would have difficulties in taking orders from midwives and 15% said they did not know (Table 8).

**Table 8. No Resentment to Carry out Midwives' Orders**

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>22</td>
<td>23</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>Mildly disagree</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>22</td>
<td>23</td>
</tr>
<tr>
<td>Do not know</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>96</strong></td>
<td></td>
</tr>
</tbody>
</table>

One respondent who strongly agreed she would have no problem carrying out midwives' orders commented "if it is a hospital policy I will do it". Another whose answer was 'strongly agree' to carry out midwife's orders stated "if
a person is fully trained as an RN first and then has successfully completed four years of midwifery". However, her choice for an answer was chosen 'incorrectly' because she stipulated a condition that cannot be fulfilled. Midwives in Ontario are not automatically 'RNs first'.

The following comments were also made by respondents who indicated they would follow midwives orders; "She [midwife] writes orders, carries them out on her patients". This respondent answered 'agree'; however from her comment one understands that she has no plans to follow midwives' orders, but expects a midwife to care for her patient totally. "Midwives administer their own drugs, RNs should work in partnership, not as subservients" was another comment and "Midwives who order medications should administer them - not a second party". The above respondents were all nurse midwives. There is a clear reluctance to take any orders from Ontario registered midwives. The respondents who made adverse comments had all answered 'mildly or strongly agree' on the questionnaire. One wonders if many of the respondents who did not make comments and answered 'agree' also felt reluctance to take any orders from midwives.

Some respondents were quite concerned about this issue of midwives' orders. "When sharing patient care in a hospital, policies need to be clearly defined due to the overlapping of responsibility - who is ultimately responsible for the patient's welfare - the RN employed by the hospital or the self-employed midwife"?

An RN respondent wrote that it is "not within legislation for RNs to carry out midwives' orders, so the question is a moot point". However, as pointed out above, this comment is not correct; nursing staff is obligated to assist a midwife on
request. Nurses do not have any problem in carrying out physicians' orders, since it is a tradition, but nurses are confused, at this stage, about taking orders from midwives.

**MEDICAL versus CONSUMER DRIVEN OBSTETRICS**

Some of the collected data were subjected to Principal Component Analysis or Factor Analysis which is "a technique to determine whether, among a large group of variables, any of them form clusters in which all of the variables in the cluster are more closely related to each other than to the variables in another cluster. Each of these clusters or groups of variables is known as a factor" (Straus, M & J. Nelson, 1968:136).

The questions that were identified for the first factor were: [9] 'home births', [10] 'doctor supervision', [11] 'midwives' independence', [12] 'medical interventions', and [17] 'holistic care'. The mean in this factor was 2.423 and this means that the nurses' responses to these questions tended to fall into the 'neutral' area between somewhat positive and somewhat negative in their view of midwifery. Again it will be shown that the comments expressed by the nurses are not necessarily in the neutral categories.
Midwives and Supervision by Doctors

Traditions are difficult to erase. Nurses have traditionally followed doctors' orders and have generally, perhaps reluctantly accepted the subservient role perpetuated in the health care system. Now that a new profession is coming to the scene, nurses expect the midwives also to work under doctors' supervision and follow the medical model. That is not what midwives and 'liberated' consumers want.

A large majority (80%) of the nurse respondents either strongly or mildly agreed that midwives should work under the supervision of doctors, while 20% disagreed (Table 9).

Table 9. Should Midwives Be Supervised by Doctors?

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>40</td>
<td>42</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>37</td>
<td>38</td>
</tr>
<tr>
<td>Mildly disagree</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Do not know</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Total 96

There were 15 individuals who made additional comments on this issue. Ten agreed with supervision by doctors and five disagreed; nevertheless, their comments were very similar. Comments from those who agreed with supervision by
doctors included, "In association with doctors", "In collaboration with doctors", "With doctors, not under supervision". Those who opposed doctor supervision added comments such as, they should "work in collaboration" or "In association with", "They should cooperate", "They should work as a team". However, there were two respondents who strongly agreed with supervision by doctors and commented, "Midwifery should be practiced under the umbrella of obstetrical medical care, with strict guidelines", and "Midwives should be supervised by doctors. After all MD has to have many years of training to become an obstetrician. I won't risk my life or my baby's to have midwife deliver without MD's supervision..." Both of these two respondents were nurse midwives and had Bachelor degrees.

No definite pattern emerged as to who advocated supervision and non-supervision. When the answers were cross tabulated according to age, university degree, years of experience and the type of hospital they work in (teaching vs. non-teaching hospital) no difference was evident in the answers they gave. However, there was some difference between registered nurses and nurse midwives. Twenty nine of the 42 nurse midwives (69%) agreed with doctor supervision whereas 48 of 54 registered nurses (89%) agreed with doctor supervision of midwives (Table 10).
Table 10. Bivariate RN vs. NMW

Midwives Should Work Under the Supervision of Doctors

<table>
<thead>
<tr>
<th>RN or NMW</th>
<th>Strongly Agree No.</th>
<th>Mildly Agree No.</th>
<th>Mildly Disagree No.</th>
<th>Strongly Disagree No.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMW</td>
<td>14</td>
<td>15</td>
<td>4</td>
<td>9</td>
<td>42</td>
</tr>
<tr>
<td>RN</td>
<td>26</td>
<td>22</td>
<td>4</td>
<td>2</td>
<td>54</td>
</tr>
</tbody>
</table>

(RN = Registered Nurse, NMW = Nurse Midwife)

There were only six registered nurses and 13 nurse midwives who disagreed with doctor supervision. The perceived need for doctor supervision, one suspects, is due to our Canadian health care system where we have come to rely only on doctors for decision making in health issues. "Although the 'medicalization of childbirth' is essentially a twentieth century phenomenon, the assumption is prevalent in North America that births 'delivered' by physicians in hospitals are the only safe ones" (Baker, 1989:1).

A reason that some nurse midwives see no need for doctor supervision may be that these nurse-midwives have worked independently in other countries where they trained and therefore know that midwives are capable of independent work. Nurses, on the other hand, hardly ever work independently.
Should Midwives Work Independently?

Although only 20% of the respondents believed that midwives should not work under the supervision of doctors, when asked if midwives should work independently, 44% of the respondents either strongly or mildly agreed and only 54% disagreed that midwives should work independently, 2% had no opinion (Table 11).

Table 11. Midwives Should Be Independent Professionals?

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>Mildly disagree</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>35</td>
<td>37</td>
</tr>
<tr>
<td>Do not know</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>96</strong></td>
<td></td>
</tr>
</tbody>
</table>

The comments again were similar to those above. Respondents who either strongly or mildly agreed with midwives' independence suggested (instead of supervision) words such as "in association with doctors", "in collaboration with doctors", "with doctors, not under supervision" and "more along consulting basis". Respondents who either mildly or strongly disagreed with midwives' independence used similar phrases to those above, "midwives and doctors should be co-partners", "not under supervision but work together", "collaborating and co-operating" and
"doctors and midwives need to be co-partners in delivering safe obstetrical care". If the wording on the questionnaire had been different, e.g. instead of the words 'doctor’s supervision', for example, the words 'in collaboration with' had been used, one suspects that the multiple choice answers would have been quite different. There were 25 respondents who agreed both to doctor supervision and midwives’ independence. This is obviously a contradiction but at the same time it demonstrates the ambivalence nurses feel toward midwives. Also it is clear that the respondents do not equate midwives' independence/autonomy with that enjoyed by the medical profession, but rather midwives must clearly be practicing, in the respondents' view, either under the supervision of or in collaboration with medical practitioners.

**Home Births**

Home birth is a topic that has created much debate in connection with midwifery. Many health care workers have strong opinions on this. We will see in the next chapter that very few doctors surveyed for this study agreed with home births and none agreed they would assist in a home birth. Nurses differed considerably from doctors in this area but they too had reservations.

Potential risks were especially emphasized by 58% of the respondents who either strongly or mildly agreed that home births are acceptable (Table 12). Many of the 38% of the respondents who objected (either mildly or strongly) to the idea of home births, did so for the same reason, that the appropriate back-up system is not in place now for safe births at home.
Table 12. Are Home Births Acceptable?

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>41</td>
<td>43</td>
</tr>
<tr>
<td>Mildly disagree</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>Do not know</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>96</strong></td>
<td></td>
</tr>
</tbody>
</table>

The multiple choice answers to the question about home births covered all 5 options from 'strongly/mildly dis/agree and I don't know'; therefore one would expect the comments also to cover a variety of issues. That was not the case. The comments consisted mainly of concerns about the lack of a proper back-up system. One individual checked 'mildly agree' and added "with a proper back-up system", probably indicating that she mildly agrees with the idea of home births if there is a back-up system in place but she does not agree otherwise. Another respondent answered 'strongly disagree' and added "not until facilities are provided in the community for obstetrical emergencies". Both of these individuals appear to feel the same way about home births, yet their multiple choice answers are counted as opposites. Four respondents had no opinion.

Several respondents who either agreed or disagreed with home births stated again that primiparas (first time mothers) should deliver in a hospital but
multiparas (having at least one birth before) with no history of complications could deliver at home.

Differences in Accepting Home Birth,
According to Age and Years of Practice

The acceptability of home births differed depending on the age of the respondent. Of those younger than 40 years, 46% agreed home births are acceptable, 51% disagreed. Of those over 40 years 69 per cent agreed and 28% disagreed (Table 13).

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Strongly Agree No.</th>
<th>Mildly Agree No.</th>
<th>Mildly Disagree No.</th>
<th>Strongly Disagree No.</th>
<th>Do Not Know No.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;40</td>
<td>2 5</td>
<td>15 41</td>
<td>6 16</td>
<td>13 35</td>
<td>1 3</td>
<td>37</td>
</tr>
<tr>
<td>&gt;40</td>
<td>7 18</td>
<td>20 51</td>
<td>4 10</td>
<td>7 18</td>
<td>1 3</td>
<td>39</td>
</tr>
</tbody>
</table>

A similar variation was found depending on the years of experience. Of those who had been in nursing practice less than ten years, 38% agreed with home births, 62% disagreed. Of those who had worked in nursing more than ten years 63% agreed and 32% disagreed (Table 14).
Table 14. Bivariate by Years of Experience

Acceptability of Home Births

<table>
<thead>
<tr>
<th>Years of Experience</th>
<th>Strongly Agree No.</th>
<th>Mildly Agree No.</th>
<th>Mildly Disagree No.</th>
<th>Strongly Disagree No.</th>
<th>Don't Know No.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10</td>
<td>1</td>
<td>7</td>
<td>4</td>
<td>9</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>&gt;10</td>
<td>12</td>
<td>33</td>
<td>11</td>
<td>12</td>
<td>4</td>
<td>72</td>
</tr>
</tbody>
</table>

A possible reason for this difference could be that the older and more experienced nurses had encountered home births in their nursing but the younger, less experienced nurses have only seen and heard of hospital births and they might find the idea of home birth somewhat frightening, or not 'medical' enough. Some of the older respondents may also have migrated from Europe, the Caribbean and the Philippines, where home births were the norm until after the Second World War. In Britain, for instance, maternity care has changed, "during the past 45 years, the percentage of babies born at home in the UK has fallen from 40% to just over 1%" (Wraight, 1994:16).

There was no difference between the registered nurses' and nurse midwives' answers to this question. Although the majority of the respondents agreed with home births on the multiple choice answers, it seems evident that many of the respondents emphasized in their comments the unpredictability of complications and the necessity of back-up systems. Although they support midwifery they do not see midwifery as an independent profession and see maternity care as medical.
There are studies conducted in Europe on the safety of home births vs. hospital births. One British doctor is quoted as saying "There is no clear statistical evidence that having their babies elsewhere than in hospital maternity units reduces the safety of women with uncomplicated pregnancies" (Savage, 1996:356), and a midwife stated "since there is no evidence that home is less safe than hospital, the provision of support for home birth seems not only fully justifiable, but mandatory" (Leap, 1996:358).

**Holistic Care**

More than three quarters of nurse respondents (77%) believe that midwives give more holistic care than do the doctors, 13% either strongly or mildly disagreed and 10% had no opinion (Table 15).

**Table 15. Do Midwives Give More Holistic Care?**

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>35</td>
<td>37</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>39</td>
<td>41</td>
</tr>
<tr>
<td>Mildly disagree</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Do not know</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>

Total 96
Holistic care means that a patient is viewed as a whole person, not an object having one disease or another. The holistic care giver takes into account all aspects of the person’s life, the physical and mental well being, the family, learning capacity, etc. Midwives accept their patients as active participants in their care, unlike the traditional hospital situation where women "often feel that their role is that of passive recipient, having things done to them rather than playing an integral part in making the decisions" (Hanley, 1993:14). One obstetrician wrote, "Most obstetricians, myself included - no matter how warm, kindly and thoughtful we are - are trained to deal only with pathology" (Bergman, 1994:48). Since nurses work with doctors, this means nurses tend to follow the medical model. However, through my observations in hospitals more and more nurses care for their patients in a holistic way.

One respondent, who strongly disagreed that midwives give more holistic care, commented "It has taken 200 years for obstetrics to be the safe procedure it is today, why take it back 200 years?".

**Medical Interventions**

Sixty-one per cent of the nurse respondents believe strongly or mildly that maternity patients are subjected to too many medical interventions, but approximately 39% either strongly or mildly disagree (Table 16).
Table 16. Women Have too Many Medical Interventions in Maternity?

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>39</td>
<td>41</td>
</tr>
<tr>
<td>Mildly disagree</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>Don't know</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total 96</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There was no detectable pattern along demographic variability, specifically according to age, education, or workplace (type of hospital) as to who agreed/disagreed with the medical intervention statement.

One individual who strongly agreed with the statement wrote "there are too many ultra sounds, IVS, too much fetal monitoring often leading to cesarian section too soon", and some respondents said that artificial rupture of membranes (ARM) to hasten labour is done and the forceps are used too often. However, some comments stated "Not all doctors intervene", "depends on the doctor and on the hospital" and "some interventions are initiated by the patient" (such as begging for epidural anaesthetic when labour pains become unbearable).

In North America, cesarean section rates are the highest in the world. From the 1960s to the late 1980s the cesarean section rate increased in the USA from 5 per cent to 25 per cent. The Ontario rate is approximately 20 per 100 births,
whereas in Holland the rate is only 6 per 100 births (Baker, 1989:13). In other words, medical interventions in North America are relatively high.

**ACCEPTANCE versus REJECTION**

**Education of Midwives (2)**

There are many issues that affect the acceptance or rejection of midwifery. One is the education issue. There are 50,000 nurses in Ontario but only approximately three per cent have a university degree. Therefore, it is interesting that a majority of the respondents (66%) agreed that a four year university program for midwives is appropriate, 19% disagreed and 15% had no opinion (Table 17).

**Table 17. Bachelor Degree Is Appropriate for Midwives?**

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>41</td>
<td>43</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>22</td>
<td>23</td>
</tr>
<tr>
<td>Mildly disagree</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Do not know</td>
<td>15</td>
<td>16</td>
</tr>
</tbody>
</table>

Total 96
Several nurses who 'agreed' emphasized that there should be a lengthy practicum/internship under supervision.

In Britain, where midwifery has a long history, the training has traditionally occurred in a hospital. Midwifery has been a nursing specialty requiring only one year of training after the three year nursing program. In Britain, university programs have now begun in some areas. It appears that university programs are made accessible part-time for working midwives. "Because our course is designed for adults with full-time jobs we are flexible about attendance and access to materials if a midwife is unable to come to classes" (Kirkman, 1994:326). By contrast in Canada, midwifery is a full-time course and no special provisions are made for nurses who would like to qualify as midwives.

In the UK there are now also graduate studies programs in midwifery. "Eleven midwives have obtained MSc degrees following completion of first ever Masters degree in Midwifery in the United Kingdom ... through a course run jointly by the University of Surrey and the Royal College of Midwives" (Midwives Chronicle, 1994:56). In the USA some states have legalized midwifery and they are mostly nurse midwives. "Certified nurse-midwives are registered nurses with advanced education in the provision of prenatal, perinatal, postpartum, newborn, and routine gynaecological care. About 61 percent had Master's degrees in 1991"(in the USA) (Sekscenski, et.al. 1994:1266). Thus the opinion of the majority of the respondents is consistent with current trends.
Should Midwives Be Nurses?

A strong majority (91%) of the nurse respondents in this study agreed either strongly or mildly that midwives should also be nurses; only 4% disagreed (Table 18).

Table 18. Midwives Should Be Registered Nurses?

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>73</td>
<td>76</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Mildly disagree</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Do not know</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Total 96

Several respondents who would like midwives to be registered nurses advocated shorter training for RNs to become midwives. One respondent wrote that "it appears that being an RN is a deterrent to being accepted into the midwifery program". Another individual, who also agreed midwives should be RNs, stated "it would help [to be an RN] but I have seen very skilled midwives who were not nurses". Doctors (if they have accepted the idea of midwifery at all) have supported the nurse-midwife concept.
In 1987, the Canadian Medical Association Journal printed a statement about the role of midwives. This clearly stated that the Association did not support the establishment of midwifery as an autonomous health care profession but believed that nurses could be trained to assume more obstetrical care responsibilities under the direction of physicians (Baker, 1989:24).

(Doctors' opinions are discussed further in the next chapter.)

It seems that in the area of education the acceptance/rejection issue could be smoothed out considerably by listening to the concerns of nurses. British or many other European trained midwives, who are nurse-midwives, are not seen as inadequate. On the contrary, they have an excellent professional reputation. Many of the doctor respondents made positive comments on their questionnaires and several maternity doctors voiced the same opinion in conversations. Nurse midwives from the Caribbean islands were either trained in Britain or on the British model, so 'British trained' includes them. Being a nurse or a nurse midwife should not be a deterrent to becoming a midwife in Canada.

The Status of Foreign Trained Midwives

Sixty-two per cent of the respondents disagreed either strongly or mildly that foreign trained midwives should be allowed to practice here without further training, and 35% agreed (Table 19).
Table 19. Foreign Trained Midwives Should Be Able to Practice in Canada without Further Training

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Mildly disagree</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>40</td>
<td>42</td>
</tr>
<tr>
<td>Do not know</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

Total 96

Fifty-nine percent of the nurse midwives disagreed with this item, and only 36% agreed that foreign trained midwives should be allowed to work here without further training (even though they are foreign trained themselves). However, many nurse midwives have not practiced independent midwifery for a long time; therefore it is possible that had the question had an option 'with minimal upgrading' the answers would have tended more to the 'agree' side. It has been pointed out to me that the term 'foreign trained' could be perceived in a negative way and this could have led the respondents to give biased or prejudiced answers. 'Outside of Canada' would have been a better term to be used.
Financial Implications of Midwifery

Because midwives' starting salary is higher than that of experienced nurses' salaries, it was surprising to read that only 27 per cent of the respondents surveyed thought that the midwives' salaries are too high, 39% thought they are appropriate, 8% thought they are too low and 26% had no opinion (Table 20).

Table 20. What Are the Salaries of Midwives' Like?

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too High</td>
<td>26</td>
<td>27</td>
</tr>
<tr>
<td>Too Low</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Appropriate</td>
<td>37</td>
<td>39</td>
</tr>
<tr>
<td>Do not know</td>
<td>25</td>
<td>26</td>
</tr>
</tbody>
</table>

Total 96

One respondent commented on the discrepancy between the midwives' and nurses' salaries and implied unfairness. Most of the comments had to do with the issue of the number of deliveries that midwives will do annually, suggesting that the salary should be dependent on the number of deliveries performed. (A few nurses also suggested that doctors' salaries should be reduced.) The nurse respondents have a different perception of doctors' income (in obstetrical medicine) from that of doctors themselves who claim that obstetrical practice is not a lucrative part of their practice. (Doctors' salaries will be discussed in the next chapter.)
Will Midwives Take away Nursing Jobs?

Another surprise answer was to the question whether midwives will take away nurses' jobs. One half (50%) of the nurses either strongly or mildly disagreed that their jobs are at risk due to midwives coming into practice (Table 21).

Table 21. Midwives Will Take away Nursing Jobs?

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>Mildly disagree</td>
<td>22</td>
<td>23</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>26</td>
<td>27</td>
</tr>
<tr>
<td>Do not know</td>
<td>11</td>
<td>12</td>
</tr>
</tbody>
</table>

Total 96

This was particularly surprising since hospital beds are being closed, whole hospitals are closing and nurses are being laid off (Crawford et.al. 1995:10-13), hardly any new full-time positions are offered, and maternity patients are sent home very soon after giving birth, usually after 24 to 36 hours (unless a cesarean section has been performed). If midwives accompany their patients to the hospital and then home again, is there going to be the same need for maternity nurses? It appears that one half of the nurse respondents have faith that their jobs will not be
affected by midwifery, but 39% of them did either strongly or mildly agree that midwives will take away nursing jobs, and 11% had no opinion.

No significant statistical difference was found between those who agreed or disagreed with the statement about job losses. RNs and nurse midwives were almost equally divided as were the two age groups (less than 40 and over 40 years). The type of hospital where they worked or whether they had a university degree or not made no significant difference in their answers. Some comments from those who saw a possibility of job losses were: "Yes, in low risk obstetrics", "If a woman uses a midwife she is not going to her doctor. Nurses only look after doctors' patients". Then finally a truly altruistic comment "If it means better care then so be it".

How Will Midwifery Affect Health Care Costs?

Thirty-five per cent of the respondents said midwifery will decrease health care costs; 19% thought that the costs will increase. Twenty-three per cent said midwifery will not have any effect on health care costs and 25% had no opinion (Table 22).
Table 22. Will Midwifery Affect Health Care Costs?

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce them</td>
<td>34</td>
<td>35</td>
</tr>
<tr>
<td>Increase them</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>No effect</td>
<td>22</td>
<td>23</td>
</tr>
<tr>
<td>Do not know</td>
<td>22</td>
<td>23</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>96</strong></td>
<td></td>
</tr>
</tbody>
</table>

One nurse commented that home births will reduce costs but another said that a duplication of services, especially in case of home births, could increase costs, i.e. if problems arise and a woman has to be transferred to a hospital under the care of doctors and nurses. The 35% of the respondents (34/96) who predict reduced health care costs as a result of midwifery all approved of midwifery in general and of those 47% (16/34) feel that midwives' salaries are appropriate.

Nineteen per cent of the respondents predict that midwifery will increase health care costs (18/96), of them 44% (8/18) said that midwives' salaries are too high and 8/18 objected to midwifery in general.

Because midwifery is still in its infancy in Ontario, it seems to be difficult to predict the costs to the health care.
Would the Respondents Use Midwifery Services?

Would the respondents themselves use midwives for their own pregnancies and deliveries? The respondents were equally divided on this issue, 38% either strongly or mildly agreed they would use midwives, and 39% either strongly or mildly disagreed and 23% did not know (Table 23).

Table 23. I Would Use Midwifery Services

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>Mildly disagree</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>Do not know</td>
<td>22</td>
<td>23</td>
</tr>
</tbody>
</table>

Total 96

One nurse stated:

I am somewhat ambivalent about midwifery. If women want this service, we must accept it. I personally would hesitate to use them without a back-up of a doctor.

Another respondent stated:

I have nothing really against midwives. Everyone is entitled to a choice. My personal preference is the safety of a hospital. Unexpected problems are numerous with 'normals'. I sure wouldn't deliver at home.
A respondent who answered 'Strongly approve' added,

I think midwifery is for some people but not for me. I think they are a great help if the consumer approves. It will make a better experience providing they ask for assistance when needed.

It seems curious that those who approved of midwifery state that it is 'not for them' and would not use midwives themselves and they always seem to doubt that midwives can do the job by themselves but that a doctor must be in the background ready to step in. As stated earlier, one respondent commented that "I won't risk my life or my baby's to have midwife deliver without MD's supervision."

This is a contradiction which became very apparent when questions #27 and #31 were crosstabulated (Table 24).

**Table 24. Crosstabulation of Questions #27 and #31**

**Would Use Midwifery Services vs. dis/approval of Midwifery**

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Mildly agree</th>
<th>Mildly disagree</th>
<th>Strongly disagree</th>
<th>RowTotal no.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Str.obj.</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>M.object</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>M.approve</td>
<td>1</td>
<td>14</td>
<td>10</td>
<td>9</td>
<td>34</td>
<td>43</td>
</tr>
<tr>
<td>Str.appr.</td>
<td>10</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>22</td>
<td>28</td>
</tr>
<tr>
<td>ColumnTotal</td>
<td>11</td>
<td>22</td>
<td>17</td>
<td>16</td>
<td>66</td>
<td>83</td>
</tr>
</tbody>
</table>
There were 22 'Don't know' answers to question # 27 and 16 to question # 31, total number of respondents 80.

Of those ten respondents who objected to midwifery, eight said they would not use midwifery services which is consistent with their objections. Of the 70 respondents who approved of midwifery 25 (36%) also stated that they would not use midwifery services. Therefore the respondents, both in answers to questions and in their comments reflect their reluctance to use midwifery services. Their view appears to be 'it is appropriate for others but not for themselves', i.e. they do not have confidence in the midwives' abilities to manage their role without the doctors' involvement. It is possible that nurses, who are over 90 per cent women, see all women as nurturing individuals and therefore feel sympathetic toward midwives at one level, but at a different level, due to their socialization, want to rely on the male dominated medical model for their own care.

Although less than 40% agreed they themselves would use midwives, close to three quarters (73%) approved (41% mildly and 32% strongly) of midwifery practice in Ontario. Just 10% objected and 17% had no opinion. Of the 42 nurse midwives no one objected strongly and only two objected mildly to midwifery. Thirteen mildly approved and 17 strongly approved; 10 had no opinion. Of the 54 RNs two objected strongly and six objected mildly to midwifery. Twenty six approved mildly and 14 approved strongly, 6 said 'I don't know' (Table 25).
Table 25.  Bivariate RN (Reg. Nurse) vs. NMW.(= Nurse Midwife)

Do You Object to or Approve of Midwifery

<table>
<thead>
<tr>
<th>RN/NMW</th>
<th>Strongly Object No. %</th>
<th>Mildly Object No. %</th>
<th>Mildly Approve No. %</th>
<th>Strongly Approve No. %</th>
<th>Do Not Know No. %</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMW</td>
<td>0</td>
<td>2.5</td>
<td>13.31</td>
<td>17.40</td>
<td>10.24</td>
<td>42</td>
</tr>
<tr>
<td>RN</td>
<td>2.4</td>
<td>6.11</td>
<td>26.48</td>
<td>14.26</td>
<td>6.11</td>
<td>54</td>
</tr>
</tbody>
</table>

Since only 31/96 respondents strongly approved of midwifery it seems that the overall feeling is rather lukewarm toward this new health care profession. Over 30 per cent (31/96) made comments following the last question. Some made rather lengthy ones. Several issues were discussed.

As stated earlier, one major determinant against midwifery is the feeling among maternity nurses that they have been excluded from this new profession despite practicing in the area for many years. "I strongly object to the way it is set up at present. It is made close to impossible for any RN working in L&D [labour and delivery] to be accepted into midwifery program."

Another foreign trained nurse midwife, who mildly approved of midwifery stated,

I am happy that things are changing and midwives are conducting more cases. But, what about the nurse midwives who are already in hospitals? Shouldn't they be allowed to practice? When I first started we were allowed to do all the normal cases, doctors only attended if there was a problem. I am sure this can work here, too, but I
find the doctors are not very co-operative at present. Things may change.

An RN respondent who answered 'strongly approve' went on to say,

however, the requirements for the program regarding RNs (currently working in L&D) is exceedingly high. It is believed that if a person interested in midwifery does not have connections with people on the midwifery committee it is difficult to be accepted in the program. My opinion is that perhaps a program should be set up for RNs already working in L&D. They (we) would be able to make a more accurate judgment/assessment while in the community. I am very much interested in midwifery, but find it difficult to attend four years [of university] especially for an RN practicing in level II obstetrical unit.

One British trained nurse midwife wrote,

Midwifery certificates and degrees of other countries should be recognized. However, a shortened course should be offered, approximately six months, concentrating mostly on practical skills, emergency actions and introduction to Canadian rules and medical laws surrounding midwifery and health care. This should be compulsory prior to being able to practice in Canada, I feel it's an insult to expect competent experienced midwives to take a four year degree course.

The issue of midwifery education is touchy among maternity nurses and a block to the acceptance of midwifery. Nurses feel very frustrated in that despite the years of experience in the area they are not accepted to train as midwives in Ontario, and despite the fact that many of them (44% of the respondents) already are midwives albeit from other countries e.g. Scotland, England, Ireland and the Caribbean. Since not many of the maternity nurses could take four years off work to
train as midwives, they would like to see a shorter, part-time program set up for them. This generalized resentment and frustration may have produced a biased sample of nurses.

Other Concerns of Respondents

As already discussed, some nurses (38%) expressed fear of losing their jobs because of midwifery. They also expressed disapproval of high salaries that midwives will get. The salaries for midwives were initially suggested much closer to nursing salaries. It was "suggested that midwives should be salaried and paid about the same as nurses, which is about $25,000 to $35,000 per year, only a fraction of the average income of a family practitioner or an obstetrician" (Baker, 1989:14).

Nurse respondents were also concerned about responsibilities for patients. What is their actual role going to be with midwives' patients. They suggest that hospital bylaws should be changed to reflect this new change. "The system should be reorganized". It was also suggested that midwives should be employees of hospitals, not granted privileges as independent practitioners like doctors.

Only two of the comments approved of midwifery unconditionally, such as, "I look forward to working with midwives in our hospital", "Midwives with experience do a darn good job. Fewer incidences of perineal lacerations noted when an experienced midwife in attendance", and "I am happy that things are changing and midwives are conducting more cases". These really positive comments were only two.
The data under this heading were also subjected to Factor Analysis. The questions ([16] 'will nurses lose jobs', [19] 'university education appropriate', [20] midwife should be an RN', [21] 'foreign midwife status', [22] 'same pay for normal pregnancy care', and [27] 'use of midwives') were grouped together. The mean was 2.30; therefore the answers again placed in the 'neutral' area of somewhat positive and somewhat negative attitude toward midwives.

**SUMMARY**

Ninety-six nurses in ten Metro Toronto hospitals were surveyed, using a questionnaire consisting of 31 items. An attitudinal scale was developed from 14 Lickert type questions. Each answer was given a value from one to four. One and two were positive (agree) categories and three and four were negative (disagree) categories. The median value of the 88 responses was 32.5. This median was used as an index, so that values below 32.5 indicate 'a more positive attitude' and above 32.5 'a more negative attitude' toward midwives. When the main question (#31, that asked whether the respondents approved or objected to midwifery) was related to the attitudinal scale, the approval of midwifery among the respondents was not as great as it appeared initially. When other questions were examined in relation to the attitudinal scale, collectively 75/96 (78%) of the nurse respondents had a more positive attitude toward midwifery and 21/96 (22%) had a more negative attitude. A large majority of the answers clustered in the 'mild' categories, i.e. most of the nurses displayed mild rather than strong attitudes toward midwives. It is noteworthy
that in some very significant questions the majority of nurses displayed a negative attitude, eg. 80% of the nurses said midwives should be supervised by doctors, and 90% said midwives should be registered nurses. Furthermore, 25/56 (45%) nurses who approved of midwifery stated that they would not personally use midwives.

The large majority of the comments were negative, and corroborated the statistics last described. In their comments the nurses strongly advocated doctor supervision of midwives or at least that a physician should be nearby when a woman is delivering. They stated that a birth is uncomplicated only in retrospect. They emphasized many problems that can occur particularly in a home birth, stating that a proper system is not in place yet to deal with these problems.

Nurses felt very strongly about the need for midwives to be registered nurses. They also felt 'left out' of midwifery planning, stating that nurse midwives and labour/delivery room nurses could be trained to do midwifery with minimal training.

Although the nurses generally were not very negative toward midwifery, a significant number would not personally use midwives, i.e. 'it is appropriate for others but not for me'.

Of the nearly 150 comments made on the questionnaires only 2 were unconditionally positive toward midwives.
Chapter 7

ANALYSES OF THE SURVEY DATA OF THE DOCTORS

Doctors vs. Nurses on the Attitudinal Scale

The data from the doctor respondents (N = 58) were also related to the same attitudinal scale as the nurses' data. It will be demonstrated here that the results indicate considerable difference between the attitudes of nurses and doctors toward midwives. As was stated in chapter 6 the median score on the attitudinal scale for nurses was 32.500.

On examining the doctors' data apart from the nurses' data, the mean score was 37.483, the median was 37.500 and the standard deviation was 7.843. It is clear that there was considerable difference between the nurses' and the doctors' responses. The doctor respondents were more negative in their attitudes toward midwives than were the nurse respondents. A t-test showed significant difference, (P = < .05)\(^{10}\).

The doctors' results were also grouped on the attitudinal scale into four categories (each answer having been placed in one of the four categories). Category 1 indicated more positive attitude and category 2 meant somewhat positive attitude. Category 3 implied somewhat negative and category 4 more negative attitude.

---

\(^{10}\) t-test is a "statistical test used to determine if the means of two groups are significantly different, e.g. not due to chance" (Skodol-Wilson, 1989:730).
Obstetricians vs. Family Physicians on the Scale

A considerable difference was also noted between the obstetricians' (N = 28) responses and the family physicians' (N = 30) responses on the attitudinal scale (Table 26). No obstetricians were placed in category 1 (more positive attitude). There were eight (29%) in category 2 (somewhat positive), and the remaining 20 (71%) were in the negative categories.

Table 26. Difference in Attitudes of Obstetricians and Family Doctors

<table>
<thead>
<tr>
<th>Categories</th>
<th>+ 1</th>
<th>+ 2</th>
<th>- 3</th>
<th>- 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetricians</td>
<td>0</td>
<td>8</td>
<td>17</td>
<td>3</td>
<td>28 48%</td>
</tr>
<tr>
<td>Family doctors</td>
<td>1</td>
<td>16</td>
<td>12</td>
<td>1</td>
<td>30 52%</td>
</tr>
<tr>
<td>Column total</td>
<td>1</td>
<td>24</td>
<td>29</td>
<td>4</td>
<td>58 100%</td>
</tr>
</tbody>
</table>

+ 1 is more positive, + 2 is somewhat positive
- 3 is somewhat negative, - 4 is more negative

The family physicians appeared less negative toward midwives on the attitudinal scale. One was in more the positive category 1 (3%) and 16 (53%) in the somewhat positive category 2, the other 13 (44%) were in the negative categories.
UNCERTAINTY AND COMPETITION

There appears to be some uncertainty among the doctors whether midwives are needed, and whether they are going to compete for patients and therefore perhaps affect the doctors' incomes.

The majority of doctor respondents, 44/58 (76%), agreed that there is a shortage of maternity doctors, although one family doctor said there is only a shortage of family doctors who do obstetrics. He felt that there are enough obstetricians. Ten (17%) did not perceive the shortage to be a problem, 35/58 (60%) advocated more doctors to be recruited into obstetrics and only two (1 obstetrician and 1 family physician) suggested midwives to overcome the shortage (Table 27).

Table 27. Doctor Shortage Problem, How to Solve It?

<table>
<thead>
<tr>
<th></th>
<th>Obstetricians</th>
<th>Family MDs</th>
<th>Row total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No problem</td>
<td>4  14%</td>
<td>6  20%</td>
<td>10  17%</td>
</tr>
<tr>
<td>More doctors</td>
<td>15  54%</td>
<td>20  67%</td>
<td>35  60%</td>
</tr>
<tr>
<td>Midwives</td>
<td>1  4%</td>
<td>1  3%</td>
<td>2  3%</td>
</tr>
<tr>
<td>Other</td>
<td>8  29%</td>
<td>3  10%</td>
<td>11  19%</td>
</tr>
<tr>
<td>Column total</td>
<td>28  48%</td>
<td>30  52%</td>
<td>58  100%</td>
</tr>
</tbody>
</table>

Several of those respondents who would like to attract more doctors into obstetrics suggested that doctors should be paid more than they are. One obstetrician said "the fee for doing deliveries is between $500 and $800". This fee includes the
prenatal care, the delivery and post-partum care. He suggested an increase in the fee to make it more attractive to the doctors. Some doctors also mentioned the legal issues, i.e. "reduce the number and size of law suits." Doctors practicing in obstetrics are perhaps sued more often for malpractice than any other specialists.

Although 50/58 (86%) perceived there to be a demand for midwifery in society, only two doctors advocated midwives to solve the doctor shortage. Unlike the nurses, the doctors favoured doctors even for uncomplicated pregnancies, only four (7%) suggested midwives alone, and 53/58 (91%) suggested either physicians (12) or both midwives and physicians (41). Clearly then there is a certain amount of 'protecting one's own turf' feeling among the doctors.

When this question was cross tabulated with the attitudinal scale, of those respondents who advocated more doctors, 9/12 had negative attitudes toward midwives which is consistent with their (questionnaire) answers. Similar consistency was found with those who advocated both midwives and doctors (either/or), 19/41 had a positive attitude and 22/41 had a negative attitude toward midwives. One assumes that a majority of those 19 doctors with positive attitudes favoured midwives and the 22 respondents with negative attitudes advocated physicians. Of the four doctors who advocated midwives to solve the doctor shortage, only two had positive attitudes toward midwives (Table 28).
Table 28. Crosstabulation #5 and the Attitudinal Scale

(Who should attend normal deliveries?)

<table>
<thead>
<tr>
<th>Attitude</th>
<th>+ 1</th>
<th>+ 2</th>
<th>- 3</th>
<th>- 4</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>3</td>
<td>7</td>
<td>2</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>Midwife</td>
<td>2</td>
<td>2</td>
<td></td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Both</td>
<td>1</td>
<td>18</td>
<td>20</td>
<td>2</td>
<td>41</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Column</td>
<td>1</td>
<td>24</td>
<td>29</td>
<td>4</td>
<td>58</td>
</tr>
</tbody>
</table>

+ 1 is more positive, + 2 is somewhat positive
- 3 is somewhat negative, - 4 is more negative

Sharing Patients

The doctors predict slightly easier working relationship with midwives than do the nurses. Twenty one of fifty eight (36%) predict it will be easy to share patient care with midwives, 18 (31%) said it will be difficult, and three family doctors said it will be impossible (Table 29).
Table 29. What Will It Be Like to Share Patients?

<table>
<thead>
<tr>
<th></th>
<th>Obstetrician</th>
<th>Family doctor</th>
<th>Row total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy</td>
<td>11 39%</td>
<td>10 33%</td>
<td>21 36%</td>
</tr>
<tr>
<td>Difficult</td>
<td>10 36%</td>
<td>8 27%</td>
<td>18 31%</td>
</tr>
<tr>
<td>Impossible</td>
<td></td>
<td>3 10%</td>
<td>3 5%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>7 25%</td>
<td>9 30%</td>
<td>16 28%</td>
</tr>
<tr>
<td>Column Total</td>
<td>28 48%</td>
<td>30 52%</td>
<td>58 100%</td>
</tr>
</tbody>
</table>

Doctors obviously feel, more so than nurses, that they will remain 'in charge' even when midwives are in practice and they have more options in this area than nurses do. One doctor simply said "I won't do it" (share care), another said "I don't share care with them". Several doctors made comments such as "it will depend on the attitude of the midwives" and one obstetrician who had answered 'difficult' said "it would be 'easy' if midwives were nurses".

When this question was cross tabulated with the attitudinal scale, of those respondents who had answered 'easy' 12/21 (57%) had positive attitudes whereas 9/21 (43%) had negative attitudes toward midwives. These negative scores on the attitudinal scale, of course, were not consistent with their positive answers. Of those who predicted difficult or impossible working relationship with midwives 14/21 had negative attitudes and of the 16 who had no opinion on the issue, ten had negative attitudes toward midwives.
COOPERATION (2)

The question was posed 'Will you assist a midwife on request?' Of the obstetricians 24/28 (86%) answered 'yes'. The family doctors were somewhat more reluctant to assist; only 19/30 (63%) said 'yes'. Most of the comments were 'it depends' i.e. on how the assistance is requested, on what the situation is and on a midwife's "ability to work in a team for the betterment of patients and babies' outcome, NOT in an antagonistic manner as some do". Although the answers on the questionnaire showed willingness to assist, the comments reveal a certain amount of reservation, i.e. they will assist if the request is acceptable to them.

A somewhat similar dichotomy was seen in the question asking if the doctors would refer patients to midwives. More than one half of the doctors 33/58 (57%) said they would refer patients to midwives (Table 30).

Table 30. I Would Refer Patients to Midwives.

<table>
<thead>
<tr>
<th></th>
<th>Obstetricians</th>
<th>Family doctors</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>4 14%</td>
<td>5 17%</td>
<td>9 16%</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>12 43%</td>
<td>12 40%</td>
<td>24 41%</td>
</tr>
<tr>
<td>Mildly disagr.</td>
<td>6 22%</td>
<td>2 7%</td>
<td>8 14%</td>
</tr>
<tr>
<td>Str. disagree</td>
<td>4 14%</td>
<td>9 30%</td>
<td>13 22%</td>
</tr>
<tr>
<td>Don't know</td>
<td>2 7%</td>
<td>2 7%</td>
<td>4 7%</td>
</tr>
<tr>
<td>Column Total</td>
<td>28 48%</td>
<td>30 52%</td>
<td>58 100%</td>
</tr>
</tbody>
</table>
The comments again were not as 'supportive' as the questionnaire answers indicated. One family physician stated "I don't do referral work for other doctors either"; this counters the numerous comments by nurses who emphasized the cooperation, collaboration and consultation among health care workers. A few doctors said "I do all my own obstetrics" and there were again the 'it depends on' answers, e.g. midwife’s attitude, training, a particular situation, etc. One female physician said "I would hate to lose my patients".

CONSUMER DRIVEN versus MEDICAL OBSTETRICS

Doctor Supervision of Midwives

There was a considerable difference between the family physicians' and the obstetricians' opinions in the doctor supervision issue. More obstetricians, 18/28 (54%), agreed with supervision; only 9 (32%) disagreed. Of the family physicians 10/30 (33%) agreed and 19 (63%) disagreed (Table 31).
Table 31. Should Midwives Work Under Doctor Supervision?

<table>
<thead>
<tr>
<th></th>
<th>Obstetrician</th>
<th>Family doctor</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>12</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Mildly disagr.</td>
<td>3</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Str. disagree</td>
<td>6</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>Don't know</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Column Total</td>
<td>28</td>
<td>30</td>
<td>58</td>
</tr>
</tbody>
</table>

One family doctor's comment was: midwives should work "along with doctors, but the chief of obstetrics has the overall responsibility for the labour floor"; this could be interpreted that a doctor should be always involved since an obstetrician is ultimately responsible anyway. One obstetrician said "midwives should ask for help at the onset of complications and not when one is fully developed." As stated earlier this could expose midwives to criticism if they asked for advice early (when they suspect there could be a complication) that they do not know their job. However, if they do not ask for help and a complication does develop, midwives could be criticised for trying to be too independent and even of endangering women's lives. Another obstetrician's comment on doctor supervision was simply "I don't agree with midwifery". His answer on the questionnaire to doctor supervision was 'Strongly disagree', which if taken in isolation could be interpreted as favouring midwifery, i.e.
having confidence in their abilities to work independently. However, with the added comment, it is clear that he has quite negative view of midwifery.

**Midwives’ Autonomy**

Whether midwives should be autonomous or not, doctors were almost equally divided; 29/58 (50%) agreed and 28 (48%) disagreed. There was considerable difference between the obstetricians and the family physicians. Of the obstetricians 11/28 (39%) agreed and 16/28 (57%) disagreed, whereas 18/30 (60%) of the family doctors agreed and 12/30 (40%) disagreed with midwives’ independence (Table 32).

**Table 32. Should Midwives Be Independent Professionals?**

<table>
<thead>
<tr>
<th></th>
<th>Obstetrician</th>
<th>Family doctor</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>6 21%</td>
<td>8 27%</td>
<td>14 24%</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>5 18%</td>
<td>10 33%</td>
<td>15 26%</td>
</tr>
<tr>
<td>Mildly disagr.</td>
<td>3 11%</td>
<td>4 13%</td>
<td>7 12%</td>
</tr>
<tr>
<td>Str. disagree</td>
<td>13 46%</td>
<td>8 27%</td>
<td>21 36%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1 4%</td>
<td></td>
<td>1 2%</td>
</tr>
<tr>
<td>Column Total</td>
<td>28 48%</td>
<td>30 52%</td>
<td>58 100%</td>
</tr>
</tbody>
</table>
From the comments emerges an attitude that many of those who agreed did so because they do not want to share the care with midwives. Those who disagreed did so for paternalistic reasons that midwives are not able to function independently. However, one obstetrician's comment was simply "I don't care".

**Birthing at Home**

Home births are a very contentious issue among the doctors. A large majority, 47/58 (81%), felt that home births are not acceptable; the obstetricians objected more strongly to home births than family physicians (89% and 73% respectively) (Table 33), and they all (100%) stated they would not assist in home births.

**Table 33. Home Births Are Acceptable.**

<table>
<thead>
<tr>
<th></th>
<th>Obstetrician</th>
<th>Family doctor</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>28 48%</td>
<td>30 52%</td>
<td>58 100%</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>21 75%</td>
<td>18 60%</td>
<td>39 67%</td>
</tr>
<tr>
<td>Mildly disagr.</td>
<td>4 14%</td>
<td>4 13%</td>
<td>8 14%</td>
</tr>
<tr>
<td>Str. disagree</td>
<td>1 4%</td>
<td>2 7%</td>
<td>3 5%</td>
</tr>
<tr>
<td>Don't know</td>
<td>1 3%</td>
<td>7 12%</td>
<td>1 2%</td>
</tr>
<tr>
<td>Column Total</td>
<td>28 48%</td>
<td>30 52%</td>
<td>58 100%</td>
</tr>
</tbody>
</table>
Of the nurse respondents only 36% objected to home births. Doctors seem to fear complications with each and every birth. This fear is not necessarily shared by physicians, especially family doctors, in other countries. A British professor Wendy Savage writes:

By virtue of their training and experience obstetricians see labour as an episode of great danger and unpredictability, and they take the view that 'no pregnancy is normal except in retrospect'. Midwives and general practitioners experienced in birth at home see things differently. As they deal with healthy pregnant women and largely with normality, their view is that 'birth is a normal process unless something goes wrong' (Savage 1996:356).

It is rather curious that a vast majority of births in the world probably do not take place in hospitals; nevertheless, most North Americans are convinced that the only safe place to give birth is in the hospital.

**Do Midwives Give More Holistic Care?**

Approximately one half (30/58) of the doctors (54% of the obstetricians and 50% of the family physicians) agreed that midwives give more holistic care. 23/58 disagreed and 5 had no opinion (Table 34).
Table 34. Midwives Give More Holistic Care.

<table>
<thead>
<tr>
<th></th>
<th>Obstetrician</th>
<th>Family doctor</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>5 18%</td>
<td>8 27%</td>
<td>13 22%</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>10 36%</td>
<td>7 23%</td>
<td>17 29%</td>
</tr>
<tr>
<td>Mildly disagr.</td>
<td>5 18%</td>
<td>6 20%</td>
<td>11 19%</td>
</tr>
<tr>
<td>Str. disagree</td>
<td>5 18%</td>
<td>7 23%</td>
<td>12 21%</td>
</tr>
<tr>
<td>Don't know</td>
<td>3 10%</td>
<td>2 7%</td>
<td>5 9%</td>
</tr>
<tr>
<td>Column Total</td>
<td>28 48%</td>
<td>30 52%</td>
<td>58 100%</td>
</tr>
</tbody>
</table>

One family doctor who strongly disagreed stated "Yes, they do claim that but family medicine is very holistic". Some other family doctors' comments were: "The difference in approach and intervention vary with which midwife and which doctor one is in company" and "They may claim that - it is certainly not always there". Another family physician wrote: "This claim has angered me because many family doctors also care about these issues and provide this type of care". Judging from this comment this doctor does not agree that midwives give more holistic care than other health care workers do, quite the contrary. Yet, this doctor had marked the answer 'strongly agree' on the questionnaire, but most likely meant to answer 'strongly disagree'. One female family physician wrote

I have felt 'caught' in the middle as a family doctor who (I hope) provides compassionate client centred, low intervention care because midwives have used [sic] themselves as the alternative to medicine (i.e. traditional obstetrics). Where do I fit in? The politics of this have been distressing personally.
Another rather angry family doctor wrote:

I fully support low intervention birthing but feel that back up services for those last minute complications i.e. PPH [post partum hemorrhage], shoulder dystocia, flat neonate, etc. should be on site. Thus I cannot condone planned home births. Birthing centres (free standing) seem wasteful since low intervention protocols could be devised and mandated in existing units which would address both low tech. and safety concerns. I am insulted as a family doctor who provides broad based and comprehensive care that I receive less compensation than a midwife... The government hopes that thousands of women will deliver without epidurals. This is insulting and shows lack of concern about the reality of pain intensity in labour. I await in sadness the inevitable results of home births that experience major complications.

There were many other comments with similar opinions. Some doctors who did not make comments made their opinion more emphasized by underlining their 'strongly disagree' answers heavily.

Medical Interventions in Obstetrics

As expected the obstetricians disagreed that women having babies are subjected to too many medical interventions. None strongly agreed but 7/28 (25%) did agree mildly. 19/28 (69%) disagreed. The percentages were reversed with the family doctors, 20/30 (67%) agreed and 10/30 (33%) disagreed (Table 35).
Table 35. Mothers Have too Many Medical Interventions

<table>
<thead>
<tr>
<th></th>
<th>Obstetrician</th>
<th>Family doctor</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td></td>
<td>4</td>
<td>13%</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>7</td>
<td>16</td>
<td>53%</td>
</tr>
<tr>
<td>Mildly disagr.</td>
<td>8</td>
<td>3</td>
<td>10%</td>
</tr>
<tr>
<td>Str. disagree</td>
<td>11</td>
<td>7</td>
<td>23%</td>
</tr>
<tr>
<td>Don't know</td>
<td>2</td>
<td>7</td>
<td>23%</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td>28</td>
<td>30</td>
<td>52%</td>
</tr>
</tbody>
</table>

The obstetricians perform most of the major interventions such as cesarean sections; therefore it is understandable that they would say that women do not have too many medical interventions. Family doctors were quite adamant in their comments that they intervene much less or resort less to surgical procedures than do the obstetricians. Several family doctors referred to "excellent research" that has been done in this area "showing lower interventions by family doctors". Perhaps the 67% of the family doctors were thinking of obstetricians when they agreed that maternity patients have too many medical interventions. Judging from their comments they do not admit to performing these interventions.

Questions about: home births (#9), doctor supervision of midwives (#13), Midwives' independence (#14), Medical interventions (#16), Holistic care (#19) were subjected to factor analysis. The alpha was .67. (See a footnote page 3 in
Chapter 6.) The mean was 2.7568 which indicates a somewhat negative attitude of doctors toward midwives.

One wonders how different the statistics would be if the questionnaire answers were more congruous with the comments.

REJECTION AND ACCEPTANCE

Education of Midwives (2)

As with the nurse respondents, it is clear that the education of midwives is one of the deciding factors in accepting or not accepting midwifery by the doctor respondents. Unlike nurses all the doctors of course are university educated; therefore it is easy to understand that most doctors advocated university education for midwives. A fairly large majority, 40/58 (69%), agreed on university education, 7/58 disagreed and 11/58 (19%) had no opinion (Table 36).

Table 36. Is the 4 Year University Program Appropriate?

<table>
<thead>
<tr>
<th></th>
<th>Obstetrician</th>
<th>Family doctor</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>15  54%</td>
<td>12  40%</td>
<td>27  47%</td>
</tr>
<tr>
<td>Mildly Agree</td>
<td>5  18%</td>
<td>8  27%</td>
<td>13  22%</td>
</tr>
<tr>
<td>Mildly disagr.</td>
<td>1  4%</td>
<td>1  3%</td>
<td>2  3%</td>
</tr>
<tr>
<td>Str. disagree</td>
<td>3  11%</td>
<td>2  7%</td>
<td>5  9%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4  14%</td>
<td>7  23%</td>
<td>11  19%</td>
</tr>
<tr>
<td>Column Total</td>
<td>28  48%</td>
<td>30  52%</td>
<td>58 100%</td>
</tr>
</tbody>
</table>
However, although some of the respondents agreed with university education on the questionnaire they added internship conditions that will not be fulfilled. Many who agreed added provisions such as "If it has a good internship", "with 2-3 years in hospital supervised", "Midwives should work first supervised at the hospital like a residency programme for doctors, i.e. 3-4 years". (The midwives take a four year course at a university with some practical experience. However, the practicum part is not as extensive as the internship/residency for the doctors.)

There were some comments that confirmed that not all doctors agreed with the university education. One stated "Not for what our government is planning -- independent practitioners". One obstetrician simply stated "I don't trust direct entry, but time will tell. Big mistake!"

Nurse Midwives?

The question statement was: A midwife should also be a registered nurse. Forty one (71%) doctors agreed, 7/58 (12%) mildly disagreed and only one obstetrician strongly disagreed; 9/58 (16%) had no opinion (Table 37).
Table 37. Midwives Should Be Nurses.

<table>
<thead>
<tr>
<th></th>
<th>Obstetrician</th>
<th>Family Doctor</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>12 43%</td>
<td>11 37%</td>
<td>23 40%</td>
</tr>
<tr>
<td>Mildly agree</td>
<td>9  32%</td>
<td>9  30%</td>
<td>18 31%</td>
</tr>
<tr>
<td>Mildly disagr.</td>
<td>3  11%</td>
<td>4  13%</td>
<td>7  12%</td>
</tr>
<tr>
<td>Str. disagree</td>
<td>1  3%</td>
<td></td>
<td>1  2%</td>
</tr>
<tr>
<td>Don't know</td>
<td>3  11%</td>
<td>6  20%</td>
<td>9  15%</td>
</tr>
<tr>
<td>Column Total</td>
<td>28 48%</td>
<td>30 52%</td>
<td>58 100%</td>
</tr>
</tbody>
</table>

More nurses agreed (91%) that midwives should be nurses also and many of the doctors who wrote comments were sympathetic with the nurses' viewpoint, writing e.g. "Nurses in the L&D [Labour and Delivery] should be trained to do deliveries", "The midwives trained through the Great Britain system where they are nurses first and then midwives second are the best trained". Many comments were complimentary to the British trained midwives, praising their abilities, wishing that the same nurse midwife route had been adopted in Ontario. One obstetrician said "midwives should be graduate nurses or equivalent. Midwives should get away from the idea that there is an adversary aspect in health care of patients versus family doctor or obstetrician/gynecologist".

It is clear that some doctors believe they can get along with nurses better than with midwives, perhaps because there has been a perception of nurses being handmaidens to doctors. There is no similar perception of midwives since they are 'new' in Canada.
Foreign Trained Midwives

The doctors were very 'impressed' by the abilities of foreign midwives, particularly by the British trained midwives. However, when asked if the foreign trained midwives should be allowed to practice here without further training, only 6/58 (10%) agreed and 48/58 (83%) disagreed and four had no opinion. One family doctor who 'strongly agreed' added "certainly those I know are more competent in many areas and have far more extensive training and experience than those here now". One wonders how he can compare the Ontario trained midwives to the British trained ones since at the time of his writing the first class of Ontario midwives had not graduated yet.

Implications to Health Care Costs

Should the midwives be paid the same as the doctors for uncomplicated maternity cases? Many doctors seemed to think that midwives get more money for maternity care than doctors do. The comments reflected this. Some family doctors added comments such as "not the higher fees they get now" and "less than they make now, obstetrics is NOT done for money by doctors" and "I am upset that you [sic] are able to spend so much time at prenatal visits. I often spend 30 minutes and am paid $18.50". All of the above respondents had 'agreed' the midwives should be paid the same as the doctors. It is clear they all feel that midwives are paid too much and would like to see equalization of fees.
Other comments included "only if they work as hard and have the same expenses, which they don't" and another family doctor who strongly 'disagreed' added "as a doctor is trained longer and in all aspects of medicine". An obstetrician who also 'disagreed' said "she has 1/3 of schooling but higher salary". He thinks that midwives make higher salaries than obstetricians and thinks they should make less.

Are the Midwives' Wages Appropriate or not?

Not one doctor said the wages are too low. Approximately one half (52%) thought the wages are too high, 31% thought they are appropriate and a fairly large number 10/58 (17%) had no opinion (Table 38).

Table 38. Are the Wages of Midwives' Appropriate?

<table>
<thead>
<tr>
<th></th>
<th>Obstetrician</th>
<th>Family Doctor</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too High</td>
<td>14 (50%)</td>
<td>16 (54%)</td>
<td>30 (52%)</td>
</tr>
<tr>
<td>Appropriate</td>
<td>11 (39%)</td>
<td>7 (23%)</td>
<td>18 (31%)</td>
</tr>
<tr>
<td>Too Low</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Don't know</td>
<td>3 (11%)</td>
<td>7 (23%)</td>
<td>10 (17%)</td>
</tr>
<tr>
<td>Column Total</td>
<td>28 (48%)</td>
<td>30 (52%)</td>
<td>58 (100%)</td>
</tr>
</tbody>
</table>

On this question there was a difference between the family doctors and the obstetricians. Of the obstetricians 39% said the wages are appropriate but only 23% of the family doctors said the wages are appropriate and 23% of them answered
'don't know'. It appears that the family physicians are more concerned about midwives' wages since their fees are perhaps closer to the midwives' wages than those of the obstetricians. There is also a concern about the comparative work load. The comments reflect this. One who said the wages are 'too high' added "for the number of deliveries they do", another stated "very complicated [issue]. It depends on work load. In my experience the midwives are making a higher hourly wage than family doctors", and one family doctor said "even the specialist does not get that, it is stupidity on the cost savings by the Ministry of Health".

Several obstetricians also commented on high salaries and comparatively low number of deliveries that midwives are allowed to do per annum.

**Health Care Costs**

A considerable difference between the opinions of nurses and doctors was found in the area of health care costs. More than one third of the nurses felt that midwives will reduce health care costs. Not one doctor felt that the costs will be reduced by midwives. Three quarters (75%) of the obstetricians and 60% of the family physicians believed that health care costs will increase as a consequence of midwives in the system (Table 39).
Table 39. How Will Midwives Affect Health Care Costs?

<table>
<thead>
<tr>
<th></th>
<th>Obstetrician</th>
<th>Family Doctor</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase them</td>
<td>21 (75%)</td>
<td>18 (60%)</td>
<td>39 (67%)</td>
</tr>
<tr>
<td>No Effect</td>
<td>5 (18%)</td>
<td>6 (20%)</td>
<td>11 (19%)</td>
</tr>
<tr>
<td>Decrease them</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Don't know</td>
<td>2 (7%)</td>
<td>6 (20%)</td>
<td>8 (14%)</td>
</tr>
<tr>
<td>Column Total</td>
<td>28 (48%)</td>
<td>30 (52%)</td>
<td>58 (100%)</td>
</tr>
</tbody>
</table>

The cross tabulation of this question with the attitudinal scale showed that the respondents who predicted higher health care costs (as a result of midwifery) had more negative attitude toward midwives.

One family physician who answered 'no effect' commented "for now, we need further research", another stated "the cost per patient is higher [with midwives]", and another said "I am not convinced that their practice is significantly more cost effective than a family doctor practicing low risk patient centred care". An obstetrician who predicted increasing costs added "possibly due to small case load". Another obstetrician seemed quite angry about the salary issue and wrote,

Top salary for a midwife is $77,000 for a case load of 40 per year. Some midwives will be working in pairs, this means salary of $154,000 for managing 80 pregnancies. An obstetrician on a fee for service basis is paid less than $40,000 for the same case load. In areas where midwives have hospital privileges they are doing more and more cases in hospital with an average length of stay being equal to or longer than doctors' [patients]. These two observations lead me to believe:
1) The introduction of midwifery will certainly not decrease health care costs,

2) There is not enough money available to pay enough midwives to have any effect on the shortage of professionals attending deliveries.

It was particularly in the areas of salaries and costs that the negative attitudes of the doctors toward midwives were apparent. No physician felt that midwives' salaries are too low, and not one of them said that midwives would decrease health care costs. Although 51% of the doctor respondents agreed that midwives should be paid the same as doctors for normal maternity care, many qualified their answers and suggested that midwives' work load is not as much as that of the doctors'. Only when the midwives work as hard as the doctors do should they be paid the same. Nevertheless, when the physicians were asked if they fear loss of income because of midwives, 60% felt confident this will not happen. Some commented that the small number of midwives 'out there now' will not have an effect on the doctors' incomes.

Would the Doctors Use (or Recommend) Midwives for

Themselves or Families?

There were 19 female doctors who answered the questionnaire (5 obstetricians and 14 family physicians). It was quite clear that the majority of the
female doctors would not use midwives' services, only five (26%) agreed and 14 (74%) disagreed that they would use the midwifery services (Figure 3).

There were 39 male doctor respondents. They seemed reluctant to recommend midwives to their family members. 9/39 (23%) agreed they would recommend midwives and 27/39 (69%) disagreed. Five respondents had no opinion (Figure 4). In both gender groups, the obstetricians were more reluctant to use or recommend midwives than were the family doctors; however, the cells are too small to draw definitive conclusions.

Approval or Non-Approval of Midwifery

Whereas only nine per cent of the nurse respondents objected to midwifery, 71% of all the doctor respondents objected. Very small variation was found in the answers by the obstetricians and the family physicians to the question about approval of or objection to (Table 40).

Table 40. Do You Approve of or Object to Midwifery?

<table>
<thead>
<tr>
<th></th>
<th>Obstetrician</th>
<th>Family Doctor</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly appr.</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>MILDLY appr.</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>MILDLY DISAPPR.</td>
<td>12</td>
<td>11</td>
<td>23</td>
</tr>
<tr>
<td>STR. DISAPPR.</td>
<td>9</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>Don't know</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Column Total</td>
<td>28</td>
<td>30</td>
<td>58</td>
</tr>
</tbody>
</table>
Figure 3. I Would Use MW's Services
Female Doctors (N=19)

MW = Midwife
Str.Agr. = Strongly Agree
M.Agr. = Mildly Agree
M.Disag. = Mildly Disagree
Str.Disag. = Strongly Disagree
Figure 4. I'd Recommend MW's Services
Male Doctors (N=39)

MW = Midwife
Str.Agr. = Strongly Agree
M.Agr. = Mildly Agree
M.Disag. = Mildly Disagree
Str.Disag. = Strongly Disagree
NOTE TO USERS

Page(s) missing in number only; text follows. Microfilmed as received.

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UMI
The main question about approval/disapproval of midwifery was cross-tabulated with the question about predicted health care costs. Of the respondents who predicted increased health care costs 24/39 (67%) objected to midwifery which is consistent with their answers to both questions. However, because it appeared to be the financial issues that caused doctors most concern about midwifery it is rather surprising that 10/11 respondents who objected to midwifery predicted that midwives will have no effect on health care costs.

The main question was also cross-tabulated with the question whether the respondents had worked with midwives and it was found that a significant number of doctors who had worked with midwives, 31/42 (74%) objected to midwifery and only 26% of them approved. Of those 13 doctors who had not worked with midwives 10/13 (77%) objected to and 3 approved of midwifery.

There was also a significant gender difference whether the doctor respondents approved or objected to midwifery. Of the 166 male respondents 32/39 (82%) objected to midwifery and 7/39 (22%) approved but 9/19 (47%) of the female respondents objected, 7/19 (37%) approved and 3 had no opinion. Perhaps female physicians are not so readily socialized as male physicians into the professional perspective that they must take over all human biology, particularly in the instance of child birth which is by nature exclusively female.

Comments added to the main question again tended to be negative. For example, one obstetrician wrote "I strongly approve of midwifery because;
a) doctors' opposition will generate an opposite effect.
b) there is a place for midwifery
c) it will prove costly
d) if it proves to be of doubtful benefit it will self-eliminate itself".

He was one of the few doctors who filled out the questionnaire while I waited. His 'approval' was very sarcastically stated.

Another obstetrician stated, "Midwifery legislation should recognize the following;
a) a pregnant woman could choose between a doctor or a midwife but not both, otherwise the health care costs will hit the roof.
b) a pregnancy and delivery are only normal/uncomplicated after childbirth.
c) Conjoint medico-legal responsibility for patient care will be a nightmare.
d) Shared care by midwives and obstetricians poses horrendous medico-legal problems that will discourage obstetricians' participation in shared care with midwives."

A family physician wrote,

There are a lot of young physicians wanting to do family medicine and family centred obstetrical care. Rather than nurturing this group, we have started yet another group. This group is being overpaid and babied really. I wish I could make $55000 and do as little work and be as minimally trained. Maternal and fetal care was medicalized and institutionalized to bring down death and morbidity rates.
A family doctor who had supported midwifery but who also had reservations, stated, "I have supported midwifery in general since 1984 and have worked to smooth the integration. My objections are:
a) Failure to use experienced nurse midwives already in the system.
b) Unexpected emphasis on home delivery.
c) Excessive pay package in addition to paid malpractice insurance and paid office.
d) Family practice obstetricians not being recognized for championing changes."

This respondent's comments seem to summarize all the areas of the doctors' comments. Of the family physicians 23/30 (77%) wrote comments and of the obstetricians 21/28 (75%) did so. Very nearly all of the comments were unfavourable toward midwifery the way it is now set up in Ontario, e.g. midwives are not nurses, they will promote [unsafe] home deliveries and their salaries are too high.

SUMMARY

The attitudinal scale showed more negative attitudes of doctors than of nurses toward midwives. There was also a considerable difference in the opinions of the obstetricians and the family physicians, the former objecting more than the latter. 'Home birth' was a very controversial issue among the doctors. Only 8/58 agreed with the acceptability of home births and all 58 said they would not assist in a home birth.

Considerable objections to midwifery came in the area of finances. The respondents felt that midwives are too highly paid and health care costs will increase
as a consequence of midwifery being part of our health care. The majority of the doctors would not use or recommend midwifery services to their families.

As with the nurses, the comments by the doctors were much more negative than the answers to the questionnaires would indicate. Respondents who chose a positive answer on the questionnaire often quite incongruously added a very negative comment on the same topic. Although the doctors answers were more negative than those of the nurses, the majority of the doctors answers, like the nurses', were clustered in the 'mildly' approve/disapprove areas.

It was rather significant that there were no detectable differences between the answers by the doctors from the teaching hospitals and the doctors from the peripheral hospitals nor were there overall differences between the doctors from the hospitals that were in the process of setting up midwifery units, and from the hospitals that had no plans to have midwives.
As a nurse educator I have worked in many Metro Toronto area hospitals, especially in obstetrical units. In the late 1980s I began to hear many discussions among the staff about the issue of legalization of midwifery which was attracting public attention. Those nurses who were nurse midwives from other countries wondered about their chances of upgrading to become certified if midwifery was legalized. Some were concerned about home births in which they had not assisted in a long time. When it became clear that the refresher course for nurse midwives would be limited to a small number and it was going to be offered only once, there was considerable anger expressed by many nurse midwives. Many of the doctors, on the other hand, tended to dismiss the midwifery issue as 'a non issue'. They were fairly confident that midwifery would not succeed "now any more than it had in the past"; i.e. they would continue to hold power over child birth firmly in their hands.

Through time immemorial, women and only women have attended child birth in all parts of the world. In Canada the native population had midwives before the Europeans came. The pioneers had no obstetricians to deliver their babies so there usually was a neighbour woman who assisted with a birth but at times women had to do it all by themselves. Medical doctors began gradually to take over baby deliveries in the 18th century. If a neighbour did help, even in the absence of a
doctor, she feared she might be reported to the 'authorities' for practicing medicine without a licence (Task Force Report, 1987). Canada had the distinction of being the only developed country in the world not having legalized midwifery until a few years ago.

Women in Ontario lobbied hard to get midwifery legalized. They had to overcome many obstacles and objections. Finally their tenacity paid off and midwifery was legalized in Ontario in 1991. Ontario was the first province in Canada to do so. Now five years later a small group (18) of Ontario educated midwives have graduated. There are also approximately 70 midwives who had trained elsewhere and upgraded their education in 1991 to meet the standards of Ontario. They are now practicing in different parts of the province.

Having midwives practicing, however, does not guarantee their complete acceptance by the other health care workers. This survey demonstrates that nurses and doctors have many reservations about midwifery.

My interest in studying the attitudes of doctors and nurses toward midwives arose from a suspicion that: a) the resurgence of midwifery would be seen as an attack on the power base of the doctors, b) male dominance is so pervasive that even female doctors would probably be anti-midwifery because in order to 'fit in' the system they (the female doctors) must adopt the patriarchal perspective.

I furthermore suspected that nurses would not disapprove of midwifery as strongly as doctors or might be ambivalent. They have been socialized into the system where the doctors have the power and therefore tend to accept their inequality in the health care system as the norm, but as women at the lower end of
the health care hierarchy, they would intuitively support the creation of an autonomous 'female' profession and would intuitively support midwifery because midwifery means returning to a very basic female role, i.e. women attending women in child birth.

Many issues arose from the study of the literature, such as holistic vs. reductionistic philosophies, pregnancy and birth as disease, medical interventions in child birth, physicians taking control over the care of pregnancy and child birth, education and autonomy of midwives. However, there were only two studies done in Canada on attitudes of doctors and nurses toward midwives prior to my study.

Theoretical Perspective

Power differences and dominance of one part of society over another are central issues studied by conflict theorists. Patriarchy means male dominance over females. Canada has been a patriarchal society, e.g. women did not receive the right to vote until after the First World War and not until later did they achieve the status of 'persons'. However, in the last few decades, 'the feminist consciousness' has awakened and women have fought - with some success - for greater equality.

Having been part of the health care system in Ontario for the last three decades, it has become clear to me that the health care system in Canada is a patriarchal system, particularly in the area of maternity care, i.e. the doctors (mostly male) have had the power over their patients (all female) and nurses (in maternity care all are female). This is particularly remarkable when we see that in other patriarchal
societies throughout history childbirth has, nevertheless, remained the women's domain. In our society, this power difference has been so dominant that up until just a few years ago women had totally lost control of the child birth process.

Most sociologists "today look at inequality from a conflict perspective" (Spencer, 1990:217). Inequality refers to power differences among different sections of society. "Power is structured or institutionalized when it becomes a regular and recurring part of everyday human existence, usually because it is established in formal laws or in accepted conventions and customs" (Teevan, 1989:134). There is economic power, political power and ideological power. The latter "comes from control over the ideas, beliefs, knowledge, or information that guide social action" (ibid.). Whether we see it as a legal or conventional issue doctors do have a lot of power within the health care system and they have had it since the 18th century in North American society. They are the ones who give orders and other health care workers follow those orders.

Traditionally since Florence Nightingale's times nurses have accepted the subservient role in medicine since doctors are better educated, assertive and usually male (some female doctors behave in the same manner as their male counter parts 'to fit in the profession'). These roles have never been reversed. Those who have power do not give it up freely. Now that midwives are part of the health care system maternity doctors see their power being eroded somewhat, and hence object to midwifery.

As I have repeatedly stated nurses do not have much power in the work place. This of course has been well demonstrated recently with the massive layoffs,
despite the union's (ONA) objections. The majority of nurses are women, whereas
the majority of doctors are men. "Substantial occupational segregation remains the
norm ... females continue to dominate occupations that are extensions of their
traditional roles ... earn considerably less than males when their work is for pay"
(Hagedorn, 1990:247). A recent study conducted at Carlton University supports the
issue of inequality. Men often fail to recognize that there is inequality. Male
executives seem quite convinced that inequalities in the workplace have disappeared
(Duxbury, 1996). The Carlton study found among other issues that "Women are still
under-represented at the top of organizations [and where they have succeeded it is
attributed to legislation, not ability] ... and ... Gender bias exists in pay, promotions
and hiring" (ibid.). Nurses and doctors are typical examples of those who have little
power and those who have more.

It appears that midwives will fit somewhere between nurses and doctors
in the health care power structure. Normally midwives do not take orders from
doctors but if there is a complication with a client, a midwife will then transfer the
care to a doctor who 'comes to rescue'. Nurses, on the other hand, fear that
midwives also will give them orders at times. This nurses are likely to resent, as
shown in this survey.

Qualitative Data

During the initial interviews carried out among those individuals who had
been part of the midwifery planning process, it was clear that the Ontario Medical
Association members had reservations and negative opinions about midwifery. According to Mr. Krauser at OMA (Ontario Medical Association) there was initially anger among doctors about midwifery, because doctors felt that they had improved maternity care very much in Ontario but their work was not recognized. When the Ontario doctors realized it was inevitable that midwives were to be part of the health care system, they were disappointed but they hoped they would have some influence in the education of midwives. Doctors objected to licensing lay midwives. They wanted midwives to be nurses with university education.

The ONA (Ontario Nurses' Association - Union) also had reservations about midwives. Their main objection was that the future midwives will not be nurses. ONA's concern is the job maintenance for nurses, i.e. if the midwives are nurses the jobs for nurse midwives in maternity would be more secure.

The College of Nurses presented a very neutral attitude toward midwives, emphasizing cooperation rather than confrontation. The College of Nurses is essentially a licensing and regulating body; therefore they abstain from passing judgment on other professions.

Karyn Kaufman, who is a nurse midwife and was very much involved in planning midwifery in Ontario, approves of midwifery. However, she stated that she had no strong feelings initially 'one way or the other' about midwives being nurses.

Margaret McHugh interviewed at the Ontario Ministry of Health was very 'pro midwifery'. She stated that the objection to midwifery by the other health care workers was due to "kind of fear of the unknown".
Quantitative Data, Problems Encountered

Initially the quantitative part of the study was a fairly positive experience. Most nurses and doctors were willing to answer the questionnaires. However, problems arose when two of the targeted hospitals refused permission to survey their nursing staff. In one hospital the reason given was that this issue of midwifery was too 'touchy' right now for their nurses to address (in this hospital the ethical review board was chaired by a male pharmacist). In the other hospital I had approached the chief of obstetrics (as I had done in all other target hospitals) and asked (through his secretary) if I might pass my questionnaire to the medical staff. Permission was given and I carried out my survey. However, later, in order for the nurses to answer the questionnaires, the hospital ethical review board had to approve the study. The same doctor was on the board, and voted against approval on the grounds that it was too biased. In these two instances it appeared likely that patriarchal attitudes dictated the decisions, i.e. male authority prevented me from approaching my female colleagues with my questionnaire, but did not prevent physicians in the same institutions from completing the questionnaires. One might conclude that the nursing staff (being female) was not deemed capable of giving their opinions and were 'protected' like minors from 'biased' perspectives.
Analyses of the Questionnaire Data

The initial computer analysis of the questionnaire data revealed a mildly positive attitude of nurses toward midwives. However, when the answers were placed on an attitudinal scale, the attitudes appeared negative. The scale showed high internal reliability as measured by Cronbach's Alpha of .80. The scores on the attitudinal scale more closely matched the comments added by the nurse respondents in the margins of the questionnaires, which were predominantly negative.

On the questionnaires the majority of nurse respondents answered that they will have no problem carrying out midwives' orders; however, in their comments they showed an entirely different attitude. They were quite clear in their comments that they would resent taking orders from midwives. Why the discrepancies occurred is difficult to explain. One can speculate on the reasons. "Opinion questions are especially difficult. The respondent often does not have an opinion because he or she has never thought about the topic" (Bailey, 1987:115). This could be a reason in some cases, i.e. the respondents just filled out the answers without putting much thought to their answers. Another possible reason is that
	since the respondent often has little to gain from answering the questionnaire (other than the social approval of aiding science), he or she often feels that there is more to lose by revealing anormative behaviour. Thus he or she will feel under great pressure not to admit to proscribed behaviour (ibid.)...
In this case the 'anormative behaviour' is disapproval of midwives. The respondents will give "answers that are consistent with a norm even though they are false answers for the particular respondent" (ibid.). That is, if the respondent feels it is (perhaps morally) wrong to disapprove of midwifery then her "tendency to agree with statements that are socially desirable or supported by norms" (ibid.:133). This social desirability bias may explain the fact that in the survey the questionnaire answers were not as critical of midwifery as were the written comments. It could also reflect a difference between approval in principal and in complex situations in practice.

A particularly striking discrepancy was that of nurse respondents who approved of midwifery, but would not use midwives themselves. But this is also a well recognized phenomenon in social research.

The nature of attitudes, their relationships and their relationship to behavior are all complex factors; this complexity, in turn, underlies one of the more perplexing problems in social psychology - the apparent disparity between attitudes and overt behavior, which has been identified by a number of researchers... one of the components of attitudes is behavioral: an attitude means that an individual has a predisposition to act in some way. Yet studies of attitudes and behavior have rather consistently concluded that the former are poor predictors of the latter (Lauer & Handel, 1983:92-93).

Finally, a possible factor in the negative attitudes of nurses and doctors toward midwives could be ethnic or racial bias. However, in this study no attempt was directed toward analyzing the ethnic background of the respondents.
Both groups of respondents had discrepancies between their answers to the questionnaires and their comments, but the nurses' answers to the questionnaires tended to differ more from the comments they made than did the doctors'.

The findings generally affirm the hypothesis of this survey especially if we emphasize the written word more than ticks on the questionnaires.

The answers on the questionnaires by the doctor respondents were more negative than those of the nurses and when placed on the same attitudinal scale they appeared to be even more negative. Comments by the doctors were even more negative than those by the nurses.

The doctors objected to midwifery most strongly in regard to financial matters. Many of them felt that midwives are being paid too much for the amount of work they do. The present day crisis in the Ontario health care system reveals the discontent of the doctors, particularly of the obstetricians.

The Current Crisis in Funding of Physicians' Services

Many of the area obstetricians have stopped taking new patients. The reason given, most often, is inadequate remuneration, in various forms, i.e. clawbacks, ceilings and withdrawal of government assistance with the high premiums for malpractice insurance. In 1993 "the former New Democratic government [Ontario] imposed a clawback on all physicians' incomes" (Gray, 1996:751), and in July 1996 the present Conservative government increased the clawback for all doctors in Ontario to 10% retroactive to April.

The ceiling (the most OHIP will pay) for obstetricians was reduced to $375,000.00. If an obstetrician makes over that amount the government takes a portion of it back. The ceilings were announced in July and they too are retroactive to April.

The government used to reimburse a large part of obstetricians' malpractice insurance premiums. In 1995 the premiums for obstetricians were set at $18,396.00, and of this amount the government reimbursed the obstetricians $13,496.00. The amount an obstetrician actually paid was $7,900.00 annually. Then in the summer of 1996 the government announced that it would no longer assist obstetricians while at the same time the premiums were increased to $23,340.00.

With the clawbacks and withholding of premium assistance the OMA protested loudly, but no one was more enraged than the obstetricians, who felt they had taken a disproportionate hit. The fee for a delivery had now dropped, in effect, to close to $200.00. In the mean time, the provincial government had licensed midwives, who were encroaching on obstetricians' traditional territory and
leaving the specialists only the most complicated, high-risk and time-consuming deliveries (Gray, 1996:751).

Many obstetricians decided not to take any more new patients. Despite "government assurances of serious talks and more money, obstetricians yesterday opted to continue their job-action ... 'Things have not changed significantly' said Dr. Janice Willett, vice-chair of the Ontario Society of Obstetricians and Gynecologists ... we need more tangible evidence that negotiations are going forward and not get stalled" (Papp, 1996a:A1).

This is creating major problems for pregnant women, who cannot find doctors to give them obstetrical care. "About 825 women have called the college [Ontario College of Physicians and Surgeons] during July and August to say they are unable to find a doctor willing to deliver their babies and with the obstetricians continuing their job action, that number must increase" (ibid.). This number has in fact doubled by the end of September 1996. Since June, about half of the province's (approximately) 500 obstetricians have turned away women seeking their care, said Dr. Janice Willett (Unland 1996b:A1).

Dr. Richard Johnston, the chairman of the Society of Obstetricians and Gynecologists stated "We're the No.1 carrier of malpractice, we work at inordinate hours, we have high on-call ratios and women's health care in this province deserves a better deal from the Ministry than currently the one they are getting" (Unland, 1996a:A5). In another paper he was quoted as saying "specialists handling the worst cases aren't being paid what they're worth ... We work our buns off. They are
complex cases. We get sued a lot, and we're not recognized for it" (Papp, 1996b:A6).

Comparing Incomes of Doctors/Nurses/Midwives

The average income of an obstetrician before taxes but after office expenses (e.g. salary of secretary/nurse, office supplies and equipment) and deductions for RRSP is approximately $107,192.00. The average take-home pay is $54,661.00. The average income of a family physician before taxes is $60,320.00 and the average take-home pay is $34,264.00 (Kralj, 1996). Some doctors deliver hundreds of babies per year. "Mississauga obstetrician Jane Wilkinson wrote to the Toronto Star to say that she earned about $37,750.00 a year (after office expenses, clawbacks and CMPA [Canadian Medical Protective Association dues] for 70 hour weeks" (Gray, 1996:752). "Some obstetricians take issue with the different way in which they and midwives are paid. The province covers midwives' salaries, malpractice insurance and overhead costs, but obstetricians are paid [fee] per service and cover their own insurance and overhead"(Unland, 1996a:A6).

A midwife's starting salary is $55,000.00. She is restricted to 40 deliveries per year.

On the other hand, Jane Cornelius, the president of ONA has stated: "The average salary for a highly skilled registered nurse is currently $43,000.00. To solve the funding crisis in health care the Ontario Hospital Association, with nodding
approval from the government, has asked nurses to take more than a 20 per cent cut in their wages!" (Dialogue on Health Reform, 1996:27).

The financial question was a significant factor in the disapproval of midwifery by doctors and nurses.

The Impact of New Midwives

When this research was started in 1993, midwifery had just been legalized in Ontario. The midwifery program took its first students in the fall of 1993 at MacMaster University and on satellite campuses at Ryerson and Laurentian universities. In September 1996 the first eighteen midwives graduated from those universities. "The graduates join 71 practicing midwives who were registered with the new College of Midwives of Ontario after the legislation was passed" (Carey, 1996:A15). These 71 were midwives trained elsewhere but upgraded their education to meet the standards in Ontario. There are three other midwifery students who will complete their program this fall, "and 22 other midwives are expected to be accepted to the college based on their experience" (Unland, 1996a:A6).

All together there will soon be approximately 114 registered midwives in Ontario. Can this small group present a threat to Ontario doctors and nurses? The anger and disapproval shown by the respondents in this survey seems disproportionately great. It is doubtful that this handful of midwives could take away enough patients to affect the income of doctors or take away a large number of
nursing jobs at this time, especially since these midwives are scattered throughout the province.

Hundreds of nurses in Ontario are losing jobs due to government cut backs in health care. "Canada's largest hospital is laying off 322 nurses - 15% of its nursing staff" (Coutts, 1996:A1), and "Ontario nurses are dreading more massive layoff announcements as hospitals grapple with cuts in provincial transfer payments" (Boyle, 1996:A6). However, these cut backs are not due to an invasion of large numbers of midwives into the health care system (at this time) but due to lack of government funds to keep the health care functioning at the same level as before. As more midwives are trained, maternity nurses could face further job losses in the future.

However, it is not unreasonable to suspect that the threat that midwives pose to nurses and doctors is not so much a financial one as that legalizing and licensing even one midwife is a symbolic attack on the patriarchal foundation of the Canadian medical system.

**Independence**

In Ontario there are the College of Physicians and Surgeons, the College of Nurses and the College of Midwives. These institutions are registration bodies that licence the members. They are also regulatory bodies which, when necessary, discipline their members. In this sense all these three occupations are similar, self-regulating professions. The difference is apparent in the work place. Doctors,
although accountable for their actions to their patients and to their college, are totally autonomous. In patient care the doctor makes the decisions about the treatment a patient gets. The doctor gives the orders and other health care workers carry out those orders.

Nurses on the other hand are not an autonomous group. Nurses treat patients mostly by following doctors' orders.

Midwives fit somewhat between doctors and nurses. If there are no complications during pregnancy and/or delivery, the midwives can treat their clients without any help or advice from a doctor. It is only in case of complications they must consult a doctor or refer (transfer the care of) the client to a doctor.

This research showed that many doctors resent these referrals, i.e. why should they (the doctors) take over the care of these 'problem' cases that are time consuming and might have serious complications making the doctors vulnerable to malpractice suits. Marshall Redhill, an obstetrician said: "I don't want parity with them [midwives]. I want to be recognized as far more experienced and trained than the midwives" (Unland, 1996a:A6).

Objection to Home Births

Home births are objected to by most doctors and some nurses. None of the doctors in this survey would assist in a home birth. The doctors do not seem to have faith in home births. They see pregnancy and birth as pathological, not natural events. The doctors emphasize that a birth is normal only after the fact, i.e. normalcy
cannot be predicted. Midwives will be assisting in home births and this is another reason why doctors object to midwifery.

Furthermore doctors do not have faith in the decision-making ability of the women who want to deliver their babies at home. However, women "do have a perspective of their own which is at least of equal value, and arguably of more value than the corresponding male perspective on the same issue" (Eichler, 1986:10). Most women who decide to deliver at home do not decide this spontaneously, 'on the spur of the moment' but they do research and think over the issue carefully in consultation with a midwife.

The spark that started the midwifery debate in the early 1980s was the deaths of some babies delivered by midwives at home. No midwife was found criminally responsible for the baby deaths; however, the debate about the illegality/legality of midwifery started to escalate. The initial reason given for disapproval of midwifery was the question of the safety of home births. There is no evidence to show that peri-natal mortality is higher in countries where midwives deliver most of the babies, e.g. in northern European countries. In fact, the contrary is true (Task Force Report, 1987). In Holland there is a high proportion of home births.

It is usually pointed out that The Netherlands is the last remaining industrialized nation with a high proportion of planned home births - and that this coincides with low rates of perinatal mortality. Dutch midwives are described as independent practitioners who have succeeded in resisting the 'medicalization' to which midwives elsewhere in the industrialized world have, to a greater or lesser degree, succumbed" (Task Force Report: 46).
Many of these European countries have demonstrated that midwives do not endanger the lives of mothers and babies and the Dutch have demonstrated that home births can be safe, with lower perinatal mortality rates. Thus the arguments against the safety of midwifery in Ontario are not necessarily valid.

It seems that the resistance has as much to do with territoriality ('turf protection') and financial competition between the health professionals, as it does with safety i.e. they all want their 'market share'.

Conclusion

Despite considerable resistance for a long period of time, midwives have now achieved a place in our health care system. This has been achieved in a relatively short time. This was likely due to the fact that the people who, 15-20 years ago, began to lobby for the legalization of midwifery were a very intelligent and diplomatic group. (This was attested by many people I spoke to, even some who opposed midwifery). However, this study has shown there is still resistance to and scepticism about midwifery among other health care workers, despite the legalization of midwifery.

A rather unexpected finding in this survey was that there was no significant difference in the answers by the respondents in the teaching hospitals versus non-teaching hospitals. My hypothesis was that the attitudes of the staff toward midwives in the teaching hospitals would be somewhat more positive than
that of the staff in the peripheral hospitals. The staff in the teaching hospitals deal with 'new comers' such as medical students and nursing students regularly; therefore, it was speculated that they would accept midwives more readily than the staff in the peripheral hospitals where the staff tends to remain the same. This, however, did not appear to be true. The respondents from both groups of hospitals were fairly consistent in their answers. The reason could be that the respondents did not perceive midwives to be the same as students who are transient, who come and go, but rather that midwives are a more permanent part of the health care system.

The most unexpected finding was the discrepancy between the answers to the multiple choice questions and the added written comments. The negativism of the comments was rather surprising when compared to the neutrality of the multiple choice answers. There were respondents who did not add comments. One wonders therefore if their answers, whether approving or disapproving of midwifery, were their true opinions? It is not possible to answer this question. Perhaps it was the limitation of this survey that the respondents to the questionnaires were not interviewed. Had interviews been conducted this discrepancy might have been clarified.

Another limitation is the smallness of the population surveyed. If there had been no time or financial restrictions this survey could have been extended to all Toronto area hospitals and even to the Greater Toronto Area. This might have produced a better representation of nurses' and doctors' attitudes toward midwives in the Toronto area.
A number of questions arise from this survey which could be the subject of future research:

1) Now that midwifery is legally part of the health care system, will nurses and doctors feel differently about midwives after actually working with them for one or two years?

2) How do the midwives themselves feel about being part of the health care system? Do they feel 'accepted' by nurses and doctors?

3) How do reproductive age women now feel about midwives? Taking into account the present crisis in health care in Ontario, e.g. not being able to find a doctor to give obstetrical care, would women seek midwifery care? Would women who have used midwives feel differently about the women who have not?

My findings that resistance and scepticism towards midwifery persist among other health care workers are consistent with the findings of the two other studies done in Canada (Blais et al. and Stewart & Beresford). In both of these studies the respondents objected to home births. They also wanted midwives to be supervised by doctors and to be Rns. Since, at the time of these studies, midwifery was not yet legalized and no midwifery education existed in Canada, the financial issues did not emerge in these two studies. In my survey the financial issues were one of the main sources of objection to midwifery. The safety of home births remains a concern more so for doctors more than for nurses. The next 5-10 years will determine whether midwives integrate successfully into the health care system in Ontario.
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APPENDIX A

Interview Guide
Possible Interview Questions for Representatives of OMA, RNAO, College of Midwives and the Ministry of Health

Were you part of the initial negotiations to get midwifery established in Ontario?

What was the attitude of (organization) toward legalizing midwifery? Did this change over the course of time?

Although nurses have always practiced legally in Ontario, they have not achieved the same amount of independence and autonomy as the midwives have in a relatively short time. Why do you think this is?

Does (organization) now have reservations about the midwifery status in Ontario - - - in what regard?

What is the current view of (organization) of midwives?

Would you say that there is difference in status of various health care professionals and how would you rank them?
APPENDIX B

Questionnaires
QUESTIONNAIRE

Please circle the appropriate answers.

1. Are you a trained midwife as well as a registered nurse?
   1. Yes  2. No

2. There is an increasing shortage of physicians who practice obstetrics.
   1. Strongly agree  2. Mildly agree
   3. Mildly disagree  4. Strongly disagree
   5. I don’t know

3. If you agree, how could this problem be solved?
   1. I don’t believe that there is a problem
   2. Try to attract more doctors into obstetrics.
   3. Having midwives
   4. Other: ____________________________

4. There is a demand for midwifery in our society.
   1. Strongly agree  2. Mildly agree
   3. Mildly disagree  4. Strongly disagree
   5. I don’t know

5. In your opinion, normal, uncomplicated pregnancies and deliveries should be attended by;
   1. physicians?  2. midwives?
   3. both?  4. I don’t know
6. Midwives should have hospital admitting privileges like physicians.
   1. Strongly agree  2. Mildly agree
   3. Mildly disagree  4. Strongly disagree
   5. I don't know

7. Where should midwives practice?
   1. community
   2. birthing centres
   3. hospitals

8. Will you assist a (Ontario) registered midwife on request in a hospital?
   1. Yes  2. No

9. Home births are acceptable.
   1. Strongly agree  2. Mildly agree
   3. Mildly disagree  4. Strongly disagree
   5. I don't know

10. Midwives should work under the supervision of the physicians.
    1. Strongly agree  2. Mildly agree
    3. Mildly disagree  4. Strongly disagree
    5. I don't know

11. Midwives should work independently, (be autonomous).
    1. Strongly agree  2. Mildly agree
    3. Mildly disagree  4. Strongly disagree
    5. I don't know
12. Mothers delivering babies in hospitals have too many medical interventions.
   1. Strongly agree  2. Mildly agree  
   3. Mildly disagree  4. Strongly disagree  
   5. I don't know

13. If in a maternity ward a midwife is allowed to write orders (eg. certain drugs) for her patients, I will have no problems (resentment) to carry out those orders?
   1. Strongly agree  2. Mildly agree  
   3. Mildly disagree  4. Strongly disagree  
   5. I don't know

14. Should midwives be allowed to carry out such procedures as;
   a) episiotomy  
      1. Yes  2. No  3. I don't know
   b) suturing  
      1. Yes  2. No  3. I don't know
   c) prescribing drugs  
      1. Yes  2. No  3. I don't know
   d) ordering blood tests  
      1. Yes  2. No  3. I don't know
   e) ordering ultrasounds  
      1. Yes  2. No  3. I don't know

15. What do you think it will be like to share patient care with registered midwives?
   1. easy  2. difficult  
   3. impossible  4. I don’t know

16. Midwives will take away nursing jobs  
   1. Strongly agree  2. Mildly agree  
   3. Mildly disagree  4. Strongly disagree  
   5. I don’t know
17. Midwives claim to have a different, more holistic approach to child birth than do the physicians.

1. Strongly agree 2. Mildly agree
3. Mildly disagree 4. Strongly disagree
5. I don’t know

18. It should be up to the woman to decide who cares for her during her pregnancy, delivery and post-partum period.

1. Strongly agree 2. Mildly agree
3. Mildly disagree 4. Strongly disagree
5. I don’t know

19. A four year university program with practicum is appropriate training for midwives.

1. Strongly agree 2. Mildly agree
3. Mildly disagree 4. Strongly disagree
5. I don’t know

20. A midwife should also be a registered nurse.

1. Strongly agree 2. Mildly agree
3. Mildly disagree 4. Strongly disagree
5. I don’t know

21. Midwives, trained in other countries, should be allowed to practice in Ontario without further training?

1. Strongly agree 2. Mildly agree
3. Mildly disagree 4. Strongly disagree
5. I don’t know
22. For uncomplicated pregnancies, a midwife should be paid the same as a physician for pre-natal, delivery and post-natal care.

1. Strongly agree  2. Mildly agree
3. Mildly disagree  4. Strongly disagree
5. I don't know

23. Do you think that the wages set for the midwives by the province are appropriate? (The starting salary will be approximately $55,000 a year for midwives in Ontario)

1. too high  2. too low
3. appropriate  4. I don't know

24. How do you think midwifery will affect health care costs?

1. reduce them  2. increase them
3. will have no effect  4. I don't know

25. Have you worked with midwives?

1. Yes  2. No

26. I consider midwives as my equal co-workers.

1. Strongly agree  2. Mildly agree
3. Mildly disagree  4. Strongly disagree
5. I don't know
27. I would use midwifery services for my pregnancy and delivery and/or would encourage women in my family and among my friends to use midwifery services.

1. Strongly agree  
2. Mildly agree  
3. Mildly disagree  
4. Strongly disagree  
5. I don’t know  

28. Your years in practice of nursing? ____

29. Your year of birth? ____

30. What post-diploma or post-graduate education do you have?

31. In Summary, do you object to or approve of midwifery practice in Ontario?

1. Strongly object  
2. Mildly object  
3. Mildly approve  
4. Strongly approve  
5. I don’t know  

32. Comments:
QUESTIONNAIRE

Please circle the appropriate answers.

1. Are you:
   1. an obstetrician?
   2. a general practitioner?

2. There is an increasing shortage of physicians who practice obstetrics.
   1. Strongly agree
   2. Mildly agree
   3. Mildly disagree
   4. Strongly disagree
   5. I don’t know

3. If you agree, how could this problem be solved?
   1. I don’t believe that there is a problem
   2. Try to attract more doctors into obstetrics
   3. Having midwives
   4. Other ________________

4. There is a demand for midwifery in our society.
   1. Strongly agree
   2. Mildly agree
   3. Mildly disagree
   4. Strongly disagree
   5. I don’t know

5. In your opinion, normal, uncomplicated pregnancies and deliveries should be attended by:
   1. physician?
   2. midwives?
   3. both?
   4. I don’t know
6. Midwives should have hospital privileges like physicians.
   1. Strongly agree 2. Mildly agree
   3. Mildly disagree 4. Strongly disagree
   5. I don't know

7. Where should midwives practice?
   1. community 2. birthing centres
   3. hospitals 4. other

8. Will you assist a midwife on request?
   1. yes 2. no 3. I don't know

9. Home births are acceptable.
   1. Strongly agree 2. Mildly agree
   3. Mildly disagree 4. Strongly disagree
   5. I don’t know

10. Would you personally assist in home births?
    1. yes 2. no

11. I would refer patients to midwives.
    1. Strongly agree 2. Mildly agree
    3. Mildly disagree 4. Strongly disagree
    5. I don't know
12. I consider midwives as equal co-workers?
   1. Strongly agree 2. Mildly agree
   3. Mildly disagree 4. Strongly disagree
   5. I don't know

13. Midwives should work under the supervision of physicians.
   1. Strongly agree 2. Mildly agree
   3. Mildly disagree 4. Strongly disagree
   5. I don't know

14. Midwives should work independently (be autonomous).
   1. Strongly agree 2. Mildly agree
   3. Mildly disagree 4. Strongly disagree
   5. I don't know

15. Should midwives be allowed to carry out such procedures as:
    a) episiotomy 1. Yes 2. No 3. I don't know
    b) suturing 1. Yes 2. No 3. I don't know
    c) prescribing drugs 1. Yes 2. No 3. I don't know
    d) ordering blood tests 1. Yes 2. No 3. I don't know
    e) ordering ultrasounds 1. Yes 2. No 3. I don't know

16. Mothers delivering babies in hospitals have too many medical interventions.
   1. Strongly agree 2. Mildly agree
   3. Mildly disagree 4. Strongly disagree
   5. I don't know
17. What do you think it will be like to share patient care with registered midwives?
   1. easy  
   2. difficult  
   3. impossible  
   4. I don’t know

18. Midwives will take away doctors' obstetrical patients therefore reduce the income of the doctors.
   1. Strongly agree  
   2. Mildly agree  
   3. Mildly disagree  
   4. Strongly disagree  
   5. I don’t know

19. Midwives claim to have a different, more holistic approach to child birth than do the physicians.
   1. Strongly agree  
   2. Mildly agree  
   3. Mildly disagree  
   4. Strongly disagree  
   5. I don’t know

20. It should be up to the woman to decide who cares for her during her pregnancy, delivery and post-partum period?
   1. Strongly agree  
   2. Mildly agree  
   3. Mildly disagree  
   4. Strongly disagree  
   5. I don’t know

21. A four year university program with practicum will be appropriate training for midwives?
   1. Strongly agree  
   2. Mildly agree  
   3. Mildly disagree  
   4. Strongly disagree  
   5. I don’t know
22. A midwife should also be a registered nurse.
   1. Strongly agree 2. Mildly agree
   3. Mildly disagree 4. Strongly disagree
   5. I don't know

23. The midwives trained in other countries, should be allowed to practice in Canada without further training?
   1. Strongly agree 2. Mildly agree
   3. Mildly disagree 4. Strongly disagree
   5. I don't know

24. For uncomplicated pregnancies, a midwife should be paid the same as a physician for pre-natal, delivery and post-natal care.
   1. Strongly agree 2. Mildly agree
   3. Mildly disagree 4. Strongly disagree
   5. I don't know

25. Do you think that the wages set for the midwives by the province are appropriate? (The starting salary will be approximately $55,000 a year for midwives in Ontario).
   1. too high 2. too low
   3. appropriate 4. I don't know

26. How do you think midwifery will affect health care costs?
   1. reduce them 2. increase them
   3. will have no effect 4. I don't know

27. How much is your malpractice insurance premium annually?
   $ ________
28. Midwives should pay the same insurance premiums as doctors.
   1. Strongly agree   2. Mildly agree
   3. Mildly disagree  4. Strongly disagree
   5. I don’t know

29. If both a physician and a midwife are caring for a pregnant woman, who is ultimately responsible for her care?
   1. physician   2. midwife   3. both equally

30. Have you worked with midwives?
   1. Yes   2. No

31. As a woman, I would use midwifery services for my pregnancy and delivery and/or encourage women in my family and among my friends to use midwifery services.
   1. Strongly agree   2. Mildly agree
   3. Mildly disagree  4. Strongly disagree
   5. I don’t know   6. Not applicable

32. As a man, I would encourage women in my family and among my friends to use midwifery services.
   1. Strongly agree   2. Mildly agree
   3. Mildly disagree  4. Strongly disagree
   5. I don’t know   6. Not applicable

33. How many years have you been in:
   a) obstetric practice? ____
   b) medical practice? ____

34. Your year of birth? ____

35. Your gender?   1. male   2. female
36. In summary, do you object to or approve of midwifery practice in Ontario?

1. Strongly object
2. Mildly object
3. Mildly approve
4. Strongly approve
5. I don’t know

37. Comments:
APPENDIX C

Letters of Request
Dear Madam/Sir

I am a doctoral student at the University of Toronto (O.I.S.E) and in my thesis I am researching the attitudes of nurses and physicians towards midwives.

Part of my thesis will deal with the process of how midwifery became legalized in Ontario. I understand that you were part of the planning team. I would like to ask for an interview with you to discuss the process, at a mutually convenient time.

Sincerely

Hilkka Davidson
Dear ____________

I came to interview you in June 1994 for my doctoral thesis. We discussed some issues on midwifery. I taped the interview with your permission. I am now analysing all my interviews. I am wondering if you would allow me to use your names when quoting you in our conversation or would you prefer that I use pseudonyms. Could you please let me know?

Your truly

Hilkka Davidson

Fax. 905-XXX-XXXX
Tel. 905-XXX-XXXX
Dear Committee Members

I am a doctoral student at the University of Toronto (OISE). In my thesis, I am researching the opinions of doctors and nurses toward midwives. I am writing to ask your permission to pass a questionnaire to registered nurses in the maternity unit, both in the post-partum unit and the labour and delivery area, at your hospital. I would like about 10 respondents in all. The questionnaire is short and takes only a few minutes to complete. I am enclosing copies of: my thesis proposal, a letter of permission from OISE ethics review committee, my questionnaires, the letters that accompany the questionnaires to individuals respondents, and the letters to chiefs of obstetrics and the unit managers at the maternity units in the hospitals.

The data and the results of my study will be kept confidential. No hospital or person will be identified in any way. The finished thesis will be available in OISE Library.

If there are any questions, please call me at 905-XXX-XXXX

Sincerely

Hilkka Davidson
Dear doctor

I am a doctoral student at the University of Toronto (O.I.S.E). My thesis topic deals with midwifery. I am researching the attitudes of physicians and nurses toward midwives.

I am requesting your permission to pass a questionnaire to some of the doctors in your department, some obstetricians and some family physicians.

The questionnaire is very short and takes only a few minutes to complete. All information on the questionnaires will be kept confidential and no names will be used to identify either the physicians or the hospital.

Thank you for your cooperation

Hilkka Davidson
Dear madam,

I am a doctoral student at the University of Toronto (O.I.S.E), in the department of Sociology. My thesis topic deals with midwifery. I am researching the attitudes of nurses and doctors toward midwives.

I am requesting your permission to pass a questionnaire to a few of your full time registered nurses. The questionnaire is short and only takes a few minutes to complete.

All information on the questionnaires will be kept confidential and no names will be used to identify either the nurses or the hospital. The completed thesis will be available in O.I.S.E Library.

Thank you for your cooperation.

Hilkka Davidson
Dear Colleague

I am a nurse and I am doing my doctorate in Education at University of Toronto. My thesis topic is midwifery. I am researching how nurses and doctors feel about this 'new' health care group. I would very much appreciate your input by filling this short questionnaire. It will only take a few minutes to circle your answers and if you have any additional comments, I would appreciate those, too.

Hilkka Davidson, RN.

PS. If you have any questions, please feel free to call me
My number is 905-XXX-XXXX or 416-491-5050 ex. XXXX

PS 2. This questionnaire is totally anonymous, no person or hospital will be identified in any way.
Dear Doctor

I am a nursing teacher and doing my doctorate at the University of Toronto. My thesis topic is midwifery. I am researching the opinions of physicians and nurses toward this 'new' health care group that has just been legalized in Ontario.

I would very much appreciate your input by completing this short questionnaire. It will take only a few minutes to circle your answers and if you have any further comments I appreciate those, too.

Hilkka Davidson  BA. M.Ed.

PS. If you have any questions, please, feel free to call me at 905-XXX-XXXX or 416-491-5050 ex. XXXX

PS2. This questionnaire is totally anonymous, no person or hospital will be identified in any way.