

A B S T R A C T

This paper reports on one aspect of the evaluation of the midwifery pilot projects in Quebec: the identification of the professional and organizational factors, as well as the mode of integrating midwives into the maternity care system, that would promote the best outcomes and the autonomy of midwives. The research strategy involved a multiple-case study, in which each midwifery pilot project represented a case. Based on a qualitative approach, the study employed various sources of data: individual interviews and focus groups with key informants, site observations and analyses of written documents. Results show that midwives were poorly integrated into the health care system during the evaluation. Four main reasons were identified: lack of knowledge about the practice of midwifery on the part of other health care providers; deficiencies in the legal and organizational structure of the pilot projects; competition over professional territories; and gaps between the midwives' and other providers' professional cultures. Recommendations are provided to facilitate the integration of midwives into the health care system.

A B R É G É

Cette étude présente une partie de l'évaluation des projets-pilotes de la pratique des sages-femmes au Québec : l'identification des facteurs professionnels et organisationnels, de même que le mode d'intégration des sages-femmes au système de périnatalité, qui favoriseraient les meilleurs résultats et l'autonomie des sages-femmes. La stratégie de recherche utilisée est une étude de cas multiples où chaque projet-pilote de sages-femmes est un cas. S'appuyant sur une approche qualitative, différentes sources de données ont été employées : entrevues individuelles et groupes de discussion avec des informateurs clés, observations sur place, et analyses de documents écrits. Les résultats montrent que les sages-femmes étaient peu intégrées au système de santé pendant l'évaluation. Quatre principales raisons ont été identifiées : la méconnaissance des professionnels en périnatalité à l'égard de la pratique des sages-femmes, un cadre organisationnel et légal des projets-pilotes déficient, la concurrence au niveau des territoires professionnels, et des décalages entre les cultures professionnelles des sages-femmes et des autres dispensateurs de soins. Des recommandations sont formulées pour faciliter l'intégration des sages-femmes au système de santé.

Integration of Midwives into the Quebec Health Care System

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In almost all countries, including the industrialized ones, midwives are integrated into the health care system. They are recognized as professionals and they work in close collaboration with other maternity care providers, especially physicians. Although their professional practice and work settings vary across countries, in general they share responsibilities with the other providers and have access to facilities and technology when needed and to consultants in case of problems. The integration of midwives into the health care system and their collaboration with other maternity care providers seem to be keys to quality care, better outcomes, efficiency, and patient and provider satisfaction.¹⁻⁶

Some Canadian provinces have undertaken to legally recognize midwifery, but the integration of midwives into the health care system is not an easy task. Introducing this "new" professional disrupts the established order among current maternity care providers. Indeed, some studies have shown that the practice of midwifery, at least in the United States and Canada, may be different from medical practice in many

respects. The midwives' philosophy, as formulated in many documents, rests on the conviction that pregnancy is a natural and non-pathological process; midwives favour a comprehensive approach to expectant women, emphasizing preventive and qualitative dimensions of care and encouraging the participation of women and their spouses.⁷⁻¹² According to midwives, their philosophy opposes the currently dominant approach in obstetrics. Introducing midwives also raises the delicate issues of sharing professional territories and defining the respective roles of the different maternity care providers.^{13,14}

If introducing midwives into the Canadian health care system is to be successful, the professional and organizational factors intervening in the integration of a new profession must be understood and taken into account. The evaluation of the practice of midwifery through eight pilot projects in Quebec, defined by Bill 4, offered a unique opportunity to study those factors.¹⁵ Indeed, one of the main objectives of the evaluation was to identify the professional and organizational factors, as well as the mode of integrating midwives into the maternity care system, that would promote the best outcomes and the autonomy of midwives.¹⁶ This paper presents the methods and results of that part of the evaluation pertaining to the integration of midwives into the health care system.

METHODS

The pilot projects took the form of birth centres administered by local community services centres (CLSCs) and located on the same premises or, more often, in a house nearby. They were staffed only with midwives and lay assistants.¹⁶

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A particular constraint of the evaluation is that the pilot projects were being evaluated as they were being implemented. Moreover, despite the many regulations set out by the law, each project had its own characteristics. Given these circumstances, the evaluative research design that was deemed appropriate was a multiple-case study,¹⁷ in which each project was a case. (Because the Puvirnituq project in northern Quebec differs from the others, it is not included in the present analysis.¹⁸)

The approach used rested on the subjective experience of the actors involved and a multifaceted qualitative data collection strategy. The strategy was adapted from the Grounded Theory approach because it is suited for studies that are exploratory and hypothesis-generating in nature and for those that examine complex social realities.¹⁹ Grounded theory and related approaches advocate a highly inductive strategy to data gathering: the conceptual framework emerges empirically from the field during the course of the study. Among the qualitative tools available, semi-structured interviews, observation and written documents were used to provide an in-depth analysis of the dynamics at play in the pilot projects.

The selection of the persons to be interviewed was based on the principle of contrast sampling.²⁰ The sample had two phases. First, an analysis of the implementation process of all pilot projects was performed. To do so, semi-structured interviews (n=14) were conducted with leaders of the seven projects (co-ordinators of birth centres and directors of CLSCs) and meetings of the implementation committees of the projects were observed. This analysis revealed important differences in three key aspects: the level of commitment of the CLSCs that had proposed the pilot projects; the extent to which there was already a local midwifery practice; and the potential for strategic alliances at the local or regional level that pilot projects took advantage of to get the collaboration of physicians and hospitals. In light of these criteria, three pilot projects representing contrasting "models" or cases were selected and analyzed in depth. Second, for each of these three cases, one member from the

different professional groups or sub-groups working in obstetrics and directly involved in the pilot projects was selected for individual interviews (n=21). These groups or sub-groups were the midwives (divided in two sub-groups: graduate midwives and lay midwives), family physicians, obstetrician-gynecologists, neonatologists, nurses in CLSCs and hospitals). In addition to the individual interviews, we conducted focus groups with midwives and nurses at different times during the evaluation (n=7).

An integral transcription of all interviews was produced; detailed notes were taken during the focus groups. The interviews and the focus groups gave a picture of the interprofessional dynamics surrounding the redefinition of professional territories. The analysis of midwives' professional dynamics was based on observations of consultations between midwives and clients and of midwives' meetings on the clinical aspects and practical operation of birth centres. A large number of written documents (e.g., project reports, rules and regulations, correspondence) completed the sources of data. Through an iterative process of data collection and analysis, data from all sources were systematically coded and content analyzed based on the emergent thematic categories.

RESULTS

Although there were some differences among pilot projects, overall results indicate that midwives were poorly integrated into the health care system during the evaluation. Although causal relationships cannot be established, this probably created situations that were detrimental to the midwives' clients, such as difficult access to consultants and technology (e.g., resuscitation expertise, lab tests, medication), delay in the referral and transfer of women to hospitals and physicians, and the lukewarm if not cold reception of midwives' clients transferred to hospitals. These situations were far from ideal, but specific outcomes on mothers and babies cannot be definitely linked to particular events.

The lack of integration of midwives into the health care system was not a single body's responsibility. Four main reasons were identified: lack of knowledge on the

part of other health care providers about the practice of midwifery; deficiencies in the legal and organizational structure of the pilot projects; competition over professional territories; and gaps between the midwives' and other providers' professional cultures. These will be discussed in turn.

Lack of knowledge on the part of other health care providers about the practice of midwifery

The fact that other health care professionals had incomplete understanding about midwives and their practice played an important role in their attitude toward this new maternity care provider. Before the pilot projects, a few dozen midwives with no legal recognition in Quebec practised home deliveries or sometimes accompanied women who gave birth at hospital. Very few health care providers had any professional contact with them. At the outset of the evaluation, little was done to educate other health care professionals about the midwives who were entering the health care system. During the evaluation, many professionals seem to have had a false or incomplete understanding of what midwives are and can do. Not knowing exactly who they were dealing with, they were reluctant to make room for midwives.

The legal and organizational structure of the pilot projects

The structure of the pilot projects defined by Bill 4 was itself partially responsible for the poor integration of midwives into the perinatal care system. Indeed, the pilot projects created a new type of setting for providing maternity care in Quebec: the birth centres. These centres could guarantee the midwives' autonomy and specificity, especially as they had not existed before and had not been invested by other professionals. Only midwives could work there (there were neither nurses nor physicians), thus limiting the opportunities for contact and cooperation with other maternity care providers. Because the modes of articulation between this new setting and conventional medical settings had not been clearly defined at the outset of the evaluation, they had to be specified as it unfolded. Bill 4 required that birth centres be

administered by CLSCs and that they collaborate with hospitals to establish protocols for the transfer of clients in cases of emergency. However, in three years of evaluation, not all pilot projects succeeded in filling the gap between the political will and the actual arrangements for such cooperation.

The same vagueness existed with regard to the legal division of responsibilities among professionals. Various types of cooperation, especially with physicians, had been planned as part of the pilot projects. However, the parameters of many situations involving the cooperation of physicians had to be specified on a case-by-case basis throughout the evaluation, such as consultation with family physicians and obstetrician-gynecologists when a medical problem arose during pregnancy, the transfer of patients to physicians or joint follow-up when a normal pregnancy presented complications, and urgent or non-urgent transfers at delivery. Throughout the evaluation, the law overlooked many important points concerning how midwives were to share responsibility with other health professionals. These deficiencies and imprecisions helped maintain a climate of uncertainty that was detrimental to the development of solid relationships between professionals.

Competition over professional territories

From the beginning of the evaluation and even before, the attitudes of professionals were tainted by distrust and resistance to the threat presented by the arrival of midwives. By defining themselves as specialists of normal pregnancy and wanting to provide a full range of services (prenatal care, prenatal classes, care during labour and delivery, postnatal care), midwives were carving their own territory from that of obstetrician-gynecologists, family physicians and obstetrical nurses. The fragile territorial equilibrium that existed in the sector was being shaken by the arrival of a new player. The degree or absence of cooperation experienced by midwives during the evaluation were largely dependent on these dynamics, which were aimed at protecting, conquering and redefining the territory of each professional group.

Gaps between the midwives' and other providers' professional cultures

The poor integration of midwives into the Quebec maternity care system brought to the fore the gaps between the midwives' professional culture and that of the other providers. These gaps seem to derive from both the philosophy of midwifery itself and the "alternative" culture of many midwives. Midwives who practiced in the pilot projects came from differing backgrounds, their group being approximately equally divided between lay midwives trained in Quebec (often through independent study and apprenticeship) and those who had received a diploma in midwifery and acquired experience outside Canada. Despite certain differences in points of view, these midwives largely shared a common philosophy compatible with that described in the midwifery literature.⁷⁻¹² Moreover, many midwives, especially among those from Quebec, had never worked as midwives within an institutional setting involving contact with other professional groups. These midwives had a history of marginal practice and a culture favouring alternative and community care. These factors led midwives to develop particular conceptions of risk, professional responsibility and the client-provider relationship that were obstacles to cooperation with other health care providers and to the integration of midwives. Although midwives most likely had these conceptions before they entered the pilot projects, their convictions seemed to have been reinforced during the course of the evaluation.

Conception of Risk

The way midwives and other professionals, especially physicians, conceive risk and professional responsibility varies considerably. The obstetrician-gynecologists who participated in the evaluation appear to see birth as a potentially risky event. For most midwives, it is a natural event whose outcome depends more on the mother's trust in her own capacities than on the technical equipment available in hospitals. Although many family physicians took a middle position between those two opposing points of view, the polarization of midwives' and obstetrician-gynecologists' perceptions was very clear. This polarization

appeared especially in situations of emergency transfers where midwives dealt directly with obstetrician-gynecologists. Such polarization is due in part to the fact that obstetrician-gynecologists are much more familiar with deliveries that go wrong than are midwives, whose practice is restricted to normal pregnancies. The burden of responsibility as conceived by those physicians brings them to intervene in situations that they consider risky. When in doubt, physicians are trained to act rather than let nature take its course. Thus they are skeptical about a non-interventionist approach such as that of midwives. On several occasions during the evaluation, non-intervention by midwives may have been interpreted as incompetence by some physicians, especially obstetrician-gynecologists. This difference in clinical judgement, based on a different perception of risk and intervention and on clinical theories about which there is no consensus in medical literature, created tension between midwives and the various professionals who were to cooperate with them.

Another dimension of risk that was raised during the interviews was the place of delivery. Contrary to midwives, the majority of physicians and their professional organizations believe that only the hospital is a safe place for birth. This difference in points of view was present during all the evaluation and limited to a large extent the receptivity of physicians toward midwives and their willingness to collaborate with the pilot projects.

Professional Responsibility and the Client-Provider Relationship

Professional responsibility is also perceived differently by physicians and midwives. The objective of medical obstetrical practice is to respond to client expectations, which many physicians translate as the demand for a "perfect baby". According to them, the considerable improvement in neonatal mortality and morbidity in the last 30 years has raised social expectations in this matter. If a problem arises during delivery and the baby is abnormal, the risk of a lawsuit is significant.

Physicians consider that their clients' expectations reflect values that are general-

ly shared in our society. Many of them also think that midwives respond to the demands of a marginal clientele that is willing to accept certain risks to give birth outside hospitals and is thus less likely to file claims against midwives. Midwives admit that the expectations of their clients are different,¹⁸ but attribute this to a client-professional relationship that is fundamentally unlike the relationship between physicians and their clients. For example, some midwives mention that they promise women neither a perfect delivery, nor a perfect baby. On the other hand, midwives assure their clients that they will have sufficient knowledge and preparation to make informed decisions should a problem arise. By giving clients greater responsibility, midwives free themselves from unrealistic expectations on the part of their clients.

Differing conceptions of professional responsibility emerge from these contrasting midwife and physician attitudes. Most interviews that we conducted with physicians (obstetrician-gynecologists and family physicians) revealed to a varying degree a perception of the physician-patient relationship as based on an asymmetry of competencies and responsibilities. In this perspective, the physician's authority derives from an expertise that is hardly shared with the patient and that in return puts the burden of responsibility on the physician. The conception of midwife-patient relationship revealed in the interviews with midwives is quite different. In the relationship that the midwife wants to promote with her client, expertise and authority, as well as responsibility, are transferred to the client.

The issues created by this gap between the conceptions held by midwives and those held by providers were all the more delicate because the structure of the pilot projects themselves generated much uncertainty about cooperation. Most physicians perceived important variations in attitude, values and expertise among midwives. Because the physicians' professional responsibility was engaged when they cooperated with midwives, the absence of standards for training and competence among midwives were all the more destabilizing.

CONCLUSION

Introducing midwives into the health care system poses the challenge of how to preserve the specificity and autonomy of their approach while promoting the inter-professional cooperation that is essential to efficient and safe midwifery practice. While the integration of midwives into the perinatal system was poor, those pilot projects that enabled midwives to develop a certain visibility and regular contact with other professionals were those that permitted a redefinition of professional attitudes and roles. The results of this study suggest that to favour the integration of midwives into the health care system, it would be necessary to undertake the following: develop consultation and reference mechanisms that clearly state the limits of responsibility of each professional (e.g., midwife, family physician, obstetrician-gynecologist); ensure that these mechanisms are defined through dialogue among professionals who have to cooperate rather than through administrative rules imposed from outside; keep consultation and reference mechanisms flexible and leave room for clinical exchange between the professionals involved; favour contact between professionals to develop mutual trust and real cooperation; increase the visibility of midwives in the perinatal system; and reach a standardization in midwifery practice, notably through the establishment of standard training and shared ethics, in order to reduce the uncertainty felt by midwives' collaborators toward their practice.

By its very nature, the midwifery evaluation could neither assess the impact of specific professional and organizational factors on the outcomes of midwifery care nor test various methods for integrating midwives in the maternity care system (only the birth centre model was implemented). However, the findings of this study suggest that the poor integration of midwives into the perinatal system and the lack of cooperation with other maternity care providers created less than ideal conditions for clients. Thus, decisive action should be taken in the future to ensure integration in provinces that want to legalize midwifery. But the integration of midwives into the

health care system is only one part of the issue. The evaluation of the pilot projects showed that both the medical and the midwifery approaches have advantages.^{18,21,22} The real challenge in terms of public health policy, therefore, is to find ways to combine the positive elements of the two approaches to attain the ultimate goal of maternity care: the well-being of the mother and the baby.

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