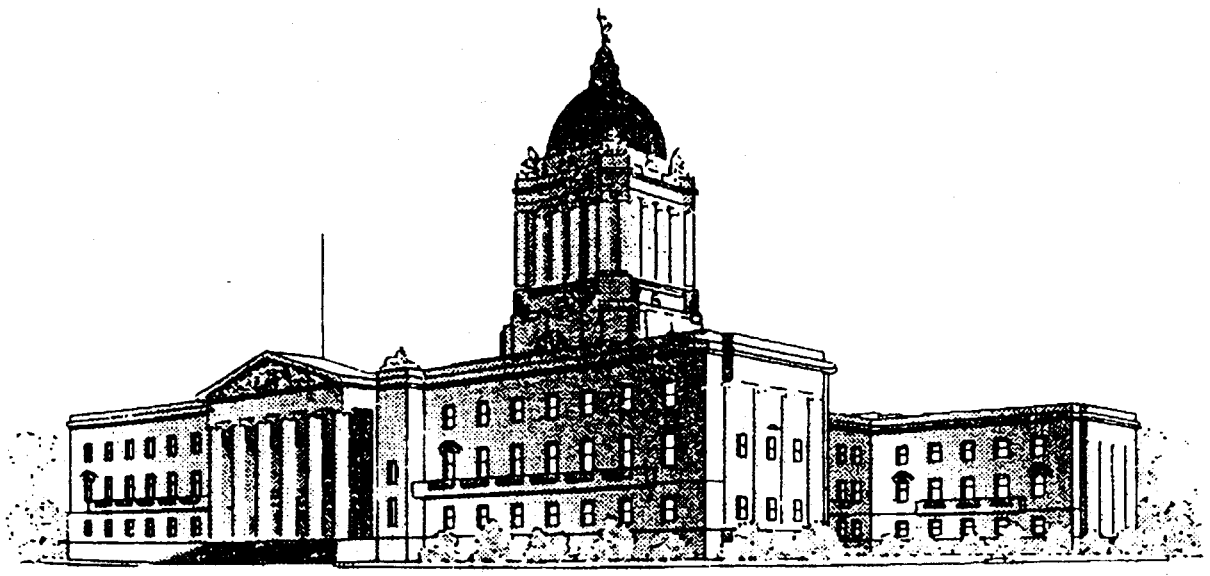
Third Session - Thirty-Sixth Legislature

of the

Legislative Assembly of Manitoba

Standing Committee on Law Amendments

Chairperson
Mr. Jack Penner
Constituency of Emerson



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MANITOBA LEGISLATIVE ASSEMBLY
Thirty-Sixth Legislature

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LEGISLATIVE ASSEMBLY OF MANITOBA

THE STANDING COMMITTEE ON LAW AMENDMENTS

Thursday, June 12, 1997

TIME – 7 p.m.

LOCATION – Winnipeg, Manitoba

CHAIRPERSON – Mr. Jack Penner (Emerson)

VICE-CHAIRPERSON – Mr. Gerry McAlpine (Sturgeon Creek)

ATTENDANCE - 8 – QUORUM - 6

Members of the Committee present:

Hon. Messrs McCrae, Newman, Praznik

Messrs. Chomiak, Dyck, Helwer, McAlpine, Penner

Substitution:

Mr. Dyck for Mr. Laurendeau

APPEARING:

Mr. Gary Doer, MLA for Concordia
Mr. Doug Martindale, MLA for Burrows
Ms. Diane McGifford, MLA for Osborne
Ms. MaryAnn Mihychuk, MLA for St. James

WITNESSES:

Bill 55–The Manitoba Hydro Amendment Act

Mr. Ron McLean, International Brotherhood of Electrical Workers, Local 2034
Mr. David Tesarski, Canadian Federation of Labour

Bill 7–The Midwifery and Consequential Amendments Act

Ms. Jacqueline Brandt, Private Citizen (read by Ms. Faith Desharnais, Private Citizen)
Ms. Veronica Reimer, Private Citizen
Ms. Esther Pallister, Private Citizen
Ms. Cynthia Cross, Private Citizen
Ms. Michelle Marchildon, Private Citizen
Ms. Chandra Malegus, Private Citizen
Ms. Judith Schulz, Private Citizen
Ms. Marla Gross, Manitoba Traditional Midwives Collective
Mr. Gordon Buchanan, Private Citizen
Ms. Leslie Hawkins, Manitoba Friends of the Midwives
Ms. Kemlin Nembhard, Women's Health Clinic
Ms. Cara McDonald, Private Citizen
Mr. Irvin Goertzen, Private Citizen
Ms. Jennifer Howard, Manitoba Action Committee on the Status of Women
Ms. Meaghan Moon, Manitoba Traditional Midwives Collective
Ms. Joyce Slater, Private Citizen
Ms. Marilyn Goodyear Whiteley, President, Manitoba Association of Registered Nurses
Ms. Yutta Fricke, Private Citizen
Mr. Pat Done, Private Citizen
Ms. Linda Thiessen, Private Citizen

WRITTEN SUBMISSIONS:

Bill 7–The Midwifery and Consequential Amendments Act:

Ms. Cynthia Cross, Private Citizen
Ms. Joyce Slater, Private Citizen
Ms. Rosemary Friesen, Administrative Co-ordinator, The Parkland Status of Women, The Manitoba Action Committee on the Status of Women, Dauphin, Manitoba
Dr. Ken Brown, College of Physicians and Surgeons of Manitoba

MATTERS UNDER DISCUSSION:

Bill 55–The Manitoba Hydro Amendment Act
Bill 7–The Midwifery and Consequential Amendments Act

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Clerk Assistant (Ms. Patricia Chaychuk): Order, please. Will the Standing Committee on Law Amendments please come to order.

Before the committee can proceed with the business before it this evening, it must elect a Chairperson. Are there any nominations?

Mr. Edward Helwer (Gimli): I would like to nominate Mr. Penner.

Clerk Assistant: Mr. Penner has been nominated. Are there any other nominations? Seeing none, Mr. Penner, you are elected Chairperson.

Mr. Chairperson: Good evening. Before the committee can proceed with the business before it, it also must proceed to elect a Vice-Chairman. Are there any nominations for Vice-Chairman?

Mr. Helwer: I would like to nominate Mr. McAlpine.

Mr. Chairperson: Mr. McAlpine has been nominated. Are there any further nominations? Mr. McAlpine will then be the Vice-Chair.

This evening the committee will be considering two bills. We will first hear presenters on Bill 55.

Committee Substitution

Mr. Helwer: Mr. Chairman, before we proceed, I wonder if I have leave to make a change in the committee, and then I would move it in the House.

Mr. Chairperson: Is there leave for committee members to be changed? [agreed]

Mr. Helwer: I move, with the leave of the committee, that the honourable member for Pembina (Mr. Dyck) replace the honourable member for St. Norbert (Mr. Laurendeau) as a member of the Standing Committee on Law Amendments for Thursday, 7 p.m. sitting only, with the understanding that the same substitution will be moved in the House and be properly recorded in the official records of the House.

Mr. Chairperson: Agreed? [agreed]

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Mr. Chairperson: The first order of business then will be to hear presenters on Bill 55, The Manitoba Hydro Amendment Act, if that is in agreement with the committee. I understand that there are some presenters here. We would then call presenters to Bill 55, if there are any presenters.

Hon. James McCrae (Minister of Environment): Mr. Chairman, I understand there are a small number of presenters on Bill 55 this evening. It had been our hope that presentations on Bill 55 would be made tonight and then presentations on Bill 7, the midwifery legislation, and that the committee would deal further with the two bills tomorrow.

There has been some alteration here. We have discussed it with members of the committee. It is agreed that those who are here to be heard with respect to Bill 55 should be heard from and that if there are some who were told that they should not be heard until tomorrow and they appear tomorrow, they ought to be heard from as well. There are those presenters plus a relatively large number of presenters to deal with the midwifery legislation.

In order to give everyone a fair and reasonable opportunity, I would move that presentations be limited to 10 minutes and that any questions flowing from those presentations be limited to five minutes.

Mr. Chairperson: Is that agreed? [agreed]

Bill 55–The Manitoba Hydro Amendment Act

Mr. Chairperson: I will then read the list of presenters on Bill 55 and then ask whether there is agreement that out-of-town presenters be heard first, and I would preclude that that would happen on both bills then. Are we agreed that out-of-town presenters be heard first? [agreed]

Alan Bleich, CUPE; Ron McLean, International Brotherhood of Electrical Workers; David Tesarski, Canadian Federation of Labour, and he is an out-of-town presenter; and Bob Maes, CUPE Local 998. Those are the presenters that I have on the list currently

before me. I would call then David Tesarski. Is he here?

Floor Comment: He is on his way but he is not here yet.

Mr. Chairperson: Then we will proceed with Alan Bleich. Is he here? Is Ron McLean here? Ron McLean, would you come forward, please. Have you presentations for distribution?

* (1910)

Mr. Ron McLean (International Brotherhood of Electrical Workers, Local 2034): Yes, I do, Mr. Chairman.

Mr. Chairperson: If you will wait for the Clerk to distribute the presentations. Mr. McLean, you may proceed.

Mr. McLean: Mr. Chairman, to the committee, I would like to thank you for the opportunity for allowing me to speak today. By way of an introduction, I am Ron McLean, business manager of IBEW Local 2034. Our local union represents approximately 2,250 employees at Manitoba Hydro. Our members work in all four major work groups in Manitoba Hydro.

We are in the areas that generate, transmit, distribute power, and sell power to the Manitoba Hydro customers. We operate, maintain, repair all of the corporation's facilities, from the large generating stations to the trucks you see driving down the road to the radios in those trucks. We are involved in every level of the corporation. Our members work everywhere in Manitoba that Manitoba Hydro has a presence. We are responsibly involved citizens of every major community in the province of Manitoba and our members are proud to work for Manitoba Hydro. We are pleased to provide 24-hour-a-day, 52-week-a-year service to keep Manitoba's lights on.

Our efforts on behalf of Manitoba have contributed to the fact that Manitoba Hydro has the lowest electrical utility bills in Canada and among the lowest in the world.

It may come as a surprise to the committee and lots in the labour community that I am here today to support passage of Bill 55. That, as I say, probably surprises many in government, many in the labour movement. It will probably surprise the odd person who has drifted through my office and has seen a button hanging on the wall that says, utility deregulation can cost you. It is probably going to surprise a few people who walk through my office and see a poster on my wall that suggests that deregulation may mean lights out.

However, I am here because the warnings that it can cost you and may mean the lights out are put together as a lobbying package by our international. It is part of a pamphlet. The pamphlet, I apologize that it is photocopies rather than the nice glossy covers, but it is the pamphlet that is in, for the lack of a better colour, a red-coloured pamphlet, and it is put together by our international. This is the Canadian version of the document, and if you look through the document, I will not use that document, I will be following the one in the blue, but certainly that document talks about the danger to the power consumer and especially to the residential consumer of what they refer to as rapid, radical deregulation. I am sure that at least some of the presenters you will hear from over the next either today or tomorrow may suggest that Bill 55 is exactly that.

However, our local union chooses not to agree with that position. The IBEW pamphlet suggests that while there are a lot of issues to consider as the power system or the power utilities deregulate, there are eight major issues: No.1 being reliability; No 2, cost to consumers; No.3, societal impact; No. 4, universal access; No. 5, stranded costs; No. 6, mergers, and in the American utilities, that is turning not only into mergers but megamergers; No. 7, environment; and No. 8, safety and employment.

The pamphlet goes on to suggest that IBEW locals become active in lobbying to ensure that the legislation addresses these and any other issues. As a number of you around the table are very aware, Local 2034 has been doing our share of lobbying long before the International got on the bandwagon. It is precisely that lobbying which makes us sure Bill 55 deals with our issues.

Our local union president, Mr. Gallant, and I are no strangers to the current minister or the previous minister who I both see here. We have met with them

on various occasions. Mr. Gallant and I are certainly no strangers to Mr. McCallum, the chairman of the board, who is sitting among the advisers on the side, and I think there are probably times that Bob Brennan, the Hydro CEO, wishes he did not know us and would leave him alone. Mr. Brennan and I do meet regularly. He and his vice-presidents and our local union executive meet regularly. He and Mr. Gallant, our president, are members of Hydro's quality council and they meet regularly to monitor Hydro's quality improvement initiative. We are involved, our input is being heard, and certainly we feel that some of what we see in Bill 55 is, in fact, part of our lobby effort being heard.

In answer to the specific eight issues that I touched on earlier, reliability, Hydro's service record is legendary both inside the province of Manitoba and outside. Certainly the people in North Dakota and Minnesota who saw over a hundred of our people down helping put things back together after the storm were amazed. They might have had microwave ovens behind the seats of their trucks to cook their dinner, but the tools and equipment that we brought with us were amazing to those folks. They had never seen equipment like that nor the dedication and the effort.

Bill 55, in several areas, promises to maintain that reliability. It, in fact, provides safeguards against interconnections to unreliable utilities and power providers. There are some interesting things we have heard from other locals of the IBEW across Canada. For instance, B.C. Hydro has several interdependent power producers who are being paid more than what the residential consumer is paying for power for interruptible power. B.C. Hydro is paying these little generating companies on the side of a river somewhere for whatever power they pump into the system. They pay more than they are selling it for, and there is no guarantee of reliability. Those things are not happening in Manitoba, and I think there are lockouts in this bill to prevent that from happening.

The cost of consumers: With the lowest rates in Canada, Manitoba Hydro is in excellent position to expand our market share and with some expanded exports, some expanded areas, certainly, we are in a position to export markets.

Social impact: I do not think anybody in the room can deny that Manitoba Hydro has been a leader in Manitoba in addressing social concerns, societal concerns, anything from the sorts of things that all citizens in Manitoba were involved in with the flood, but certainly, if you look at the Free Press, if you look at the Sun, if you look at the internal Hydro documents, Hydro got a lot of plaudits and praise for the efforts of our staff members and our co-workers for the flood activities. We are involved in things like the Canada Games torch run, and nothing in Bill 55 threatens these situations or any of Hydro's other initiatives in terms of addressing major issues of First Nations concerns, other things Hydro is a leader on.

The act clearly proposes in the restated Section 2 of Bill 55 that universality of power access to every consumer in Manitoba is a major part of both the existing act and the new act. Section 15(2) prevents retail competition fiascos like what is happening in the power utilities in California. It prevents that which is happening when Sprint phones you every night and says, would you like to convert from the Manitoba Telephone System? It says that there will be no retail competition. There will be no fly-by-night power providers who bail out halfway through their guarantees, leaving someone stuck, holding the bill and the service. Bill 55 leaves Manitoba Hydro's mandate and obligation for a full province-wide service intact.

I guess my heart sort of lies in the rural areas. I spent most of my life in the rural areas. I spent 24 years living in Brandon. Seventy-five percent of our members live outside the city of Winnipeg, and my personal feeling is if this had not been a public utility, the people in Mafeking might still be reading by coal oil lamps. So, certainly, the fact that it was a public utility and a government-owned agency certainly meant that every citizen of Manitoba has equal access to the system. That is still there.

Section 5, Stranded cost, or issue 5: Hydro has pursued a course of prudent planning. We do not have any nuclear generating stations that will be isolated like Ontario Hydro has. We do not have the situations that we will find ourselves with white elephants in the system. Bill 55 does expand the range of investment but limits the scope and magnitude to a reasonable level and certainly gives the stakeholder and the Legislature

control about where the corporation can go in terms of buying any white elephants. There is no potential stranded cost. In fact, most of our facilities will pay for themselves as, for instance, the Winnipeg River generating stations have probably four and five times already, and their lifetime is far from their end.

* (1920)

Megamergers: Bill 55 clearly leaves Manitoba Hydro as a public utility owned by the citizens of Manitoba. It allows subsidiary organizations to be created on business need. It leaves major business mergers as the business of the Legislature subject, of course, to the scrutiny of the electorate.

Mr. Chairperson: I am going to interrupt just for a wee bit. You have about a minute left.

Mr. McLean: Okay.

Mr. Chairperson: Thanks.

Mr. McLean: Environmentally, Hydro is a leader. Safety and employment-wise, the most obvious concern of a union whether they are facing deregulation or not. We are very involved in safety. We are very involved in the corporation's quality initiative. We are involved in a recently signed workforce adjustment strategy to help organizational change take place rationally.

At the bottom of page 5, you will see a note that I am asking that you consider one amendment to the act. We have a member on Hydro's board of directors from Mr. Praznik's constituency who has served for approximately 15 years. I think that the right to have a board member for our organization should probably be added as an amendment to this bill, and we are asking that as you consider that legislation that you provide that. CUPE 998 who are also on the property had a representative. I am not going to put words into their mouth as to whether they do or do not. So we are asking you to consider that.

The last two pages of the document–I am being signalled for time–deal very much with the current state at the negotiating table. It is no surprise to either of the former minister or the current minister that we are concerned about the fragility of our relationship with Manitoba Hydro. The bill allows Hydro to act as a business. We are asking that when it comes to employee relations, they also be allowed to act as a business. We have not tried to negotiate with either minister. We have not tried to negotiate with the board, but certainly expecting consistent pattern mandates for a profitable organization versus the civil service does not make good business sense. We ask that you look at that carefully as you consider how you operate under the new bill or the old bill, whichever exists.

So, with that, I guess, I will honour the Chairman's request that I cut it short.

Mr. Chairperson: Thank you, Mr. McLean. Are there any questions of Mr. McLean?

Mr. Gary Doer (Leader of the Opposition): Just one question. Reading back in Hansard over the years, there was a considerable public debate on the construction of Limestone and the Northern States Power sale. There were political parties that were proceeding with it, political parties that cancelled it, political parties that proceeded to build it.

What is your analysis as a worker at Hydro of the Northern States Power sale and the development of the Limestone project in Manitoba? Do you think it has been good for Hydro, or what is your opinion of that?

Mr. McLean: Well, certainly it has been good for Hydro. It provided employment while it was being constructed. It provides employment for people today. It provides system reliability that would not be there, and it certainly provides the chance for–what is it?–37-some percent of the revenue in Manitoba Hydro comes from outside the province. That would not be possible without Limestone.

Mr. Doer: When the debate was taking place here and people were voting against it in the '80s, there was a prediction on the revenues and a very negative prediction on the revenue side on the Limestone project and on the expenditure side. It seems to me that the Limestone project came in quite a bit under budget, and I would like to ask your opinion about the revenue side of that project and whether it has met the expectations of the workers you represent at Manitoba Hydro.

Mr. McLean: Certainly, from our perspective, from the operating people who operate the generating station, it is a pleasure to operate. It is a newer technology than most of the other generating stations.

From the perspective of the maintenance people, there were a couple of construction flaws. I think they send nose cones down the river every now and again for diver practice, but other than that, there have been no major problems and flaws that our people have had to put back together. It is a well-built generating station that our people are proud to operate and maintain.

Mr. Doer: You mentioned the labour relations "climate" as frigid–it has been a cold winter–frigid from the government's perspective through to Hydro management, I am sure. I would not want to suggest anything in your proposal on the 0, 0, and 2.

The government, the former Minister Downey has alleged in the Legislature that the decisions of how many people would be laid off, when they would be laid off and who would be laid off would all be initiated and recommended and implemented by Hydro management.

Can you give me your views on the numbers of downsizing at the time that Hydro was running a surplus for purposes of the operation?

Mr. McLean: There were 172 jobs out of our jurisdiction and 512 jobs deleted in a reorganization and downsizing that took place in 1993-94. We as a bargaining unit for the 172 people in our jurisdiction, in fact, worked with Manitoba Hydro so that of those 172 job losses, there have been no permanent layoffs of any of those 172 people. They have been placed, many of them placed in situations where, with some initiative on their own part, they are, in fact, qualifying for better pay, and some of them took apprenticeships. Some of them went back and took some individual training, and, in fact, they are, in some cases, in better positions or equivalent positions.

Since that point in time, we are down approximately 90 members, again by attrition. Most of those have been early retirements and the normal moves, some out of our jurisdiction to management, some to other employers, but large numbers by early retirement packages.

I have certainly been lobbying Mr. Brennan to try and give us some dollar refunds for those people who are not on the payroll, but he is somewhat restricted by some other folks here in the room.

Mr. Chairperson: Thank you very much, Mr. McLean, for your presentation. That is 15 minutes and a few seconds for the entire presentation, as agreed to by the committee when we started. Thank you very much.

The next person I will call, and I understand Mr. Tesarski has arrived. He was an out-of-town presenter, and it was agreed that we would hear out-of-town presenters first.

So I would ask David Tesarski to come forward. Have you a presentation for distribution?

Mr. David Tesarski (Canadian Federation of Labour): Yes, I do.

Mr. Chairperson: We will ask the Clerk to distribute. You may proceed.

Mr. Tesarski: The Manitoba Council of the Canadian Federation of Labour appreciates the opportunity to express our position to the proposed amendments of The Manitoba Hydro Act.

The Manitoba Council of the CF of L is a politically nonpartisan labour organization representing local unions and associations across Manitoba with approximately 10,000 members in communications, construction, health care, manufacturing, mining, utilities and the public sector.

The mandate of the Manitoba Council is to proactively represent our member organizations in a nonpartisan manner to promote labour issues to government, business and workers in our community. In keeping with that statement, the Manitoba Council is committed to strengthening our economy by supporting long-term growth and development for all of Manitoba. This, however, can only be accomplished with fair and equitable legislation. Today, many industrial sectors

are affected by various agreements that are intended to open up markets and promote competition.

These agreements incur changes to the acts that affect industries in Manitoba. Change is often feared by many because it brings with it uncertainty. However, with change comes a challenge and that challenge creates opportunity. The Manitoba Hydro Act has functioned through the economic cycles of the last few decades and should from time to time be reviewed, so that we can look forward to a future with a greater, more progressive act.

When changes are considered, past performance of the act must be examined. Proposed amendments must be designed to enhance the act, not make it detrimental to those affected.

We ask the Minister charged with the administration of The Manitoba Hydro Act (Mr. Newman) to consider the following comments regarding Bill 55.

With respect to Sections 15.1 and 15.2, no power to transfer facilities or guarantee, and retail supply of power, the Manitoba Council of the CF of L supports these two amendments. The Manitoba Council believes that the Manitoba Hydro corporation should not be privatized. Manitoba Hydro has built a legacy of supplying cost-efficient hydroelectric power to the residents and businesses of Manitoba. In reference to a study done by KPMG, A Comparison of Business Costs in Canada and the United States in 1995, it stated that electric costs for industrial users are significantly lower in Canada than in the United States. Based on consumption of 250,000 kilowatt hours per month and a demand load of 400 kilowatt amps, electricity costs are on average 38 percent lower in Canadian cities than in U.S. cities. Winnipeg was among the eight Canadian cities that was studied, and it ranked second lowest.

* (1930)

Low-cost hydroelectric power in a business perspective means lower operating costs and the ability to expand and attract new business to the province of Manitoba. In an economic perspective, it means job creation directly and indirectly. With an increased demand for hydroelectric power comes new infrastructure projects, hydroelectric dams, to supply the upsurge of demand. With the construction of hydroelectric power dams, this employs thousands of highly skilled tradespersons, namely the Allied Hydro Council, and as an end result, will create more jobs for the people of Manitoba.

Manitoba Hydro will benefit greatly by being able to export more hydroelectric power to the provinces and states. Having the second lowest hydroelectric costs in Canada, this puts Manitoba Hydro in a very competitive position. This alone will boost export sales, thus providing more employment to the residents of Manitoba.

Manitoba Hydro has been and is a responsible member for the business community. Manitoba Hydro is a strong driver of our economy and provides a good income for Manitobans. It has provided stable employment and good employment for many Manitoba Council CF of L affiliates, and we believe it will continue to do so in the future.

Mr. Chairperson: Thank you very much, Mr. Tesarski. Are there any questions?

Mr. Doer: Yes, thank you very much for the presentation. I was curious, your comments about the building of dams, can you indicate how many of your members were working in the Allied Hydro Council on the construction of the Limestone project? Do you have any rough estimates about that?

Mr. Tesarski: I would have to say 5,000 at least.

Mr. Doer: Was it your experience and the experience of your Allied Hydro Council that the employment and the way the employment programs worked, with the united approach, was a fairly positive way to work? It was obviously not perfect, but the way the different organizations worked together with the agreements they made back and forth to the government and the Crown corporation was generally a very positive model for both labour relations peace and the security of union employment on those projects.

Mr. Tesarski: I believe so.

Mr. Doer: I recall at one of your recent conventions, the questions being raised about the Manitoba Telephone System and the questions that went on about the sale taking place after the election and your members not expecting it to be sold, you know, in terms of the mandate that the government received.

Was it your members' expectation that the Manitoba Telephone System would not be sold in terms of the commitments that were made in the provincial election?

Mr. Tesarski: I think at that time, yes.

Mr. Doer: You probably know that to sell Manitoba Telephone System, there had to be radical changes of The Manitoba Telephone Act, and that The Manitoba Hydro Act really does speak about this organization being a publicly owned Crown corporation owned by the public. The ability to therefore sell or privatize Hydro by a majority government and therefore amend this bill still remains, would it not?

Mr. Tesarski: I guess with a majority government, sure, they could do what they want. I can only speak with the information they have given me so far.

Mr. Doer: That is fair enough. I mean, The Manitoba Telephone Act had to be amended in radical ways, as you know, right down to the wire with pensions, and even that is still in dispute with the pension payback, after the election campaign and, in our view, the break of the commitment to the people.

The present Manitoba Hydro Act really does speak to this being a nonprivate corporation now, does it not? It is a public, nonprofit Crown corporation answerable to the Legislature, and it has no ability to be a private corporation under the existing act before Bill 55. It is just a public, nonprofit corporation, Crown corporation now, and I just would like your view on the existing act, which is a Crown corporation act.

Mr. Tesarski: The existing Crown corporation act?

Mr. Doer: The existing Manitoba Hydro Act.

Mr. Tesarski: Well, I guess any experience I have had with that would be through Ron McLean being the president of our council and also being the business manager of IBEW 2034. I do not think they have really had that much of a problem with it. As you heard before, they are in fair support of Bill 55, asking for one amendment to get one of their members to be put in the legislation so that they would have one of their members as a board member. So from my experience, no, I do not think there was much of a problem.

Mr. Chairperson: Thank you very much, Mr. Tesarski.

I will now call Allen Bleich. I understand that he is away. We will leave that name on the list then until tomorrow. Bob Maes. Also not here. He might want to present tomorrow.

We will then defer the rest of the hearing on this bill until tomorrow morning, and we will, I understand, do clause by clause after we have heard the presenters.

Bill 7–The Midwifery and Consequential Amendments Act

Mr. Chairperson: We will now refer to Bill 7, The Midwifery and Consequential Amendments Act. Before I do that, however, there are a few items that I need to attend to. One of the issues is, has the committee given any consideration as to how long we want to hear? Do we want to hear all the presenters that are here today?

Hon. James McCrae (Minister of Environment): Mr. Chairman, the discussion between the House leaders was that tonight would be to hear presentations, both on Bill 55 and Bill 7, although there may be some presentations on Bill 55 to be heard tomorrow. It is our expectation that we can probably achieve that before it gets too terribly late tonight.

So I suggest that we get going on this and see how far we get, because this committee will be sitting again tomorrow morning to deal with the clause by clause on this bill, and we hope that these presentations will be such that we could actually get completed this evening.

Mr. Chairperson: Thank you very much, Mr. McCrae. Is that agreed to? [agreed]

Mr. Doug Martindale (Burrows): One other item of committee business, I am wondering if out of consideration for some of the presenters, we might encourage a change in the line-up if any of the presenters with young children want to go first rather than waiting until midnight.

Mr. Chairperson: I was just coming to that. We have a request from a mother that has a small child with her who could not get a babysitter, and her name is–the number on the presentation list is No. 11, Judith Schulz. I have a request here that she be heard first, and if there are others with small, little children–

Floor Comment: Mr. Chairman, Judith Schulz has not arrived yet.

Mr. Chairperson: Oh, she has not arrived yet? Okay, that is fine then, but if it is the will of the committee and if the presenters agree to this, I would ask then that those presenters with small children and out-of-towners be allowed to present first. Is that agreed to? [agreed]

Ms. MaryAnn Mihychuk (St. James): Just on a matter of committee administration, I would ask that the government and committee consider in the future when we anticipate families to be present for public hearings to provide child daycare in anticipation for that, so these types of supports are available in the future.

Mr. Chairperson: Thank you. The committee will take that under advisement.

I understand also that we have a presenter, No. 5, Jacqueline Brandt, who is unable to be here today and has requested that Faith Desharnais read her brief. Is the committee agreed to that? [agreed]

We will then proceed. I will call the presenters with small children, if you could identify yourself, and could you decide who would be first? We will ask that you identify yourself to the Clerk, and we will ask then that those presenters present first. I will however identify the out-of-town presenters, and the out-of-town presenters especially with small children will be allowed to come forward first.

* (1940)

Hon. Darren Praznik (Minister of Health): Mr. Chair, appreciating that many times as an MLA not being able to get a babysitter either, I have had to take children to functions, and in this kind of weather it is pretty miserable. I think we have a committee room, that small one on the other end of the building, the members' lounge, that is air-conditioned, and if members agree I think we should ask staff to open up that committee room and make it available for anyone who would like to be in there. It is somewhat cooler and more comfortable for young children.

So I do not know if that is possible, but I think the staff know the committee room I am talking about. You know, the little one with the picture of Queen Victoria in it, and King Edward. If that can be opened and it is air-conditioned, why do we not make that available? It will make life a little easier if that is possible.

Mr. Chairperson: Okay, we will continue then with the presentations, and I have six names here with babies. I will ask that out-of-town presenters with babies come forward first. The first presenter we have is Jacqueline Brandt. Is she here? Would you come forward, please.

Clerk Assistant: She is actually Faith Desharnais on behalf of Jacqueline Brandt.

Mr. Chairperson: Okay, then I will ask you at the same time to read then the presentation by Jacqueline Brandt. You may proceed.

Ms. Jacqueline Brandt (Private Citizen) (read byMs. Faith Desharnais, Private Citizen): Hi. I am Faith Desharnais, and I am reading this presentation on behalf of Jacqueline Brandt.

In response to the issue of midwifery legislation, my first question is does pregnancy, labour, birth and the postpartum period represent the medical model, encompassing the theory of disease and illness where medical professionals are needed to intervene? I believe this time in a woman's, a couple's or a family's life represents normalcy where doctors need not tamper with nature by setting stringent limits on progress or lack of it.

Women were created in a unique way. One facet of that uniqueness includes the ability to give birth. It is

a natural part of our life cycle. Pregnancy, labour, birth and the postpartum period is not a disease which needs treatment as a focus. With that in mind, I must acknowledge the fact that there are occasions in which complications do arise, and it is necessary to recruit a doctor's expertise. The doctor should be given the freedom to focus on these specialty cases; however, childbirth need not be the exclusive right of the medical system.

This time in a woman's life is extremely exciting but also very stressful. I believe that, in order to reduce the stress of this situation, we must increase our knowledge, surround ourselves with supportive and encouraging people and hold on to those people, places and things which are familiar to us.

The midwife's focus is a family and their desires. She also provides a continuity of care throughout the prenatal, labour, birth and postpartum period. These, too, are a major factor in contributing to the reduction of stress in a woman's experience. This, in turn, will decrease fear which also decreases the chances of unnecessary intervention. All this leads to a more satisfying and rewarding experience.

I have been extremely privileged to have experienced both a hospital and a home birth. We are fortunate to be able financially afford a midwife's services. Not all people who would like to involve a midwife in their experience are so fortunate. Is this right? Midwifery is cost-effective care with minimal medical intervention, so why not insure such services and promote midwifery as a service available to all women and families?

We sought the help of a midwife with our second pregnancy because we felt needed an advocate to represent us and speak on our behalf. Our hospital experience had left us feeling as though we were at the mercy of everyone else's wants and needs for us. In contrast, our midwife encouraged us to explore and discuss our wants for this special time in our lives. The focus was always on us as a family, and our requests were acknowledged. These feelings of empowerment enriched our family relationships and gave us all a sense of importance and self-worth. We are all unique individuals. Do we all not want to feel special, to know we have been listened to and heard, and to have our ideas acknowledged?

Our midwife was able to confidently guide us from the prenatal to the postpartum period. The high level of skill and knowledge she displayed was exceptional. Her expertise left us feeling extremely confident of the care we were receiving. From thorough physical exams to lengthy discussions on parenting strategies, we were never rushed away from our visits. We were always kept thoroughly informed, and our care was holistic. Our physical, emotional, spiritual and social needs were met. We were reassured to know, that should any concern or complication arise and we required hospitalization, our midwife would stay with us and continue to support, encourage and attend to us whatever the outcome might be.

In our minds, we truly believe the transition for our family from three to four was as successful as it was because of our midwife's involvement. She enabled and empowered us to have a truly wonderful experience. We received excellent care; we gained a wonderful friend in our midwife; and we had a beautiful experience, the way birth was intended.

I want this to be fully available for my other family members. My friends and I especially want this opportunity for our children to be able to honestly say they experienced the joy and fulfilment of childbirth and all it entails. For this end, I feel we need midwives, and we must allow them to practise and fulfill their mission of family-centred care and to continue their labour of love.

Thank you for allowing us the privilege to voice our opinions and concerns regarding this issue.

Mr. Chairperson: Thank you, Faith, for your presentation.

Are there any questions, comments?

Mr. Praznik: I just want to thank you for coming out tonight to make this presentation; this is what this bill is about. Thank you for your support here at committee.

Ms. Mihychuk: Thank you very much for coming out. There have been some recent changes to the number of facilities available for women to give birth, and one of them is the closure of the Misery, which had a number

of family birthing rooms. Now there is the possible closure of the Grace Hospital. Do you have any opinions on the reduction in those community services?

Ms. Desharnais: Personally, I think having the midwifery coming to be legalized and paid for by the government, it gives the women options, so that if they choose not to go to the hospital, they have other options such as home birth and things like that. It will be a concern not to be able to go to a hospital if that is what you would like, but it also gives you other options so that you have the choice.

Mr. Chairperson: I want to remind committee members that we are discussing the presentations and the bill, and I would ask that we maintain a relevance in our questions to the actual bill and the presentation before us.

Ms. Mihychuk: I think it is fairly relevant, having babies.

My next question to the delegation, are you familiar with the facilities at the Health Sciences Centre, the Women's Centre?

Ms. Desharnais: No.

Ms. Mihychuk: Okay, thank you.

* (1950)

Mr. Praznik: For the record and for the information of the presenter, what Ms. Mihychuk did not point out in her question about the Grace and Misericordia is that the number of births performed in hospitals in Winnipeg in the last four-year period has declined by some 900 and that the total number of births at the Misericordia, for example, are just under 1,200 a year and at the Misericordia were under 700, so that is part of the pressure of why that is happening.

I would like to say to you as Health minister that I concur very wholeheartedly in your comment that giving women options that they wish to pursue is what this legislation is about here tonight. Thank you.

Mr. Chairperson: I think we have just seen the reason why I caution that we use relevance in our response and our questions. I caution all of you, let us make sure that we retain our comments to the bills.

Ms. Desharnais: That is it.

Mr. Chairperson: Thank you very much for coming.

Next I would call Veronica Reimer. Have you a presentation to distribute?

Ms. Veronica Reimer (Private Citizen): Yes.

Mr. Chairperson: I will ask the Clerk to distribute. You may proceed.

Ms. Reimer: Hi. My name is Veronica Reimer. My husband, two daughters, and I live near Steinbach. I want to express my appreciation for what the government is doing to implement midwifery. I am also grateful for this opportunity to express my views on this issue.

When I was pregnant with my first daughter, I had read about home births and midwives but had no idea that this was even available in Manitoba, so I did the best I could to educate and prepare myself for the birth. My hospital birth turned out to be a relatively positive experience. After speaking with many friends and acquaintances about their recent birth experiences, I realized I had been pretty blessed to have had a birth which did not include many of the interventions that they had to endure. I have listed some of them below.

In italics after each point are measures which midwives might use to prevent these things from happening.

Induction by Pitocin and/or artificial rupture of membranes: A midwife could use simple patience and/or noninvasive measures to encourage labour. That would often be all that was necessary.

Unbearable pain with no support person to stay with us, Demerol, epidural: A midwife would support and encourage mother; education before the birth that birth is a normal process; also teach ways to cope with, lessen, or eliminate pain without medication.

Comments by caregivers like, oh, you have a birth plan, that is why all these bad things are happening: A midwife would respect the woman, her choices and preferences, and show compassion in difficult circumstances.

Continuous fetal monitoring in a lying position: This is often forced in response to drug intervention.

Routine episiotomy: A midwife would help to ease the baby out, and women would learn during pregnancy about ways to avoid this.

Forceps, vacuum extraction, C-section: More than one in seven women in Manitoba experience C-section. A midwife would provide patience and support, as earlier mentioned, also teaching, encouraging and giving freedom to use various positions for labour and birth.

Being too drugged and exhausted to rejoice in the new baby and the accomplishment of giving birth: And again, unlikely that drugs would be used if a midwife attended.

Baby taken away from mother for a routine four-hour observation: A midwife would facilitate and strongly encourage baby and mother togetherness to enjoy, bond, get to know each other and get breast-feeding off to a good start.

Postpartum blues or depression, loneliness: The midwife would provide follow-up visits, ease the transition into motherhood by providing a listening ear and inform the woman of support networks and ensure that the woman has an opportunity to discuss and reflect on her birth experience.

The list could go on and on. It is so disappointing to me that women are expected to view these interventions as normal parts of birth. Midwives respect pregnancy as a state of health and childbirth as a normal physiological life process, rarely needing medical intervention.

My second daughter was born in the hospital in November, with a labour support person in attendance. Our main reason for not having a home birth was financial. Looking back now, we are sorry we did not make it work. My labour was short, only about three hours. It went so quickly that I was fully dilated by the time we left for the hospital. At the time, I felt it would be almost impossible to make it from the living room to the car, then travel the seven miles to town and get up to the second-floor birthing room at the hospital. The transport put a lot of stress on me and slowed my labour. Reflecting on that specifically made me realize how much more relaxed I would have been had we stayed at home. Overall, my second birth was again a positive one. We were especially pleased about the support we had received from our support person.

The most wonderful parts about birth for me were the joy I felt, meeting my little miracles and the feeling of power, knowing that I had been able to give birth naturally.

Midwives understand that giving a woman respect and support so that she may give birth safely, with power and dignity, is fundamental.

Because of cuts to health care, I know that nurses and doctors have been stretched to levels that have brought about many of the difficult situations that pregnant women have to deal with. I am very interested in ways which money can be saved. Midwifery is a wonderful way to care for mothers and babies, which in the long run will save dollars. Some of the ways it will save dollars: by encouraging self-care, lower rate of C-sections, less drugs, shorter or no hospital stays with support given to the new mother and baby at home.

I feel I am representative of women in this province who are excited to see this kind of positive change in maternity care. If no one had ever spoken out before me, I probably would have given birth flat on my back, with my arms tied down and my legs tied to stirrups. Now I felt that it was my turn to speak out for change.

I strongly encourage you to support the recommendations of the MIC, including a woman's right to choose location of her birth and who will attend her, including home birth; that midwifery be a fully autonomous profession; that midwifery be available to all women as an insured core service; and that education for midwives should be structured to be accessible, flexible and sensitive to the needs of individual students.

Even though I may never have another baby of my own, I really want to see my daughters and all women in this province have the opportunity to choose to have a midwife attend birth in the setting they choose, be it at home, at a birthing centre or in the hospital. As my daughters get older, I look forward to pursuing a career in midwifery and hope that the education will be available and flexible enough for me to do so.

Here I just want to insert a personal letter that I received from a friend of mine, she could not be here today.

My name is Gwen. I would like to see midwifery implemented in Manitoba. After a very healthy pregnancy and strong, positive labour at home, I entered the hospital and gave birth under conditions that caused me great concern.

I went for hours at a time without seeing a nurse and then only for a minute or so to be given Demerol. Four different people did internal exams. The environment was very noisy and lacked privacy. Under those conditions, a lack of privacy, lack of experienced labour support and high doses of Demerol, my strong and robust labour slowed down. I then received oxytocin to speed up labour. I was then forced to remain on my back tethered to an I.V. and fetal monitor. When things still did not progress quickly enough to satisfy my caregivers, I was yelled at and physically pushed.

My baby was delivered instrumentally and taken away at birth. She was born healthy, and my doctor was fully aware that I did not want her taken away. For three hours after the birth, I was left alone and did not see a nurse or my baby. I woke up fainting and bleeding. This is understandable as I did not have my baby's presence and her nursing to stimulate oxytocin production, which would have minimized bleeding. My caregivers were actually competent and caring and worked very hard. However, heavy nursing workload and an intensive medical approach to birth turned a safe and natural function into a medical situation.

For my next birth, I desire a midwife-attended home birth in the safety, peace, quiet and privacy of my own home. With the constant attendance of caring midwives who are skilled in watching and waiting, birth can progress most optimally.

Women deserve choices. A solitary labour and medical birth should not be the only option as it was for me. Thank you for listening.

Mr. Chairperson: Thank you very much, Ms. Reimer.

Mr. Praznik: I want to thank the presenter for your presentation. I note two references to C-sections. The former Minister of Health who initiated the work on this legislation as minister during the period, Mr. McCrae, I remember some of the studies he flagged about when we have our C-sections, the greatest number, in hospitals, and tended to be in some institutions a tendency right before holiday periods.

It just underlines your fact, women should not have to undergo procedures like that for the convenience of caregivers. It is about the person receiving care. So thank you for flagging those points, and thank you for being here this evening. It is very much appreciated.

Mr. Chairperson: Thank you very much, Ms. Reimer.

I call next Esther Pallister. Have you a presentation for distribution?

Ms. Esther Pallister (Private Citizen): No, I do not. I just have some notes.

Mr. Chairperson: You may proceed.

Ms. Pallister: Okay. Greetings, Mr. Chairman and Honourable Minister of Health, as well as other distinguished members of the committee. I want to first of all congratulate you on your efforts to legalize midwifery and to recognize it as a valid and safe option for the people of Manitoba.

What I would like to offer you today is a mother's perspective. We have two children. The first one was born in a hospital and attended to by doctors and nurses, and the second one was born at home and attended to by a midwife. Although we feel both births were successful and positive, there were also some distinct differences between the two. So when I heard that midwifery was going to be legalized, I was both

excited and concerned. I was excited because I knew that it would provide greater understanding and allow people to see the need for midwives and the place and unique role that they do play and that they do offer to mothers and babies.

* (2000)

I was also concerned because I thought that perhaps, in the process, they would lose their autonomy and fall into a category that was already being done well by the medical profession and thus lose the value that I saw in them. The value that I see especially is that they offer to a woman and to the baby a chance to have individual attention, the chance where you work continuously with one midwife or two for the prenatal care as well as the labour and delivery and as well the postnatal care. Because of the one continuous caregiver, there is a deep level of understanding that helps in the safety of the birth and allows the mother to be more relaxed and therefore allows the whole proceeding to go much more easily.

Other things that were very important to me were that there was the choice available to give birth where I chose to give birth. We chose to give birth in our home. There was also the choice to have the people that I wanted there in attendance. We chose to have my daughter with us which would have been difficult in a hospital setting, my mother as well as my husband and the midwife. We chose to create an environment that I thought would be gentle and would allow the baby to come into a place that was easier to come into because the transition is a big one for the baby coming out of the womb and into the world.

Also, there are the choices that were mine to make for how we would bond together after the birth. There was also no worry or no concern about needing to make any decisions other than the decisions–there was just the knowledge that I would be listened to and heard, that the midwife was there to serve me, and that I did not have to fit into a system that was already established. As I say, our hospital experience was good also, but it was very different in that way. In that experience I was going into a system that was already established. I did a lot of research and did talk to the doctors and nurses and made my wishes known, but there was a shift in attention that I wanted in a second birth, where in the second birth the attention was on me, the mother, and the baby, rather than me having to decide or say no to a lot of things that I did not want.

I also, in that sense, want to encourage you with the midwives who are educating or forming their association to educate other midwives, that that also be able to be autonomous because I think they perform a unique role that is distinct and different from the role of the medical profession, and both are needed. The emphasis or the point I want to make is that we want to give women, families and babies the choice. So give women the choice by having an option, such as midwifery.

Thank you very much. I know that you all work very hard for our province and the work that you do is very important. I appreciate the fact that you come and sit here night after night when the weather is so glorious outside.

Mr. Chairperson: Thank you very much for your presentation. Are there any questions, comments?

Mr. Praznik: I just want to thank Ms. Pallister for being here today. We remember another Pallister, and perhaps this one is more articulate. Please give our best to Brian, and thank you for being here today. Very much appreciated, Esther.

Ms. Pallister: Thank you.

Mr. Chairperson: Thank you very much.

I call next Cynthia Cross. Have you a presentation for distribution?

Ms. Cynthia Cross (Private Citizen): Yes, I do.

Mr. Chairperson: You may proceed.

Ms. Cross: Hi, I am Cynthia, and I am a mother of four children. My first three were born by cesarean and my last was born by a natural birth at home. I have come to indicate that I agree with the midwifery bill, and that I support it. I had lots of things I wanted to say, as you can see, although I feel that all of us are here to support, and so I am going to make this much briefer than what it is.

My son, my firstborn, he was delivered, as I said, by cesarean. He was quite a big child. I am not necessarily sure that he would have been delivered any other way, as he was like 10, 5½ when he was born. Although the other children were smaller and I had different doctors, they did not believe in attempting a natural birth and I wanted to, and they gave various reasons for not doing so.

In short, I wanted to give–my last page. I want to emphasize the benefits for having a home birth. The recovery time for having a natural birth was three weeks rather than three months after my cesareans. I had less pain; my energy level was much higher, even though I had other children to attend to; my self-confidence was greatly increased; I had no side effects from the drugs that were given for cesareans, which I did not have in my last birth. I had continued strong support from my midwives and still do. I had the luxury of doing the birth by my schedule rather than by the doctor's schedule. At home I was accustomed to all the germs that were there and therefore had no reasons to be worried about infections and so on, even though my water had broken five days before I had delivered the baby. At home it was an easy transition to bring the baby into our family for everyone.

My experience has shown me that what I needed for a good birth was not available through doctors and hospitals but through midwives. I believe that this opportunity needs to be available for all women who may encounter similar circumstances.

If you like, you can have a further read. Thank you.

Hi, I am Cynthia, a mother of four children, the first three born by cesarean and the fourth by natural home birth. I would like to expand on the events of the births so that you have a better picture of each and may then see my great appreciation for midwifery.

After attending birthing classes sponsored by St. Boniface Hospital I felt prepared for the birth of my first baby. I was wrong. Will, my first born, was a very large baby weighing 10.5 lbs. During the last weeks of my pregnancy the doctors had me go for fetal assessments using ultrasound every second day. They determined this was necessary as we were not sure of the due date. The day before Will was born, fetal assessment indicated that he was under stress. This meant that he did not pass the test which consisted of questions like–how many times does the baby move in one minute? or How many times do the baby's lungs practice the breathing motions? or How many heartbeats per second? When he did not pass the test they said that today was the day for the baby to be born. Once admitted, I was hooked up to an iv drip. It was to put medicine into my system and bring labour on. At no time did anyone actually tell me what the medicine was or what it would do to me or the baby. After several hours of strong amounts of medicine they came to me and said that things were not working out as well as they had hoped. They wanted to give me some pain medicine to help me sleep through each contraction. An internal exam was performed and then they suggested that I have an epidural just in case an emergency cesarean needed to be performed. Will's head had not dropped. I was dilated to 9.5 cm but the fetal monitor indicated that he was stressed. The epidural was in place by 4 am and by 6:56 am Will was born by cesarean.

For Christy, my second, I chose to research cesareans more so I attended classes at St. Boniface Hospital. The classes covered operating procedures, and emphasized for us to leave everything in the hands of the doctors. Once again I was not really getting all the information about epidurals and the risks involved in having one or what the side effects to the baby could be.

The doctor indicated that he would like me to try to have this baby natural but that we would have to play it by ear. At 4 am my water broke and I rushed to the hospital as the doctor indicated I should do. Once I was there and admitted I was told that I had to have this baby within 24 hours or else. Not long after that everything stopped for me no more labour pains. I was then told that I would still have to have the baby because there was a high risk of infection and no longer the right amount of liquid around the baby. At the time not knowing that your body creates more fluid as needed, I became scared for my baby. The doctor then performed an internal exam and said that I had not dilated at all and this meant that they could not put a clip on the baby's scalp. Without the clip they would not be able to give me medicine to bring me back to

active labour. They then decided to do another cesarean. Christy was born weighing 9 lbs 1 oz.

Kathleen, my third, was 7 lbs 3 ozs–the smallest. When I discussed natural birth with my doctor. He said that there were no real statistics about natural birth after two cesareans and there was no real good reason to want to go natural. He asked: What was wrong with me? was I being selfish? and why would I want to put my baby in so much jeopardy. He said: The best case scenario was everything would go fine; worst case would be that my scare would burst open and the baby would drown in my blood. The doctors would have to choose between the baby and me to live and they would choose me. This, of course, scared me to death and I chose to have a cesarean.

When I became pregnant with Elyssa I happened to be around other women who had had home births. We spoke of our experiences which were from one extreme to another. Each time I visited, the doctor made me feel as if he really didn't care about me I was just part of his job. Each visit was as fast as possible and did not leave any room for questions. The straw that broke the camels back was when we were discuss the birth and he said that he would "do me" on the 10th, no, that day was not good because it was a Monday and clinic was too busy then, so he would "do me" on the following Thursday, and if things happened before then we would just "do me" then. After this meeting I phoned a midwife and basically explained more of my situation to her. She suggested we get together and discuss natural birth but first I should do more reading. I did that and learned more and more about births; natural and cesarean, the effects to mother and child and possible alternatives. Once my husband and I had weighed out the risks of hospital cesarean birth versus natural home birth we chose home birth with two midwives.

The midwives were so helpful in giving me encouragement each time they saw me. They took the time to answer all of mine and my families questions. They made sure to have at least an hour with me each visit to get to know me and my family.

Elyssa's birth was a five day event. The first day I lost water and was concerned I called the midwives they asked me to stick relatively close to home and take various vitamins to help ward off infections and to not take any baths, only showers. During the next four days the midwives checked in with me each day and one came to visit regularly. This provided much needed support and when I became concerned because I had not felt the. baby move, one of the midwives dropped in just to check the baby's heartbeat. Everything was fine. On the fifth day active labour began. The midwives came to support me and help me feel as comfortable as possible. After two hours of pushing my healthy 9 lb 1.5 oz baby girl was born, naturally and with no complications.

It amazes me how much the midwives taught me about hormones and my body–things I had not learnt with my first 3. The midwives were educated; they were experienced and they themselves had the experience of giving birth.

In closing, I'd like to emphasize all of the benefits of my home birth:

-The recovery time was 3 weeks compared to the 3 months it took after my cesareans.
-Less pain.
-my energy level was much higher even though I had three other children to attend to
-my self-confidence was greatly increased.
-no side effects from drugs for the baby or myself
-continued strong support from my midwives
-I had the luxury of doing things by my schedule and not by that of a doctor's
-at home I was accustomed to any germs that were around and not exposed to anything new that may be at the hospital.
-easier transition for everyone in the family

My experience has shown me that what I needed for a good birth was not available through doctor and hospitals but through midwives and I believe this opportunity needs to be made available to all women who may encounter similar circumstances."

Mr. Chairperson: Thank you very much.

Mr. Praznik: I would ask if the presenters who have written presentations, because they are very interesting stories and personal experiences that support the need for this bill, I would ask, if they do not read them, that

we can make sure that they form part of the record of the committee, so that some day when someone out there is reading the history of the midwifery bill, these personal testimonies will form part of the committee record. Can that be included to make sure that this is done, Mr. Chair?

Mr. Chairperson: If the committee is agreed, the submission in its entirety will be recorded. Agreed? [agreed]

Mr. Praznik: I would ask that be the case for anyone else who files a written presentation and does not read the whole thing, that it also form part of the record.

Mr. Chairperson: The record will show, and the submissions made in writing will form part of the Hansard.

Are there any questions of Ms. Cross? No. Thank you very much for your presentation, Ms. Cross.

The next ones are Gilles and Michelle Marchildon. Did I pronounce that right?

Ms. Michelle Marchildon (Private Citizen): Yes, you did.

Mr. Chairperson: Ms. Marchildon, you may proceed.

Ms. Marchildon: I would like to say that this letter is written by myself and my husband. He wished he could have been here, but, unfortunately, he had another commitment. I will simply read my letter.

My husband and I are both certified Manitoba teachers. We have two children. Miguel is four years old and Josué is eight months old. Their births were two very different experiences. Miguel was born at the St. Boniface General Hospital. All prenatal care was given by doctors, and prenatal classes were offered to us by the Youville Clinic. At the time, we thought we were sufficiently prepared for the birth. To assist me with the birth, I also asked my aunt, a registered nurse who worked on the labour floor, to help me.

In comparison to other hospital births, Miguel's birth seemed to have gone well enough. However, there was much unwarranted medical interference, for example, inducement and even unsolicited medical advice, for example, epidural. This caused us unnecessary grief and could have potentially been harmful to me and my child.

Believing that birth should be simpler and safer, my husband and I researched midwifery alternatives for the birth of our second child. Initially, due to our financial situation, the provincially funded nurse midwifery program at the Health Sciences Centre seemed our only choice. Therefore, we began prenatal care there. As the pregnancy progressed, it became obvious that this was still going to be a hospital birth with the renewed risk of medical interference. It became apparent that these midwives were working under doctor-imposed policies. Here were competent and qualified midwives without the real freedom to do what they do best, allow truly natural birth.

* (2010)

Finally, we chose to hire two traditional midwives for a home birth. They immediately took on all prenatal care. Apart from empowering us to learn more about all our birth options, they gave us emotional, moral and medical support. Thanks to them our needs were met. We had a wonderful birth. Josué was born at home in a loving and nurturing environment. His two grandmothers, his aunt and his brother were there to greet him. Both midwives provided ample and excellent postnatal care, something wanting after the birth of our first son.

To conclude, women need more freedom in regard to childbirth. First, they should be able to choose who will assist them during childbirth. Their choice must include fully provincially funded midwives, so that all women can have access to traditional midwives from prenatal to postnatal care. Second, women need to be able to choose where they want to give birth without restrictions placed upon them or their midwives. Their choice should include the home, a birthing centre, a hospital or any other place. Third, provincially funded midwifery must be an autonomous profession ungoverned and unfettered by doctors, nurses or any political or medical authority.

Contrary to medical dogma, childbirth is not a medical crisis needing doctor intervention. Women

assisted by midwives are empowered to trust in their bodies and in themselves. Childbirth then becomes a normal and natural event.

Mr. Chairperson: Thank you very much. Are there any questions or comments? Thank you very much for your presentation.

I call next Chandra Malegus. Chandra Malegus. Ms. Malegus, am I pronouncing your last name right?

Ms. Chandra Malegus (Private Citizen): Malegus. It depends if you are from the country or the city.

Mr. Chairperson: It is my German that comes out on that. Have you a written presentation?

Ms. Malegus: I do not, I am sorry.

Mr. Chairperson: You may proceed.

Ms. Malegus: Thank you. I just wanted to, obviously, put my support for the midwifery bill, and my bottom line is for women to have a choice of where they want to birth, whether it be the hospital, birth centres, hopefully, or at home.

Personally, I had two home births, but I am also the labour companion co-ordinator for MACFE, the Manitoba Association for Childbirth and Family Education. We do prenatal classes but we also have a group of labour companions who go with women into the hospitals.

I have had 20 births at different hospitals. I am very sad to see the Misericordia Hospital close. That was my best hospital. St. Boniface and the Health Sciences Centre rooms, if you have had a baby there, are not even set up for birth. There are no showers. There is nothing for birth. It is just a normal room.

I can remember my first home birth experience was when I was a lot younger, a teenager. A friend of mine had a home birth in B.C., came to Winnipeg seven years later, was going to have a home birth, I got to be there. For other reasons, I got to attend a few other home births. That was my natural way to go. I knew no other way. I, finally, as I was pregnant with my first son, knowing I was going to have a home birth, visited the Victoria Hospital, heard about these awesome birthing rooms there and was expecting to be wowed.

So I went in there to visit my good, good friend, went into her room and said, where are the birthing rooms? She said, right here. I said, no, no, no, the birthing rooms. She said, this is it. This is where you labour, have the baby and stay postpartum, and I went, oh, that is nice; that is nice. I was expecting the films that you see from the States birthing centres where you have a double bed, a whirlpool tub and, heaven forbid, a carpet even on the floor.

So even Victoria Hospital, to me, although they have showers in the rooms now, is still way far behind where we need to be, so my individual choice was to have home birth. I had lots of people who knew nothing about midwives or home birth who thought I was a little crazy and other people like my mother who totally supported what I was going to do.

With me, I had my sisters, my best friend, my husband and my midwife and had a long, long, long first birth, but I still tell people that it was a wonderful experience, but the best birth so far was my second because it was quick. I, again, had it at home, and I just want to put my two cents in for choices for women to have their birthing place. It is their body, their baby, and to enjoy that. I have had hospital and home birth experience just because of my going with other women, and I know there is a big difference. If anybody has experienced both, they would really support home birth. Although hospital birth can be exciting and a wonderful choice because that woman has made it, there also needs to be support for those who want to have their babies at home.

So that is all I need to say. Thank you very much.

Mr. Chairperson: Thank you very much. Are there any questions or comments?

Mr. Dave Chomiak (Kildonan): Thank you for the presentation. I have been struck by your presentation and others. I am not sure if you are aware, but this is one of the few bills, and I am only guessing, where probably all 57 members of the Legislature are going to vote in favour of a bill. I think that speaks strongly to the work and support of what people have done in the

community and, as well, I think, an acknowledgment of this very, very important transformation in our society.

I do not know if you and others were perhaps aware of that, but that certainly is something, particularly when you often see us–we fight about a lot of things, but I do not think you are going to see a lot of that during the course of this particular debate.

Ms. Malegus: I think that is very exciting.

Mr. McCrae: Mr. Chairman, I cannot resist. I will not do this very often, but I have to follow on what the honourable member for Kildonan said in response to yourself and also to some of the other presenters.

This is a very positive development in Manitoba. In the room tonight is Carol Scurfield who has headed up the midwifery implementation work thus far. Without the skills that Carol Scurfield brought to the task in bringing the various interests and concerns together and bringing us to the point we are at today, I would not be able to look at the Minister of Health (Mr. Praznik) today and tell him how lucky we are to have this legislation.

I know there were a lot of other people involved, too, on the council and with all of those with whom they consulted, but there are people in Manitoba who made this happen, and I just wanted to say so before the evening was out. Thank you.

Mr. Chairperson: Thank you very much. Thank you very much, Ms. Malegus.

Ms. Malegus: Thanks.

Mr. Chairperson: Are there any other presenters with small babies in the room who have not presented?

Mr. Praznik: Or in the other room?

Mr. Chairperson: Is there one more? Would you come forward?

Mr. Praznik: I think we are going to get a testimonial here.

Mr. Chairperson: You know, I cannot resist as Chairperson to comment. This is the first time in the nine years that I have been in this building that I have seen as many small children and babies in this committee room, and I think that is exhilarating. I think this is great. We should have more family involvement in drafting and presenting legislation. I think we would have different legislation.

Mr. Gary Doer (Leader of the Opposition): You obviously missed Judy Wasylycia-Leis's stay here as a member of the Legislature.

Mr. Chairperson: I was the minister when she was here.

Mr. Doer: Yes, that is right.

* (2020)

Mr. Chairperson: Judith Schulz.

Ms. Judith Schulz (Private Citizen): Yes, my name is Judith Schulz. I am blessed with three beautiful sons. Labour and birth was very long and hard for me with all three children.

My first son was born in Germany in a hospital with the attendance of a doctor and a midwife who worked well together. He was healthy and had no breathing problems and stayed with me right away after birth. A strong bond between me and the baby was there.

My second son, Julian, was born in Winnipeg at the Grace Hospital with a doctor, several nurses, no midwife and a series of medical interventions. I have an attached letter for that that I wrote to my health insurance; it is right in the back. He was in very bad shape at birth, and for days after he scored actually five out of 10 at birth. There was by far not the strong bonding experience compared to my other children, because I was apart from him all the time. He was in the incubator.

Son No. 3, that is this one, Fabian-Skye, was born at home with the attendance of two midwives, no medical interventions and no doctors. The baby was in perfect shape, stayed with me from the moment he was born, and the bonding between baby and mother and the

other family members was the strongest we have ever experienced. This birth was by far not comparable with my first two children. Both midwives were extremely skilled and trained through many births they had attended and also through countless upgrading training seminars, and the most important thing was that they let me have full control over my own childbirth, an experience of accomplishment I had never experienced before, since the midwife at my first birth in the hospital had to submit to the authority of the doctor who decided over the position I had to be in labour.

I am German. Sometimes my sentences are not right, but you will just have to forgive me that, okay. I notice it though.

For the first time in my life I felt and knew deep in my heart that I was made perfect, that the Lord created my body in order to give birth and to nurse and comfort my baby, who needs nobody more than a loving mother who is confident in her own capability. I know also that my two other children could have been born in the same way had I known better. My second child could have been in his mother's arms under the key knowledge and loving care of two birth attendants with no harm from unnecessary interventions.

The physical, emotional, medical and spiritual support I received from my midwives was more than outstanding. Fabian-Skye was in breech position during the last month of pregnancy. The doctor I saw during pregnancy commented that, well, it looks like we are going to have a cesarean section with this one. When I went to see my midwife, she showed me several exercises to turn the baby naturally. It worked. After two days the baby turned in the right position. Wow.

Where a visit to the doctor would take me an hour waiting followed by a five-minute checkup without her hardly looking at me, the midwife took at least an hour of time each session. She really cared if I was well, how my physical being was, how I was eating and how the baby was.

Where I received a large episiotomy–that is a cut–at the hospital, the experienced hands of the midwife would prevent me almost completely from tearing. Where the hospital staff starved me to death, I was eating pizza with my family two hours before I gave birth. That is possible. Where I was flat on my back in the hospital with my legs up, I walked around at home to almost the minute I gave birth with my third child. Where my baby was crying his lungs out in the incubator at my second birth, the midwives prepared a warm bath with candlelight for me and my third baby.

I believe midwives have by far more knowledge when it comes to childbirth than doctors and nurses together, and I hope that there will soon be more trust and confidence in this hardworking profession. A midwife's services are far beyond prenatal care, labour and birth and postpartum. A midwife commits her whole being to the life of this new child and to the mother.

Thank you very much.

Mr. Chairperson: Thank you very much, Ms. Schulz. I heard your comment on structure and pronunciation, and I think you did it wonderfully. I am also German.

Are there any questions? Comments?

Mr. Praznik: I would just like to thank the presenter for a job well done. It was a very informative presentation. Thank you.

Mr. Chairperson: We will now start from the top of the list. I understand that we have two outside presenters, and I wonder whether they are here. I understand one might not be here yet. The first one would be Jennifer Howard.

Floor Comment: Not here yet.

Mr. Chairperson: Jennifer Howard is not here yet. How about Meaghan Moon, is she here? [interjection] Not here either.

Floor Comment: They are from Brandon. They are travelling together.

Mr. Chairperson: Okay, thank you. Let us know when they are here. Marla Gross.

Ms. Marla Gross (Manitoba Traditional Midwives Collective): That is me. She is speaking with me.

Mr. Chairperson: Who is?

Ms. Gross: Meaghan Moon, the one who is not here yet.

Mr. Chairperson: Okay. We will make note of that as well.

Gordon Buchanan. Gordon Buchanan, would you come forward, please. Mr. Buchanan, you may proceed.

Mr. Gordon Buchanan (Private Citizen): I would like to start by saying that I am very much in favour of this bill, but I am going to cut my presentation a little bit short because I know there are lots of other people who want to talk. I am here as a private individual representing myself and my family. I have two children. The first was born in a hospital with a midwife as a support person, and the second was born at home. Both births, I believe, were easier and safer for my wife and the baby because of the midwife support.

Doctors are supposed to do their work based on a scientific basis, and I believe they have not been doing that. I think midwives do a better job on a scientific basis than doctors do. One of the stories that I like to tell people at work–I talk about this quite a bit to people–is the whole thing about fetal monitoring. Fetal monitoring has been around for quite a while, and midwives know that it is generally not a very good thing. What happens is, to do continuous fetal monitoring the mother has to lie down on a bed and be hooked up to this machine. She cannot move around, and that slows down labour. Also, scientific studies have been done, and I think everybody knows that fetal monitoring leads to much increased risk of having C-sections because it is very difficult to read the fetal monitoring. So I was happy to hear last year when the Canadian obstetrical society announced to all the doctors and everybody that continuous fetal monitoring was not a good idea and that a fetoscope, which is what a midwife uses, is as good–well, is better than that.

But I know that doctors take a while to catch up to the latest scientific findings, and I know that many doctors are still using continuous fetal monitoring when it is not necessary. So I think that midwives know more about normal deliveries and labour than doctors do, and until doctors catch up, I think midwives are the way to go.

I am going to mention four things that I would like to see happen in the implementation of this bill. One is that midwife services should be completely covered under the provincial Health Services Insurance Act so that it is available to all Manitobans equally. As an employee of Great-West Life, I was fortunate to have our home birth covered by insurance from that company, but I know most people do not have that. A lot of people do not have the money to pay for it either. It is fairly expensive.

I think that there should be some method of widely publicizing that there is a midwife option. There should be some method of educating people as to the benefits of having a birth by midwife. I think all expectant mothers should be given this knowledge and given the option to choose and should be given facts on the advantages of having a midwife birth. I think that something should be done to make that happen because I know many doctors will not do that. They will not tell people that they could have a birth by midwife. That is understandable. It is their living. They are going to reduce the amount of work that they get by midwives.

* (2030)

I know the more people that have births by midwives, the more money we are going to save, so I think it is important to publicize it. I think we have to have the option of having a midwife-assisted birth at home. Home birthing offers a relaxed, familiar environment that also allows you to have your family there. I think many studies have been done showing that home births are safe. In many other countries, home births are very common. It has been shown for a normal low-risk pregnancy that a home birth is at least as safe as a hospital birth.

I think that something should happen to make sure that doctors and midwives will work together, because I know currently–our first birth involved a doctor, and then we had a midwife support. I mentioned that we had a midwife, and they did not really want to talk about that. It was very defensive.

We had the same doctor. We also had the same doctor for our second birth. So we ended up going to see a doctor and a midwife, which was kind of a waste of time for us, but we knew that we would need to have this relationship with a doctor, even though we planned on having a home birth, if something came up that we had to have a hospital birth. We needed to have this relationship with a doctor. So we had to go see both of them.

It should not be like that. It should be that we could go to see the midwife and have her follow us until there was a specific need to see a doctor. Then the doctor could be involved and work together with the midwife. The same with a hospital birth; we should be able to have a midwife come in and handle the birth up to the point--even the whole birth, unless there was specific need for the doctor.

Those are all the points I wanted to make. Thank you very much for allowing me to present this evening.

Mr. Chairperson: Thank you very much, Mr. Buchanan. Are there any other questions? Comments? Thank you for your presentation.

I call next Leslie Hawkins. Have you a presentation for distribution?

Ms. Leslie Hawkins (Manitoba Friends of the Midwives): No, I do not. My computer broke down, so what I have is it.

Mr. Chairperson: You may proceed then.

Ms. Hawkins: Thank you. Good evening, honourable ministers and thank you for allowing us to speak this evening.

My name is Leslie Hawkins. I am here tonight to add my voice to the many advocates of the midwifery bill. I have followed closely the process of the Midwifery Implementation Council, and I am pleased with the tone, scope, sensitivity, thoughtfulness and professionalism with which they have carried out and continue their mandate.

I believe this legislation is a significant milestone in the history of health care in the province of Manitoba. As we approach the millennium, we are poised to facilitate and nurture a tremendously positive change in the attitudes of society toward birth and family interactions.

The legislation of midwifery means choice for women. Women of childbearing status would be able to choose their caregiver and location of birth. That ultimately will result in greater social health and economic benefits. These are all part of the positive and progressive aspects of encouraging the acceptance, growth and practice of midwifery in our community.

A catch phrase that has been tagged to the midwifery model of care is continuity of care. This refers to prenatal, nutrition, lifestyle counselling, labour and birth, postpartum, birth control information and well-baby care. Ultimately, however, this continuity of care is not restricted to midwives, as any pregnant women can have access to these services.

The difference with the midwifery model of care is the continuity of the caregiver, and this is something that cannot be underestimated for the pregnant woman and her family. In terms of prenatal visits, a midwife usually spends at least 10 hours over a period of the months of her pregnancy with the expectant mother building a relationship that is trusting and comfortable. This amount of time provides ample opportunity for the woman to voice concerns about her pregnancy, ask questions, receive reassurance on the normalcy of her situation. Furthermore, the birth of a baby is highly significant with a midwife-attended birth. The mother can be relaxed in the knowledge that someone who knows her very well and who knows her birth very well is there with her.

This is remarkable. The effects of high anxiety on the body are obvious, and many studies have shown that having a midwife present consistently reduces birth times, difficulties and medical interventions. Midwives typically encourage the woman to make the decisions that will be right for herself, her baby and her family. When women are encouraged to make their own decisions, their experience of pregnancy and childbirth tends to be positive, leaving her feeling empowered as a woman and a mother.

In fact, there is literature to support the idea that a woman's birth experience influences her mothering. In

Immaculate Deception II, Suzanne Arms states that how a woman gives birth is of vital significance to her physical and emotional health and to the relationship with her child. I think it is safe to say that a confident mother will raise confident children, and the repercussions of improved familial relations will eventually affect the greater community in substantial ways.

In the short term as well as in the long run, midwifery care represents undeniable social benefits. A midwife concerns herself with making sure the woman has enough information about the birth process, so that she can make informed decisions about such things as diagnostic tests, herbs and nutrition, birthing positions and breast-feeding. Midwives recognize that there are specific health benefits to breast-feeding for both mom and baby. For example, recent research shows that there is a reduction in breast cancer for breast-feeding moms and an increased protection from diabetes in infants that lasts throughout their lives. Indeed, it is common that women who have had the support of a midwife are more likely to breast-feed and breast-feed longer than the medically predetermined six months.

A further consideration for the institutionalization of midwifery practice would encourage the community health model which is already in place. As I understand, community health strives to teach people about the prevention of illness in an attempt to decrease the amount of treatment required. Therefore the legalization of midwifery would be another step in this direction since the midwifery model of care is based on pregnancy and childbirth being a natural and normal physiological process.

In the instance of normalized childbirth, there are enormous economic benefits. Pregnancies which are medicalized require more medical intervention and cost the health care system money and require more resources. For instance, the World Health Organization has noted the impact midwifery care has on improving infant mortality and reducing cesarean birthrates. Midwifery offers safe and low-cost care for women of our community.

As I stated earlier, I am in favour of this midwifery legislation and support the bill as it stands. To reiterate, midwifery is important to our community because it offers continuity of care and, more importantly, continuity of caregiver. It also offers greater social, health and economic benefits, and I believe it is a benefit that can have positive ramifications for generations to come.

I would like to thank the Midwifery Implementation Council for all of the work that they have done, and on behalf of the thousand or so citizens who sent in their cards of support, thank you for your efforts to pass this bill.

Mr. Chairperson: Thank you very much, Ms. Hawkins. Are there any questions, comments?

Ms. Diane McGifford (Osborne): Mr. Chair, I do not have a question, but I do have a comment. I wanted to thank Ms. Hawkins for her presentation and for her specific information and also for sharing her knowledge. I also wanted to thank her personally and the Manitoba Friends of the Midwives for their advocacy work on behalf of midwifery and for their educating the public on these issues. Specifically, I want to thank Ms. Hawkins for the work she has done in educating me. I am very grateful.

Mr. Praznik: Mr. Chair, I am very glad the presenter has commented on the many people who have written in cards and sent their support, because it is very important to know that is there, and I am glad it was recognized tonight. Thank you.

Mr. Chairperson: Thank you very much, Ms. Hawkins.

I call next Marianne and Dave Connelly. Marianne and Dave Connelly are not here. I call next Sandra Delaronde and Audreen Hourie. Not here.

I call then next Barbara Wiktorowicz. Ms. Wiktorowicz, have you a written presentation for distribution?

* (2040)

Ms. Kemlin Nembhard (Women's Health Clinic): I am not Barbara. That is Barbara. Barbara and I are going to be making the presentation together.

Mr. Chairperson: And your name is?

Ms. Nembhard: My name is Kemlin Nembhard. I am on the board of the Women's Health Clinic, and Barbara is the executive director of the Health Clinic. Our presentation is fairly short, but I will not go through the whole thing, because I think, pretty much, most people who are speaking are in favour of the bill. So I will not go through it completely, but there are some points that I will highlight.

We are here to provide the strongest possible support for this legislation and to commend all of those that have had a part in its creation. In particular, we are very supportive of the community-based primary care model of autonomous practice envisioned by the act. The need for such legislation has been the subject of many hours of discussion, consultation, and is supported by both the current evidence of effective services and the vision of care desired by pregnant women and their families, as we have witnessed here tonight already. As an agency particularly concerned with prevention, we believe midwives will provide an effective model of birthing care, especially for women most isolated from existing services either by location, culture, age or complex social problems.

As acknowledged by the Quality Health for Manitobans: The Action Plan, the dramatic and creative reforms in childbirth have been driven not by health service professionals but by consumers of health services. We are confident that this legislation reflects the vision and desires of women.

I will just sort of go through some of the main points that we really want to strongly support in the legislation itself.

We support the creation of midwifery as an autonomous self-regulated profession. Midwifery practice operates under a different philosophy and values than those of the existing services. The philosophy and values reflected in the Midwifery Model of Practice and other documents reflect a new approach.

Pregnancy and birth are intimate events. Women want care by someone they know, not a series of strangers, however well meaning. Women ceaselessly requested continuity of care and care provider during their birthing year. To date, these requests have not been respected. This legislation says to us that someone is finally listening.

It is the committed community-based and accountable care provider who promotes continuity of care. Many researchers have noted that a further reduction of mother and infant morbidity will only occur in an integrated, prevention-focused model. This includes new models of preconception, prenatal, and postpartum care. Midwifery provides this model.

Now, while we support the concept of collaborative health care teams such as the model we have at the Women's Health Clinic, we strongly believe that midwives and their clients require autonomous models of governance that ensure this new philosophy will develop and flourish such as the college described in the proposed act.

We support the flexibility inherent in the legislation regarding site of birth. We support a midwifery practice model that provides for birth in a variety of settings, including the home, birthing centre and hospital. This reflects policy in other jurisdictions in Canada and elsewhere and is based on evaluative research.

We support the model proposed for the College of Midwives. Its strong role for public representation and the aboriginal advisory committee with a designated council position creates a new model for ongoing, more accountable and open governance. This reflects recommendations of consumer groups, the recent Law Reform Commission's report on the Regulation of Occupations in Manitoba and models for governance in other jurisdictions. I think the most important part for us is the last sort of point.

We strongly support midwifery as an insured health service and urge the development of mechanisms to ensure midwifery is accessible to everyone throughout the province. We see the legislation as the first step in implementation and recognize that many more tasks are ahead. Therefore, we are very concerned that the 1997 budget is silent on the issue of funding for midwifery. The environment of restraint and cutbacks and a transfer of budget authority to the regional and urban

community and long-term care health boards will create confusion on the part of a variety of budget decision makers. Therefore, we strongly support designated budget line for midwifery.

The funds that we are talking about are really important for things like salaries for midwives, resources to support the initial phases of accreditation and regulation, resources for upgrading courses for local midwives where necessary, and, a Manitoba-based midwifery education program, because we need it be tailored for our community here in this province.

We are aware that in other jurisdictions, the demand for midwifery services has far outstripped the availability of midwives, and we have every reason to believe this would be anticipated here as well. The implications for this are:

Firstly, that we need to create a support for upgrading of midwives currently in Manitoba who wish to practise. This involves midwives who are trained internationally. An open, flexible accreditation program that focuses on skills and knowledge, not professional degrees, will assist in this.

Secondly, a Manitoba-based educational program that is truly accessible needs to be developed. This means that bursary and scholarship programs need to be expanded; distance education and affirmative action programs needs to be instituted.

Thirdly, we need proactive international recruitment for midwives. Although all Manitoba women would profit from this increased access, this action would be of particular help to our newcomer communities where birthing women and their families could receive care that reflects their own culture and in their own language of origin.

Fourthly, the mechanisms will be put in place to ensure that midwifery services are accessible not only to women who want them but also women who would most benefit from them.

Before I finish, I just want to give a little brief of who we are in terms of the Women's Health Clinic. The Women's Health Clinic is the first Canadian community health centre for women to be funded by the public insurance system. We were established in 1981 by an extensive network of women's groups, consumers, volunteers, as well as, health care providers.

We endeavour to give voice to women's perspectives and needs regarding their health and to demonstrate effective programs and services to address them. The Women's Health Clinic's approach is to facilitate empowerment, choice and action. We are an example of an integration of women's services and health services particularly in the area of health promotion, prevention and education. We see midwifery as a core primary service for women and welcome the opportunity to include services in our programing.

I will just end there and open it up for questions.

Mr. Chairperson: Thank you very much. Are there any questions?

Mr. Chomiak: Yes. Thank you for the presentation, and just a comment for your information and perhaps the information of others here. After we finish all of the presentations, generally we go then clause by clause through the bill to pass and ask questions, and generally during that time, we have an opportunity to raise issues with the minister such as the issues you have raised today. That will happen here later on, I suspect later tonight or tomorrow.

So those who have questions and comments like you have raised today, you can be assured that they will be discussed at this table later on, but you do not have to stay until the sometimes ridiculous hours of two or three in the morning like we do, because all of the comments will be contained in Hansard.

I just want to assure you and others that if you have questions, we make note of them and the minister does as well. We have an opportunity for discourse after all the presentations are done, so those issues will be questioned and addressed later on.

Mr. Praznik: I just want to thank the member for Kildonan for that comment.

I was just going to respond very briefly to the presenter with respect to the budget items. I understand from the staff who have worked on this that, after the

passage of this legislation we expect this summer when it becomes law, there is still a great deal of work to be done on the regulations side, which our drafters all have to obviously put together to fill in the regulation.

There is also the work that has to be done on the accreditation, the upgrade and recognizing those who are practising now. So the expectation from the implementation committee when we would actually start to have people in place is in the spring of next year, just the physical amount of work that has to be done after this act. So the reason one does not have a budget line for midwifery in this year's Health Estimates is because we do not expect that we physically can have that operational until the next budget year. I just thought I would address that.

* (2050)

Ms. Nembhard: I guess, yes, we would just like to put our strong support in there hoping that we will actually see it in next year's budget then.

Mr. Praznik: We have to.

Mr. Chairperson: The minister says it will be there.

Are there any further comments or questions? If not, thank you very much for your presentation.

Ms. Nembhard: Thanks for your time.

Mr. Chairperson: It has come to my attention that there is a person by the name of Cara McDonald who is with the presenters who also has a baby. Would she wish to present now? Please come forward. Sorry we missed you before. Have you a written presentation for distribution?

Ms. Cara McDonald (Private Citizen): No, sorry, I do not.

Mr. Chairperson: Thank you very much. You may proceed.

Ms. McDonald: Okay. I guess I am in favour of this.

Just a little brief history about myself and just how things have gone, I am the mother of four children. Three were born in the hospital and one at home with the traditional midwife. My first child was an induced birth ending in a forceps delivery, which broke my daughter's clavicle bone. I left the hospital feeling very unsure and afraid and alone, with very little support from my doctor. Changing doctors for my second daughter, I had an easier birth but felt I was missing out on something that should be special in my very normal births.

For my third child, I asked a midwife to come with my husband and I. The experience was very good. I was well supported in labour so my birth was fast and easy. In my postpartum time, my phone calls were always answered even for the smallest detail for my baby and myself by my midwife.

My fourth daughter–I decided early on that I would be having my last child at home. In my heart I felt it was my missing experience in my births. My midwife faithfully came to visit me and answered questions and gave wonderful advice. My birth was wonderful, peaceful and very fulfilling to me as a mother. I felt well cared for and cherished by my husband and my two attending midwives.

The differences between my doctors and midwives were very different. Doctors were very impersonal and take no time to listen, and always show up at the last moment. Midwives spend as long as it takes for all questions to be answered. There is a bond between mother and midwife, and it is always there.

Sorry, I have just scribbled here.

Mr. Chairperson: Take your time.

Ms. McDonald: Okay. The trust and confidence I felt in my midwife and in myself I feel has made me a better mother by my experiences in my births.

Mr. Chairperson: Thank you very much for your presentation.

Are there any questions or comments from the committee?

Mr. Praznik: Thank you.

Mr. Chairperson: Thank you very much for your presentation.

I call next Irvin Goertzen. Irvin Goertzen, have you a written presentation for distribution?

Mr. Irvin Goertzen (Private Citizen): Yes, I do.

Mr. Chairperson: Mr. Goertzen, you may proceed.

Mr. Goertzen: Honourable members of the committee, I want to thank you for having the opportunity to speak to you.

My wife, Sharon, and I are here to express our support for this midwifery bill. We would like to see the establishment of an autonomous College of Midwives in the province of Manitoba. We believe that the services of a midwife and the option of having a home birth should be available to all Manitobans, urban and rural, and should be covered by Manitoba Health insurance.

Our support for this bill is rooted in our own experience, like many of the other presenters here. We have two children. The first was born in a hospital and the second was born in our home with a midwife in attendance. Both of them were low-risk pregnancies, but there was a drastic difference between the two births.

When our first child was born, the doctor and hospital staff did their work well, but it soon became apparent that they saw the birth primarily as a medical event and were prepared for medical intervention. Several hours after we entered the hospital, the staff decided that the labour was not progressing quickly enough, and so they administered Demerol. This was the first in a snowballing series of medical interventions. The end result was a large episiotomy, a forceps, birth and a fourth degree tear. Our baby was healthy but he had facial bruises from the forceps which lasted for nearly two months. He required chiropractic care to restore his neck mobility. He had only been able to turn his head one way. Sharon's recovery was complete, but it was painful.

At the time, we simply accepted that the staff had done their jobs and we believed that the results had been unavoidable. Upon reflection, though, we realized that most of the difficulties seemed to have been caused by unnecessary medical intervention.

When we began to anticipate the birth of our second child, we wanted to avoid a similar experience so, after much reading and consideration, we hired a midwife. She assured us that if any trouble should arise and it became necessary she would accompany us to the hospital at once. She provided excellent physical and emotional support and assessment throughout late pregnancy, labour, delivery and postpartum. The difference in the amount of time spent by the midwife as compared with the medical professionals we had seen with our first birth was phenomenal, an extraordinary amount of time getting to know Sharon, getting to know her needs, and just keeping us very well informed.

During the actual labour and delivery she helped my wife relax by using massage and verbal encouragement, and she suggested changes of position to help cope with pain and that sort of thing. Our second son was born naturally and without any injuries, in spite of being 9 1/2 lbs., which was well over a pound heavier than our first son. Sharon had no episiotomy and only a very small tear. She also recovered much more quickly. With the first birth she had suffered from a great deal of exhaustion. It took her a long time to recover. The second time it was much easier for her.

So we feel we made a very good choice but, unfortunately, many Manitoba women do not have this choice. They are not informed about the option of midwifery or they are misinformed about it or they simply cannot afford it. We feel that the services of a midwife should be covered by Manitoba Health just as a physician's services are covered. Midwives should be allowed to practise in homes, birthing centres, hospital settings without a doctor's supervision. This way women with low-risk pregnancies could choose where they want to have their babies. We will soon be moving to a rural area, and we hope that midwifery services would be available in rural areas as well.

We believe that the College of Midwives should be a self-regulating body in the same way that other professionals such as accountants, engineers, and physicians have their own self-regulating bodies. We

hope that this would foster respect and co-operation between midwives and physicians. We were fortunate in that our family physician respected our decision to retain a midwife and continued to provide us with good care. Unfortunately, some couples we know have had very negative reactions from their doctors. For instance, some friends of ours wanted to have their child injected with vitamin K, which is a clotting agent or a clotting factor and is routinely administered in hospitals, our friends had a very difficult time even getting a prescription for vitamin K from the several doctors that they tried. There just was not any co-operation there.

We believe that it is time for midwifery to be recognized as a profession in our province. Midwives provide an invaluable service to Manitoba families. Thank you for listening to our viewpoint.

Mr. Chairperson: Thank you very much, Mr. Goertzen. Are there any questions or comments, committee?

Mr. Praznik: I just want to thank Mr. Goertzen for coming. It was most informative. Thank you.

* (2100)

Mr. Chairperson: I understand that Jennifer Howard and Meaghan Moon have arrived.

Would Jennifer Howard please come forward. Ms. Howard, have you a presentation for distribution?

Ms. Jennifer Howard (Manitoba Action Committee on the Status of Women): I do not, no.

Mr. Chairperson: You may proceed.

Ms. Howard: First of all, I would like to thank you for agreeing to hear us this evening. It was a fun journey in from Brandon. We look forward to some day hosting a legislative committee out there.

I am speaking tonight for the Manitoba Action Committee on the Status of Women. I work for the organization. It is a women's organization in the province of Manitoba. We have just recently celebrated our 25th anniversary as an organization, and we have been following the issue of midwifery for some years now. So it is with great gladness that we see this legislation come forward.

We have been kept informed of the Midwifery Implementation Council's process and their recommendations. We support the Implementation Council's recommendations to the government. The Midwifery Implementation Council's approach to midwifery shows a respect for the needs of women and the needs of midwives.

Should the recommendations be accepted, we feel Manitoba will be well on its way to providing a safe and comprehensive service to Manitoba women. We are pleased to see that provisions have been made for the establishment of a governing body of midwives to oversee the profession. The College of Midwives is necessary in establishing autonomy within the professing of midwifery.

Midwives are best qualified to govern themselves as they cannot be seen as an extension of the medical model. Birth is a normal life experience. Although there will be some exceptions, it is midwives who are the experts in the normal, and it is up to them to identify the boundaries, limitations and skills assessments of those individuals who will work in the field of midwifery and call themselves midwives.

We concur with the recommendations that midwifery be an autonomous profession. Midwifery in this province has existed for many years and has proven itself to be in demand insofar as it has been available. For women who did not live close to a midwife or who could not find one in their area, this often meant disappointment and frustration. Now, as women begin to see the government move towards the legislation of midwifery and the forthcoming certification of midwives, it is extremely important to provide rural and northern women with the same opportunities to access as those who live in big cities.

Accessibility to midwives must be available simultaneously in both rural, northern and city communities. As demand for midwifery services increases within the city limits, special provisions may become necessary in order to assist midwives in upgrading and practising in rural communities. Those

provisions should include community education, midwifery-friendly hospitals, and job sharing with enclosed catchment areas.

Other provinces that have already regulated midwifery or implemented midwifery services have admitted to problems which impeded the quality of service that was available. In particular, the province of Ontario was unsuccessful in certifying adequate numbers of midwives to meet demand. We stressed the importance of providing rural and northern midwives with opportunities to upgrade their education without leaving their communities.

Assisting rural communities in providing upgrading skills for midwives, as well as support for the implementation of midwifery services, is an important necessity. Encouraging rural individuals to pursue the profession of midwifery must be supported concurrently with opportunities to practise and be educated outside the city.

Providing all women with access to midwives as their primary caregivers will certainly require the government to include midwifery care as an insured core service. All women who request this type of care must have access to it, regardless of their income level. The experience of birth and empowerment through birth are not to be measured in dollars and cents. Healthy, confident mothers and families are often the result of midwifery care. Women are seeking more support and assurance in their lives as birthing mothers and primary caregivers for their family. Birth is a normal life event for women, has transformed women's lives and strengthened countless families. Certainly no one should be denied this experience because of monetary reasons. However, it should be noted that midwifery care will save the health care system a great deal of money.

One of the most contentious issues for many is the issue of a woman's right to where she will birth, with home birth included as one of the options. As a cornerstone in the strength of this legislation, place of birth, including home birth, protects and promotes women's personal choices. Making sure this choice is available for women must be a priority in this legislation. Midwifery without personal choice restricts a woman's opportunity to accept responsibility, impedes her intuition, has the potential to depress the experience of personal empowerment and may create hostilities. I am personally convinced of the need to provide women with a variety of birth settings, including home birth.

When midwives practise in a variety of settings, it will be important to provide different settings for different women. Ideally, many women may choose environments such as alternative birthing centres and clinics as they make the transition from the hospital model of care to the midwifery model of care. Still unresolved is the amalgamation of traditional midwifery with certified midwifery and the consequences and/or benefits that are inherent in this change.

There are a lot of concerns that traditional midwifery as we know it will not be recognized nor allowed to continue under the auspices of the certified program of midwifery. Some of our concerns include, will there be provision for alternative forms of treatment between midwife and birthing mother? Will midwives be given ample time to create meaningful trust relationships with their clients? Will midwives be welcome to practise, as they have been, without obligation to embrace and/or provide medical procedures? Will there be pressure to adopt these and other measures because of their challenging role of helping birthing women birth in and out of the hospital? Many traditional midwives have viewed their intuition and instinct as having an essential bearing in the art of midwifery. Traditional midwives have an inherent knowledge of birth as a natural life event. They should not be forced into a role of medicalized intervention.

In closing, we urge you to consider these crucial issues and include the recommendations as they have been put forward by the Midwifery Implementation Council. We applaud the government of Manitoba in seeking to decriminalize and implement midwifery in the province. Women who help future parents discover their own resources, both before birth and after, are making a tremendous contribution to our communities and our future. These women are midwives, and they deserve to be recognized, encouraged and listened to. Thank you.

Mr. Chairperson: Thank you very much, Ms. Howard. Are there any questions?

Ms. McGifford: I do not have a question, Mr. Chair, but I do have a comment. I wanted to thank Ms. Howard for driving in from Brandon, and we hope, too, we can meet you some day in Brandon for a legislative committee hearing.

Also, I wanted to assure her that we have taken very careful notes and will bring up some of her concerns when we go through the bill clause by clause.

Mr. Chairperson: Are there any other comments or questions? Thank you very much for your presentation.

I call next Meaghan Moon who will be presenting for Marla Gross. Have you a copy for distribution? We will wait until the Clerk has distributed, and then we will commence.

Ms. Meaghan Moon (Manitoba Traditional Midwives Collective): My name is Meaghan Moon. I am from Brandon. I am a founding member of the Manitoba Traditional Midwives Collective and a practicing midwife.

The process leading up to this day has been a long, hard struggle. The work of midwifery is not easy and working in a political climate that has not recognized the elegance of the art of midwifery has been a challenge. The midwives of the MTMC have worked hard with policymakers to bring to this legislation an understanding of the nature of midwifery practice. We are hopeful that by participating in this process, there will be greater access to midwifery care for all Manitoba women. We anticipate that the simplicity and common-sense approach to childbearing embodied in midwifery will save health care dollars. But most of all, we look forward to an increased ability to assist women and babies in achieving and maintaining optimal health in the childbearing years.

Midwifery is a cornerstone of primary health care. It is health care as opposed to sick care. It involves the monitoring of women and newborns as they adapt to the physiological, emotional and social changes of pregnancy and birth. Midwifery is about caring for people in their communities where they can access social support during a time of transition. Midwifery is about looking after healthy people and making sure they stay that way. Midwives are the guardians of normal birth. It is for this reason that midwives are often linked with home birth. Home is a natural and normal place to have a baby.

The revival of midwifery in Manitoba is a response to women choosing home birth. Midwives arose spontaneously out of the home birth community to assist others in childbirth. These women were named by their community as midwives. The development of midwifery as a profession is relatively new in human culture. While we acknowledge that in order for legislation to occur, the definition and restriction of a professional title appears to be necessary, we would like to state for the record that the title of midwife has traditionally been one that is bestowed upon a woman by the community she serves. The use of language in this common sense cannot be legislated.

* (2110)

At this moment, I would like to explore the question of safety. The Manitoba College of Physicians and Surgeons has issued a statement condemning the practice of home birth. Some facts regarding home birth are as follows:

The burden of scientific evidence overwhelmingly supports our contention that home birth is safe. Over the years many articles have been published in midwifery, nursing and medical journals showing the safety of planned home birth. Most recently the November 1996 issue of the British Medical Journal published several studies supporting the safety of planned home birth with skilled attendants and adequate infrastructure support. I have attached an annotated bibliography–although it is a two-sided copy and only one side was copied. I think it has gone to be recopied so that you have both sides of it–which is scientific support for midwifery and home birth references from medical and other journals.

Our neighbouring province of Ontario currently funds midwives to practise in a variety of settings, including private homes. Home birth is accepted in other jurisdictions such as Britain, Holland, and many of the states of the U.S.

The Alberta College of Physicians and Surgeons recently rescinded its anti-home birth statement.

Given the dearth of evidence to support the anti-home birth position of the Manitoba Medical Association and the Manitoba College of Physicians and Surgeons, one is tempted to conclude that such strident opposition is motivated by economic and social privilege. A more charitable conclusion is that the intense nature of birth experienced by physicians in hospitals contributes to fear of the process. It is this cultural fear of birth that skilled midwifery addresses and attempts to overcome.

The practicing midwives of Manitoba are committed to bringing the highest quality care to women. The safest obstetric and perinatal care is carried out in a collaborative environment. While childbirth is inherently safe, when medical attention is sought the response needs to be respectful and sometimes swift. This is true for births taking place in any setting. To deny or delay access to medical treatment when requested increases risk to women and babies.

The practicing midwives of Manitoba are dedicated to providing care that is evidence based, where scientific literature is reviewed and concepts put into practice. The midwives of the MTMC are not afraid to look at their own practices to see how their outcomes compare to the practice of midwives in other jurisdictions.

The practicing midwives of Manitoba have been the first group of midwives in Canada to collect systematic epidemiologic data on midwife-attended home births in their region before legislation. The results of this study will be presented at the perinatal research symposium being held in October in Winnipeg. The practicing midwives of Manitoba are deeply committed to maintaining the option of planned home birth for women. To legislate the practice of midwifery without leaving this option open would disembowel the very practice of midwifery and would miss the whole point of legislation.

The reason we are here today is precisely because women choose to birth at home accompanied by a community midwife. The aim of this legislation should be to make all births, including home birth, as safe as possible. Many feel that this must come about by regulating midwifery as a profession. If the legislation does not allow for skilled attendants to attend home births, midwives will continue to be chosen from their community to attend births at home. Thank you.

Mr. Chairperson: Thank you very much.

Mr. Praznik: Mr. Chair, I just wanted to assure the presenter, in the drafting of this legislation, which is the framework or the legislative authority to establish the college which empowers them to establish the profession and license the profession and the rules around it, there is nothing in this legislation–I look to the framers of it from the committee–that prohibits home births. Those are issues that are determined by the college and, you know, under what conditions, et cetera, and those are the standards that the profession, in essence, will determine.

So I just wanted to clarify that point. I would not want it to appear on the record in any way or leave any impression that this bill, by its nature, prohibits by its absence of referring to home birth. Home birth is a matter of professional issue that the college will determine, and I suspect we know what that answer will be. It is a matter of the standards around it. So I just wanted to deal with that issue, and thank the presenter for their presentation, but I would not want to leave an impression that in some way this prohibits home births.

Mr. Chairperson: Are there any other questions or comments? Thank you very much for your presentation, Ms. Moon. [interjection] Did you wish to present as well? Okay, thank you very much.

I call next then Joyce Slater. Joyce Slater, have you a presentation for distribution?

Ms. Joyce Slater (Private Citizen): I do, and because we have listened to all the articulate people before me, my fellow citizens, I am not going to read that. I will just have that submitted.

I would just like to say that I, too, have my own story of the birth two months ago of my daughter. There is no teacher like experience, and my experience was having a breech baby. None of the tricks I tried would turn it around, and I ended up having my birth at one of the large teaching hospitals here in town. I was lucky enough to be supported by a midwife through that birth. I know that the outcome would not have been as

positive as it was had she not been there. So I wholeheartedly support this bill, and thank you for your support and allowing me this opportunity to speak here.

Mr. Chairperson: Thank you very much, Ms. Slater. Are there any comments or questions? Thank you very much for your presentation.

Next I call Marilyn Goodyear Whiteley. Have you a presentation for distribution?

Ms. Marilyn Goodyear Whiteley (President, Manitoba Association of Registered Nurses): I do.

Mr. Chairperson: I ask the Clerk to distribute. I should explain to the committee that Marilyn is substituting, as I understand it, for Arlene.

Ms. Whiteley: Well, Arlene is our admin assistant who made the arrangements. I am doing the presentation.

Mr. Chairperson: So you are doing the presentation. Thank you very much. That clarifies that. You may proceed.

Ms. Whiteley: Mr. Minister and honourable members of the committee, my name is Marilyn Goodyear Whiteley, and I am president of the Manitoba Association of Registered Nurses. I would like to thank you for the opportunity to present here this evening.

As I was listening to the wonderful presentations that have been presented so far, I realized what we were missing in ours was a personal testimonial, so I thought maybe I would deviate a bit from the script and give you a rather dated testimonial. My role as a pioneer in the childbirth arena was the fight that I took on to have my husband present in the delivery room. Now, this was 27 years ago this upcoming fall and, at that point in time, of course, home births were just not considered at all, and we were really pleased that we were able to have this take place but, believe me, it was with great duress that we were able to have John present.

The Manitoba Association of Registered Nurses, or MARN, is pleased to have this opportunity to comment on Bill 7, The Midwifery Act, before third reading in the Legislative Assembly. As the regulatory body and professional association for over 10,500 registered nurses, MARN's mission is to regulate the practice of registered nurses and the quality of nursing to protect the public interest. We would like to congratulate the many people, several of whom are registered nurses, who have worked tirelessly to see midwifery established as an independent, self-governing profession with a legislated mandate.

The establishment of midwifery as an independent profession is a trend that is well underway in other parts of Canada. In Ontario, the demand for midwifery services exceeds the supply of midwives. In British Columbia, the College of Midwives of British Columbia has just had its by-laws approved and is accepting applications for registrations.

MARN's position statement on nurse midwifery supports the development of registered nurse midwifery as a nursing speciality, but we are not suggesting that government revisit the decision to establish midwifery as an independent profession. MARN will take this opportunity to highlight our views with respect to The Midwifery Act and its potential effect.

The act has many strengths. We believe its fundamental strength is the creation of a legislated mandate for midwives to offer women and their families a continuum of care throughout pregnancy, labour, birth, and after birth that is client centred and reflects two basic principles, one, childbirth is a normal process, and, two, protection of the public from harm by creating mechanisms to support midwives in providing competent, safe, ethical care, and mechanisms to respond to public concerns and complaints.

The second strength we would like to highlight in The Midwifery Act is that registration is competency based. In order to meet the fundamental responsibility of protecting the public from harm, a self-regulating profession must address the issue of incompetent practice. Historically, health professionals have relied on credentials for initial and continuing registration. Professional groups are now recognizing that competency is a more appropriate requirement.

* (2120)

Competency goes beyond knowledge to include skills, judgment, and attitudes. Competency is more specific to the individual at a given point in time. Competency assurance can be a more flexible and efficient tool for regulatory bodies in meeting their mandate to protect the public. Competency is the essence of professional self-regulation.

The one concern MARN has with this legislation is the wording of Section 3(2)(b): 3(2) "Nothing in this Act prevents a person from performing any action described in section 2" (b) "under the authority of another Act of the Legislature."

MARN's legal counsel has identified a problem with this wording if a strict interpretation is applied. The Registered Nurses Act does not set out a definition of practice to the same extent as the definition of midwifery practice in Bill 7. The Registered Nurses Act includes a very general and broadly worded definition of nursing practice. The lack of express authority with respect to specific tasks and functions enhances the ability of the registered nurse profession to evolve and change in response to the needs of the community. However, because The Registered Nurses Act does not expressly authorize registered nurses to perform the practices described in Section 2 of Bill 7, it is arguable that Section 3(2)(b) may not allow registered nurses to continue those nursing practices that overlap with midwifery practices. This is our major concern.

Today, in Manitoba, the practices of health professionals often overlap. This is also the case with the practice of midwives and the practice of registered nurses. For example, registered nurses in community health centres are often involved in the prenatal care of their female clients of child-bearing age. RNs in hospitals provide maternal child services and/or assist with labour and delivery. Public health nurses follow up with new mothers and their newborns in the community. These RNs have acquired their competencies through education programs, in some cases midwifery programs, and experiences.

In discussions we have had with the Midwifery Implementation Council and the Association of Manitoba Midwives, we are assured that it is not their intent to exclude registered nurses from the areas of practice identified in The Midwifery Act. This perception on our part is further reinforced by their wish to ensure that registered nurses who join the College of Midwives may also maintain their registration with MARN, that is, dual registration. We already have a mechanism in place to evaluate the practices of registered nurses and to determine to what extent their practices are nursing practice and can be counted towards meeting MARN's practice hour requirements to maintain registration. At this point in time we do not see a problem with dual registration, but each request would be considered on its own merit.

We are seeking clarification in the wording of Section 3(2)(b) in The Midwifery Act to ensure that (1) registered nurses whose practices overlap with midwifery will not be required to register with the College of Midwives of Manitoba; and, (2) registered nurses whose practices overlap with midwifery and who are not registered with the College of Midwives of Manitoba will not be prosecuted for unauthorized practice under The Midwifery Act.

In closing, once The Midwifery Act comes into effect, the transitional council will be faced with many challenges as it seeks to establish the college and develops its regulations, by-laws and policies. Given our many years of experience as a regulatory body, MARN will be contacting the transitional council to offer what assistance we can.

Thank you for this opportunity to participate in shaping legislation, and we look forward to the passage of The Midwifery Act.

Mr. Chairperson: Thank you very much for your presentation.

Mr. Praznik: Mr. Chair, first of all, we want to thank the Association of Registered Nurses for their general support of the bill, and one part of this committee process is to flag issues that may have come up in the drafting process that are an oversight or a difficulty in the bill so that we can address them by way of amendment here.

If I just may for a moment, I guess, one of the benefits of this committee is I have a legal background as does my colleague Mr. Newman as does my critic

Mr. Chomiak, and when we looked at your presentation we looked over to Val Perry, who is our draftsperson, and in the framework I appreciate that your legal counsel have flagged that issue as it may be arguable. I think I would suggest, certainly on the advice of our counsel, that is all that concern would be. If one wanted to address it, in fact the only way to address that would be to amend your act, your legislative body, to specifically allow certain practices that you are outlining. However, the problem with that, right now, as you have pointed out, the authority for nursing is a very broad term, nursing practice.

Ms. Whiteley: Our act does allow for it.

Mr. Praznik: That is right, for nursing practice. That is defined, as time evolves, differently, and I imagine that has changed. From a pure perspective of health planning, we expect that will evolve more as we move to the four-year BN program in nursing and as nurses take on more and more in the practice responsibilities that traditionally doctors have done. So we would like the flexibility, as I am sure nurses do, in the act. There is no way to deal with your issue to give you a comfort level if you feel that is what you need without amending your legislation.

Our legal counsel here advises us that the act, as written, would not be the place in which to deal with that issue and, quite frankly, does not view that argument by your counsel as one that is particularly the problem. It is arguable but not one that is particularly a strong one, and so I just wanted to flag that. I have made sure that both my colleagues who are lawyers are also brought into that discussion. So to deal with your specific issue if you wanted to deal with it, we do not think there is a problem, but if there was one, you would have to define in your act those issues.

The second part, I guess, of what you asked about whether or not a member of your profession would be prosecuted for breaching The Midwifery Act, that would be something that would depend solely on the facts of the case. If a registered nurse held herself out to be a midwife, as I read this legislation, without being licensed by the College of Midwives, yes, they would be in breach of this act. If certain nursing practices overlapped with midwifery, that would breach no act, as long as they were practising under your act.

I guess the third example is if a nurse carried on with practices that were not approved by your professional body as part of nursing practice but were acts that were governed under midwifery, then they could be prosecuted because they exceeded their jurisdiction under The Nursing Act, and that would depend on the case.

So the real way I would suggest we deal with that concern is with the status quo under your act as the nursing profession evolves and develops. We cannot think of any amendment that we could put in this legislation that would be appropriate. The appropriate place would be to amend your legislation, but our legal counsel does not believe it is there. So I hope it gives you some comfort level that we both want the same thing, and this is not a concern that is likely to cause anyone any difficulty. Thank you.

Ms. Whiteley: Well, we are pleased to hear and have it on record this evening that you do not see any problems, the way that the act is written. We certainly do not feel that there are any problems in looking at it from the way The Registered Nurse Act is presently written in terms of the practice that nurses are involved in at this point in time. So thank you for that assurance.

Mr. Praznik: Thank you. That is what this is about.

Mr. Chairperson: Are there any further questions or comments? Thank you very much for your presentation, Ms. Whiteley.

I call next Katherine Martines.

Floor Comment: She is in Toronto.

Mr. Chairperson: She is in Toronto?

Floor Comment: And it is Martens. It is spelled incorrectly.

Mr. Chairperson: Okay, it is Martens.

Floor Comment: She is very sorry that she was not able to make her presentation.

Mr. Chairperson: How long would it take her to fly back?

Floor Comment: I do not know, but you could read her book. She has just published a book on Mennonite women's birth experiences of the 19th Century. It is called In Her Own Voice.

* (2130)

Mr. Chairperson: Thank you very much for that information. We will then next call Yutta Fricke. Yutta Fricke, have you a presentation for distribution?

Ms. Yutta Fricke (Private Citizen): I do have one to distribute, and for Hansard I will say that I also read the book by Katherine Martens, and I thought it was wonderful. I suggest it for reading, too. It is In Her Own Voice. Now it is in Hansard.

I will not read my–

Mr. Chairperson: Could we wait just till the presentation is distributed.

Ms. Fricke: At any rate, I will not be reading the presentation.

Mr. Chairperson: Thank you very much. You may proceed, Ms. Fricke.

Ms. Fricke: I am here tonight, along with the other women before me, to support this bill. I did not realize it was so far along. I am really pleased to hear that.

My own experience in reviewing midwifery and the options of hospitals is recent. I gave birth last spring and now I am preparing to give birth again. At the time of becoming pregnant, I was going to be turning 35 in March. The very first experience I had in terms of my vulnerability of not knowing what was going, you know, all of my options and such was that my general practitioner said that while you are a high-risk person–and I have never thought of myself like that. I am healthy, fit, a nonsmoker–for that reason she thought that I should see an obstetrician.

She also thought I should have amniocentesis, which it turns out later in the conversation she had to advise me to have but she was not entirely for, having had a disabled child herself. The reason why at 35 she is recommended to pass on the suggestion for amniocentesis is that I had a one-in-200 chance of having a child with Down's syndrome. I also had a one-in-200 chance of having a miscarriage due to amniocentesis. She did not offer that information, and I do not know that had I gone for further screening that that information would have been provided. For me, that was an introduction to the risks debate that I would be facing throughout the nine months and then also with birth.

Early on, although I took her advice initially about having an obstetrician, someone else told me that person is going to want to be interventionist, you do not want to go that way. Here is the name of a GP. I stuck with a GP and then I also decided to have a midwife. I did think that I was going to have a hospital birth, and it was only with further reading and confidence in myself and also with a fear that the birth plan I had prepared would not be respected by the hospital, as I heard had happened to other people, that I would enter the hospital environment, I would be seen as a troublemaker. When you are in labour, that is not a time when you want to play out your advocacy role. You just want to be taken care of. That really was the essential factor that led me to having a home birth, which was a wonderful experience. Other people mentioned about having given birth and then entering a warm bath with your child and then my midwife laid out my nightgown, fixed up the bed and I felt like I was in paradise with this new baby.

This is now round two–a little faster than I thought–and this time I am very confident that it is going to be a successful birth and that it will be a home birth. I feel also that my GP is there as a backup, and if the necessity arises I will be in the hospital where I prefer not to be but I know it is there for security.

In closing, I know that the midwives have also set out their hopes in the midwifery legislation, that I would like to reiterate that it be an autonomous profession with opportunity for education of midwives that also be autonomous, that it be available to all women. I know many women to whom I mention that I had a home birth, they are fairly shocked at first. They think I have taken a risk as well, which I would have to try and explain to them afterwards, but basically people do not know what it is about. So I think that the education

has to be there for the midwives, but it has to be there for the public as well.

I think that is has to be an insured core cost. Even for myself and my partner, where we have a two-income family while I am working, it is still a debate, you know. We have got these choices to make, and it would be free if we were in the hospital. I would like to have it be an insured core cost, and many people have mentioned the importance that there be the choice to have the birth where you want the birth. I hope that in reviewing this legislation that one option that becomes a future possibility for Winnipeg is that there be a birthing centre. Misericordia seems to be a hospital that is free and available right now, but the birthing centre would be an entirely different option again, and I think maybe that would be the one that I would take if I had it.

Thank you very much for listening to us. Just as a wee aside, I was here for the MTS hearings as well, and I want to compliment you that this evening the environment is entirely different. I feel like I am being listened to and that other people are being listened to, and it has sort of given me confidence in the word "hearing." Thanks very much.

Mr. Chairperson: Thank you very much, Ms. Fricke, for your presentation. Are there any comments or questions of Ms. Fricke? Thank you very much.

The next person I call is Dr. Ken Brown. Dr. Ken Brown, is he not here? I call then Pat Done. Mr. Done, do you have a written presentation for the committee?

Mr. Pat Done (Private Citizen): I do not.

Mr. Chairperson: You may proceed then.

Mr. Done: I am going to make this very brief. Everyone has been so articulate before me, and I do not have the personal experiences that they have all outlined for you. My wife, who does, told me that if she had to come here before a legislative committee and a room full of people that she would probably puke, so I am going to skip all of the anecdotes, but suffice that–

Floor Comment: That is on the record. Children will be able to read that.

Mr. Done: My wife and I both support the passage of this bill, but with some trepidation. So many people have outlined all the wonderful aspects of having a home birth and a midwife, and the midwives that they have referred to have been traditional midwives trained in the traditional way. We are concerned that with the passage of this bill that the council and the committees and the college that governs midwifery practice will have the same kind of constituency that the task force group had with all compliments to them for a job well done.

I do not think that midwifery could maintain the same flavour under governance of doctors and nurses as the flavour that so many people here have attested to. So a caution from our family that midwifery should be governed by midwives. Thank you.

Mr. Chairperson: Thank you very much, Mr. Done. Are there any questions or comments?

Mr. Gerry McAlpine (Sturgeon Creek): I appreciate your comments, Mr. Done, because I had the same feeling with a previous presenter. I think that this is a piece of legislation that warrants the consideration and the power given to those who have taken part in this.

One of the things that I have noticed from the presentations is that we get the impression that this is something new; midwifery has been around for many, many years. I guess I am really pleased and satisfied and moved by the fact that we are now going to finally have some legislation that allows people to do what has been natural for thousands of years. I certainly share and I hope that we can reinforce the statement that you have made here with regard to leaving the governance with midwifery with the midwives and to keep it out of the hands of the medical profession, because it will be only a matter of time that the control will be lost and that would concern me greatly.

So I hope that this committee for many years to come will remember what you have to say here, and thank you very much for your presentation.

Mr. Done: Thank you for listening.

* (2140)

Mr. Chairperson: Are there any further comments or questions for Mr. Done? Thank you very much for your presentation, Mr. Done.

Next I call Candace Wright. Candace Wright. Not here. Linda Thiessen. Have you a presentation for distribution?

Ms. Linda Thiessen (Private Citizen): No, I am sorry, I do not.

Mr. Chairperson: Linda Thiessen, you may proceed.

Ms. Thiessen: I am speaking as a private citizen, although I did sit on the minister's working group for two years. I believe you were the Health minister then. Before I start, I just wanted to read a little bit about the history–

Mr. Chairperson: You know that you have 10 minutes.

Ms. Thiessen: This is from the Report of the Task Force on the Implementation of Midwifery in Ontario. At the back, they have a little bit about the history of midwifery in Canada, in particular, this little section is about Manitoba.

This is in regard to the College of Physicians and Surgeons trying to get rid of the midwives. This is 1895 here in Manitoba. I do not want to read too much here.

The college urged in 1895 that they conduct some prosecutions to demonstrate to the profession the need and usefulness of their existence. The college thereupon took a midwife called Mrs. Thiessen to court, and they got a conviction. As Mrs. Thiessen left the packed court room, the member of Parliament for the area, a Mr. Winkler, stepped forward and publicly handed her the money to pay the fine for her conviction. He later informed the college that he intended to bring forward a motion in Parliament to repeal the clauses forbidding medical practices without registration. There was much debate among the members of the College of Physicians on what to do about this threat. Eventually, they gave an assurance that if Mr. Winkler agreed to drop his motion, they would stop any further prosecution of Mrs. Thiessen and she could carry on with her work. Legal counsel for the college wrote to the registrar urging him to remind doctors that no professional man is supposed to have any chartered rights. The medical act is for the benefit of the public and not for that merely of the profession.

Here lay an important difficulty with the act. Although many doctors evidently believed that a restrictive medical act had protection of doctors' rights as its central function, the ostensible purpose of all the medical acts was, in fact, the protection of the public. When a midwife was taken to court, it became apparent that she was not damaging her clients. The midwifery section of the act came to be seen as irrelevant or downright mean. Prosecution of a midwife through the courts seemed only to gain public sympathy for her. During this particular trial, a defiant Mrs. Thiessen had threatened to challenge the legislation by pressing the college to give her a licence. She appears to have been in a very strong position and, politically, had she pressed her demand, Manitoba and perhaps even Ontario might have got licensed midwives, 1895. Here we are, 102 years later.

So why did she not pursue licensing? The answer is most likely that Mrs. Thiessen, like the other women who helped out at births, had no desire to form a profession. Birth was an accepted element of folk knowledge and mutual help was not separated out as an exclusive job and assignment for anyone. What caused Mrs. Thiessen to challenge the college and made her community rise up in her defence was not that she could not get credentials to be an official midwife but that the community was being interfered with at birth times. When the interference was stopped, the midwife disappeared back into her everyday life, and we hear no more about Mrs. Thiessen nor about licensing for midwives until now.

I found that quite interesting when I came across it, especially because of the name, of course. I have come here to show my support for the legalization of midwifery so that women in Manitoba will have more choices, both in their birthplace and in their caregivers. I have had seven pregnancies and a variety of experiences. My first birth was a home birth 24 years ago with a doctor who had trained in Holland, where home births were quite normal. That was because, as

one of the previous speakers had mentioned, having husbands attend births was quite unusual in those days. You had to get permission from the director of the hospital practically.

I had two subsequent hospital births, a stillbirth and a cesarean. I also had a home birth with a traditional midwife last of all, and I can say unequivocally for me that the midwifery care I received was the most satisfying. I was not treated as a walking, talking, potential risk factor.

You know that idea that when we walk out the door there is a chance we will be hit by a car or we will be killed in our cars as we drive home does not stop us from getting in our cars. Yet during care we are often treated as a risk factor as women. I feel strongly about the mind-body connection, and I feel that that fear leads to adrenalin and problems in the body. Therefore, my care with my midwife was that much more satisfying because that element was not there.

The midwifery care model stresses, as Leslie Hawkins had mentioned earlier, not only continuity of care, but the continuity of caregiver, so that when you go and have your blood test and when you go and get weighed and when you go and when you are having labour and you are labouring and after the baby is born, it is all the same person. That develops incredible communication and trust, which leads to better care.

I know that care consumers in general, not just me, are much more satisfied with caregivers who spend more time, and I am not talking about the time that you have in the waiting room. I am talking about actual time that you get with them one on one answering questions. Midwives are not second-rate caregivers with obstetricians at the top of the totem pole. Midwives offer an entirely different model of care, and I strongly support midwifery as an autonomous, self-regulating profession, as everyone else has said and as you all agree with.

I will not go on about the electronic fetal monitors and how I have a problem that they still are being used even though it has been 10 years that the information has been out that they cause problems. I urge you not to put too many restrictions on the midwives practices, as Pat Done before me has said, but rather to trust their judgment as trained, competent professionals, and I urge you to learn from the mistakes of the other provinces who have been implementing midwifery so that we do not make those same mistakes, and I urge you to safeguard home birth, although you have assured us that the legislation does not discriminate against it.

So, in conclusion, I look forward to the day that midwifery is available as an insured health care service here in Manitoba for my daughters and other women. Thank you very much.

* (2150)

Mr. Chairperson: Thank you very much for your presentation, Ms. Thiessen. Are there any questions?

Mr. Chomiak: Thank you for the presentation and the very relevant historical perspective. I wonder if you can just briefly summarize for us in the committee, because we will be going through the bill tonight, can you highlight some of the mistakes from your experience and obvious knowledge in the area that have been made in other provinces?

Ms. Thiessen: Well, probably somebody here behind me could speak more eloquently about this, but I know that in Ontario, when they started, they had the opposite problem to what we have. They had a large body of practicing, credentialed midwives and ended up having to select a very small number of them leaving--do you know the numbers, Carol?--300 applied and 70 were accepted. That left 230 women who had been practising as midwives up to that point out in the cold, never mind the people they had been serving. Now, as I said, that is not going to be a problem here. It is going to be almost the reverse.

However, I would suggest speaking to Carol. She probably has kept in touch with what is going on with the other provinces more than I have since leaving that working group.

Mr. McCrae: Before you came to the microphone, you were saying something from the back. I do not think Hansard picked it up and it might be--the Hansard for this discussion may be around for a long time, and 102 years from now somebody might want to read it.

So why do you not put on the record what it was that they may have missed a little while ago.

Ms. Thiessen: Right. My dear friend Katharine Martens, whose name appears on your list as Katherine Martines, unfortunately is in Toronto this weekend. She has just published a book which has been 10 years in the making called In Her Own Voice. She interviewed women of all ages in the Mennonite community and in their birthing experiences. These stories are just rich with the times they occurred, and it goes all the way up to the 1990s. So I just wanted to say that from her, I wish I could speak for her. I know that this is a very important issue for her and that she strongly supports the legalization of midwifery.

Mr. Chairperson: Wish "Katharine Martines" our best.

Ms. Thiessen: Thank you.

Mr. Chairperson: Would you hang on just a minute, Ms. Thiessen.

Mr. Praznik: Ms. Thiessen, I just wanted to make a comment with respect to home births and about people practising the profession. I am a former Minister of Northern Affairs, and it has always astounded me when you look at the fact that we have many, many communities in rural Manitoba, both aboriginal, Metis and European, that are small, isolated communities, and there are births that take place. There are high birth rates in many of those communities. Births take place all the time. We do not air ambulance people out. We do not have doctors in those communities, but those babies are born.

When we discussed this bill internally, and I was then Minister of Northern Affairs, I was very supportive of the work Mr. McCrae did, because I recognized that we had an urgent need. It was being filled today, but this was a way to make sure it was legal, not challengeable, et cetera, because in so many rural and northern isolated communities midwifery has been there forever, and it is a reality of life, despite what other people say.

So I just wanted to reassure you that I know how important this bill is. It is important for a lot of agendas in delivering good quality health care with options for Manitobans.

Ms. Thiessen: I agree. Actually, I should add, I worked with several of the immigrant communities and became aware of how desperate it is when you do not speak English and you go to a hospital. People can be smiling at you and with all good intentions but you do not have a clue what they are saying, and if you are in labour at the same time, how much more wonderful to be attended by someone from your own community who knows the customs and the language. Thank you.

Mr. Chairperson: Thank you very much, Ms. Thiessen, for your presentation. That concludes the list of presenters. I will call again those that were not here, and I will ask first whether there is anybody in the audience that wants to make a presentation that has not yet presented. Is there anybody here that has not presented that would like to make a presentation?

Seeing none, I will start then the–well, first of all I am going to read into the record the name and presenter of a bill or a presentation that has been passed on to us in written form and is presented by The Parkland Status of Women, a branch of the Manitoba Action Committee on the Status of Women, Box 23, Dauphin. The contact person is Rosemary Friesen, the administrative co-ordinator. Is it the will of the committee that this presentation also be recorded in the Hansard? [agreed] Thank you. The committee will show that.

I will then call the names that were not present before. Marianne and Dave Connelly, are they here? No. Sandra Delaronde and Audreen Hourie.

Mr. Praznik: Hourie. Ran in Morris, in 1986.

Mr. Chairperson: We have a person by that name. Katherine Martens, Ken Brown–I said I would repeat them. Candace Wright, and that is the last one.

That concludes the presentations. Is it the will of the committee that we proceed to clause by clause?

Mr. Praznik: Mr. Chair, I think there is a will, as you have indicated, for us to proceed clause by clause on this legislation. I think there is tremendous interest and

support for the bill. I think people would like to actually see it pass this committee here tonight.

Mr. Chair, I indicate to my critic and members of the committee that we have no amendments to this legislation that arise out of its drafting, so I have none to present, for the information of my critic.

Mr. Chairperson: What is the will of the committee then? Normally, well, I do not know if there is any normality here, but what is the will of the committee? Can we pass this clause by clause, or do you want to pass blocks of clauses?

Mr. Praznik: Blocks of clauses.

Mr. Chairperson: Is that the will of the committee?

Mr. Chomiak: Mr. Chairperson, normally, in the interests of time, I would allow us to go by blocks, but I would prefer if we do clause by clause, just so that we can flag any questions or any issues that develop during the presentation to make sure that we gather all viewpoints.

Mr. Chairperson: Thank you very much. During consideration of a bill, the preamble and the title and the table of contents are postponed until all other clauses have been considered in their proper order. Is that the will of the committee again? [agreed]

Clause 1–pass; Clause 2(1).

Mr. Chomiak: The definition and the practice of midwifery is fairly broad, and I assume that the recommendations came out of the viewpoints and out of the recommendations of the committee and/or other legislation, other jurisdictions.

Mr. Praznik: Yes, that is correct.

Mr. Chairperson: Clause 2(1)–pass.

Mr. Chomiak: Much that is contained in this act is dependent upon regulation. It is yet to be produced. Can the minister indicate what the time frame is with respect to the regulations and when we might have an opportunity to review the regulations?

Mr. Praznik: Mr. Chair, the council that is working on this is currently drafting proposed regulations. I would hope to have them early in the fall for our own internal review and I will be pleased to share them with others shortly thereafter, but I think our expectation is to be able to be in operation in the spring of next year. A lot of work has to be done in regulations, in establishing the interim college, of getting the profession up and running, the certification programs, so we are going to be on a pretty tight time frame aiming for the spring of '98.

Mr. Chomiak: We certainly support the expeditious implementation of the recommendations and the practice coming into place as soon as possible. Is the minister saying though that when the regulations are in draft form, prepared in the fall and they are internally reviewed that there will be an opportunity for obviously the council and perhaps members of the public and members of the Legislature to have a chance to view the regulations?

* (2200)

Mr. Praznik: Mr. Chair, I understand that many of the policy drafts have already been circulated. Certainly I am a great believer that before you enact this legislation or regulation, you should make sure you flag it with the committee, the people who are involved and get the feedback so when you actually put it into law you have it right. So I have no problem sharing that with a broad base, including members of the Legislature, once we have had it for some time to see it.

Mr. Chairperson: Clause 2(2)–pass; Clause 2(3). Shall the item pass?

Ms. McGifford: Several of the presenters brought up the consideration of education for midwives. I do not know if this is an appropriate point to bring it up in our discussions this evening, but I know that several presenters, especially the Women's Health Clinic and the women from MACSW, were concerned that there be a Manitoba-based midwifery education program. I wonder if the minister can respond to the possibility of that existing.

Secondly, the presenters talked about the importance of there being the availability of upgrading programs

for midwives. I wonder if the minister could talk about both those issues, which are educational issues for midwives.

Mr. Praznik: This is really the administrative work that the first appointees to the college will have to undertake. I imagine eventually we will get to the point where we will have that program in Manitoba. We are in a rush to get people accredited and in the field and working, and that college I think will have to use whatever methods work to get the profession up and running, so I am not going to be restrictive to them today with my comments.

You know, there are limited training opportunities available in the country. To some degree we are building a new profession in terms of a professional structure, and those are the kinds of responsibilities that we charged this college with. They will have to work them out, and I certainly do not want to preclude any or restrict any options for them with my remarks here tonight.

Ms. Mihychuk: No, I do not want to restrict options either. I was looking at, I was trying to ascertain as to whether there were options for the education of midwives in our province, and I understand the minister to say then that the college that is established through this act would be responsible or that would become a part of their work to establish such programs?

Mr. Praznik: Mr. Chair, the college in its work licenses the training programs. They approve the training programs, the training that is required to be licensed by their statute. So this, along with the ministry, will have to develop over the next while. What is critical for us is to have this legislation passed so we can get the body in place to be setting those standards and then administratively figuring out how we are going to meet them. So the member is jumping ahead of us a few steps. That is why we need the legislation, to get on with the next stage.

Ms. McGifford: Well, I think the minister opposite knows that members opposite are often ahead a few steps but, leaving that aside, I want to ask the minister if there is a commitment on behalf of his ministry to introduce midwifery education programs into the province of Manitoba so that midwives can receive that training in the province of Manitoba. I think somebody, one of the women in her presentation made the point that it was very important to train in the community in the province where one was working and develop a Manitoba model. So that is also part of the thought that is behind my question.

Mr. Praznik: Mr. Chair, I am not going to get into that detail tonight because, quite frankly, I do not know enough about what options are there and what is going to work and where it is going to work and where we are going to obtain the training from and what is going to work in different parts of the province. If you are in northern Manitoba it is just as easy to go to a program perhaps in Saskatoon than it is to Winnipeg. So I do not want to be restrictive. Obviously, we want to see midwives trained. We want to see them meet the requirements of the college as they are set out, and we will take what steps we can to see that happen.

I would think inevitably we are going to have that training offered within the province of Manitoba if there is a sufficient demand for it, but those are all issues in the future, and tonight to make those kind of policy statements in committee, quite frankly, I am not in a position to do it, because we do not have enough detail before even me as a minister to make those kinds of decisions. It will evolve as the demand is there and the opportunities to find trainers evolve. I think our preference, obviously, we would like to see training closer to home, but I do not know when that can happen or how that can happen. Those details we are still some ways away from working out.

Having the legislation in place is the first step. Appointing the college under the act is the next. Setting the standards and regulations of practice is the next step. Then finding the training opportunities to meet them is the one after that. So we are taking things in each piece and, to be blunt, my staff, who have been working so very hard on this, who have put all their efforts in designing this legislation, although they are aware and thinking ahead to those points, do not have all that detail together, nor could they possibly have it all together at this stage of the process for me to give you and to give members of this committee an informed opinion as to how this will evolve over the next year. So I am not going to do that, but I know we all have a preference to see training opportunities in our province.

Ms. Mihychuk: Mr. Chair, I do note that midwifery and midwifery concerns and education have been under discussion in Manitoba for several years, so I do not think it is untoward to ask the question which I asked but, leaving that aside for a minute, I wonder if the minister could then assure us that in the future there will be a commitment or he is working towards establishing training opportunities for midwives in the province of Manitoba.

Mr. Praznik: Mr. Chair, certainly I would not want to give the impression that it was wrong to ask the question. It is a perfectly logical question. I hope the member would appreciate the logic of my answer because, certainly, in asking for specific commitments, it is no doubt probably in the best interest of the profession that we have training opportunities available within the province, and that certainly is our goal.

One big factor in this will be, what is the interest? If we are only training two or three or four midwives a year, it is unlikely that one is going to have a training program in the province of Manitoba. It is likely in that case to have one training program in western Canada. We do not know that today. If we are training 20 or 30 or 40 midwives a year, it is very likely we are going to have that program.

So those are factors I cannot control, as the member appreciates. We will have to work this through step by step, but certainly if there is sufficient demand and interest, as we expect we will, and we can find the people to provide the training, which is also a critical factor, provide the training in Manitoba, and it works for the people who are interested, then that is certainly where we would want to be.

Mr. McAlpine: Just an observation. I think it is interesting that here we are talking about midwifery and natural births, and I think we have to be cognizant of the fact that there are going to be some ground-breaking experiences here, and I think that we have to allow the natural process to take place just like we expect in midwifery the natural births to occur. I think that I certainly have faith in the organizations and those people who are involved in this and have brought it along this far. So I think that we have to maybe cast the aspects of legislation to some extent aside and go with some faith with this rather than trying to legislate everything that is going to happen, including the birth of this midwifery bill. I offer those comments, and I would hope that the committee would take heed to that and allow this to proceed and have some faith with the natural process of this bill.

* (2210)

Mr. Chomiak: I can ask this under Section 51 or here because it refers to regulations, but I just want to put on the record, and I am sure the minister will, there certainly was the expectation through the bulk, in fact I would say unanimously, all of the presenters assumed that in terms of locale, home birth, of course, would be considered a normal place of practice under the regulations. Certainly I am looking for the minister's assurance of that. That certainly is the direction of the council, and I am just looking for assurance on that regard.

Mr. Praznik: I would concur, I think, listening to the presentations and the work of the committee. It is obvious that a very big part of the practice of midwifery is home birth. My comments about the North, I think, indicate very clearly in many parts of the province having a birth in a hospital is just really not a realistic option unless it is high risk, or not a practical option if you have to go out in advance, et cetera, from an isolated community. So yes, and this is why this bill is so important to us for the overall health delivery system in our province because it gives us another option to better meet the needs of women in Manitoba.

With respect to the regulations, it is my anticipation that the regulations will define the circumstances or conditions or what have you around when a home birth is appropriate as opposed to when risk factors suggest that it is not. I only say that because that becomes an extremely important issue for the liability of those who practise midwifery. I think like all professions they are looking for this body to set the standard of care by which they will practise because should something go wrong in a birth anywhere, be it a hospital, be it in a home, be it under the care of a midwife or under the care of an obstetrician, if a law case, a legal case results, a case of negligence, what the person advancing the case has to prove is the practitioner did not meet the standard of care in carrying out their practice. What is

the standard care? It will be that defined by the professional body.

So the regulations as I envision them, and I think the government envisions them, will set out the kind of standards or rules by which midwives can make those decisions about where is the most appropriate place to have a birth, when do other caregivers have to become involved on risk. In essence, it gives the guidelines or standard by which I think midwives will be protected from cases of potential law suits when they have, in fact, met the standards. So it is very important we have that in our regulation to give that comfort level to those practising, and that is what we envision those regulations to do, in essence.

Mr. Chairperson: Clause 2(3)–pass; Clause 3(1).

Mr. Chomiak: Mr. Chairperson, I just flag 3(1) and 3(2) with respect to the comments by MARN, and the minister gave assurances. It is always interesting to me that when matters come up in argument in court with respect to what legislation actually means, the judges often rule that it was the intention of the legislators to do one thing or another. I think it is fairly clear from the minister's comments and our comments here that the intention of this section is not the intention as raised by the legal counsel for MARN, and I just wanted to put that on the record.

Mr. Chairperson: Clause 3(1)–pass; Clause 3(2)–pass; Clause 4(1)–pass; Clause 4(2)–pass; Clause 5(1).

Mr. Chomiak: Just a quick question. Within what time period does the minister expect to appoint the council and what criteria is he going to use to appoint the council?

Mr. Praznik: I think the planning envisioned using the current council working on this issue, as I think the expertise is there obviously, that current council would become, in essence, the transitional council under this act and their current authorities carry on until next March. So once the bill becomes law, we can make those appointments any time thereafter.

Mr. Chairperson: Clause 5(1)–pass; Clause 5(2)–pass; Clause 5(3)–pass; Clause 5(4)–pass; Clause 5(5)–pass; Clause 5(6)–pass; Clause 6–pass; Clause 7(1)–pass; Clause 7(2)–pass; Clause 8(1)–pass; Clause 8(2)–pass; Clause 8(3)–pass; Clause 8(4)–pass; Clause 8(5).

Mr. Chomiak: We agree with respect to the establishment of standing committees–I am referring now to Clause 8(5)(b)–with reference to the minister's voiced concerns with respect to northern aboriginal communities in terms of his earlier comments. Is there already in place a standing committee, and can the minister perhaps give us some brief background on the establishment of the committee and the issues that it will be dealing with because there are a lot of issues surrounding the midwifery issue and aboriginal peoples?

Mr. Praznik: As I have indicated, one step at a time, each step in its appropriate place, not as the member for Osborne (Ms. McGifford) might want to do as jump ahead and miss a step. Once the initial legislation work was prepared, the council I understand, the advice I have been given, is now working on the next stage which is what one does after the legislation. I believe an aboriginal council is being planned and work being done on recruitment of members all ready to deal with this issue. That is very important, obviously, given its role in northern health care.

Mr. Chairperson: Clause 8(5).

Ms. McGifford: I am not sure, again, Mr. Chair, if this is the right point at which to ask this question, but several presenters were concerned about the accessibility to midwives services, that these be accessible throughout the province. I wonder if the minister can address that issue.

Mr. Praznik: First of all, this legislation is not going to order the establishment of midwives everywhere in the province. This is enabling legislation to create the governing body to govern the profession. The availability of midwifery, like any other medical profession, will depend on the number of people who are interested in the service and the willingness of people to be trained and take up the practice. I think we are all hopeful that the practice will grow in popularity and be able to support a growing number of providers, and one leads to the other. Over time, if

Manitoba women are interested in having births with midwives, this will create the demand obviously, and if people are interested in being midwives, there will be professionals to deliver the service.

I cannot predict today, nor do I think any reasonable person could predict what the demand is going to be in its entirety and the number of people who show an interest to take up the profession. Ultimately we hope that every Manitoba woman who wants to avail herself of the services of a midwife will be reasonably able to do so. There are always going to be places in the province that are smaller communities, maybe distant from centres, where there is no one who practises midwifery and is not interested in doing it that they may not be able to get that service in their own community. But that is not something government is able to control on its own. We hope that we will have very widespread coverage in the system. But as I have said, this legislation today is the establishment of that college that sets in place the legal means to enter in this profession. I can say to the member, as I look ahead to the future, I hope very much that this profession takes off and grows and expands in the province.

* (2220)

Everything we have heard tonight and everything we have seen says it is a very good option for the vast majority of women in having their births. But I say this to the member for Osborne (Ms. McGifford) tonight on the record of the House, if that, in fact, happens and if we have 2,000 or 3,000 or 4,000 births a year delivered by midwives, that is going to result somewhere in the reduction of obstetrical services, because we will not have the babies being born in hospitals. When that happens, I hope the member is not going to get up and criticize us for changes in obstetrical services because we are not seeing babies born in those hospitals. I just flag that tonight as well.

I think we both share the desire to see midwifery grow and expand and, ultimately, as it does, as Minister of Health I would rather see our dollars go to pay for the services that women are comfortable with, that they want and are able to deliver their babies in a manner that is suitable to them. I would rather spend the money there than on services that they do not want.

But please appreciate, if the profession does grow as we think it will, it will reduce the number of births in our hospitals, which will then change how we run our obstetrical programs. When that happens, I will remind the member of her support here tonight, because she will not be able to criticize the changes in the system that result from this move tonight, which I believe is a very positive one.

Ms. McGifford: I am pleased to know the minister is monitoring me so closely, and I will return the favour.

Mr. Edward Helwer (Gimli): Mr. Chairman, I wonder if you could speed the process and go page by page or all the clauses that are on that one page to speed the process up.

Mr. Chairperson: Are we agreed to that process?

Mr. Chomiak: So the suggestion is we–

Mr. Chairperson: Page by page. I will not go too fast.

Mr. Chomiak: Okay, as long as we have an opportunity to address the issues, we can move on that basis.

Mr. Chairperson: Clause 8(5)–pass; Clause 9–pass; Clause 10(1) to 10(3)–pass. Clauses 11 to Clause 12(2).

Mr. Chomiak: Mr. Chairperson, with respect to competency-based registration requirements, I know what the recommendations were of the Midwifery Implementation Council. Certainly, the presenters were under the assumption that registration as a midwife in Manitoba will include traditional practitioners as well as those educated in the system. I am just for the record querying that of the minister for assurances in that regard.

Mr. Praznik: Yes, I believe the member's question is that those who were already engaged in the practice, how they will be registered. I believe the plan is to put in place a competency program of some sort, whether it involves some education or testing or review, so that, of course, the college is not liable by licensing someone

who may be practising midwifery today who may not be able to do the job and puts the college at risk.

So, obviously, we want to recognize those who are practising. If they require upgrade or some review or some program, that is part of that whole administrative work that has to go on in the next year.

Mr. Chairperson: Clauses 11 to 12(2)–pass; Clauses 12(3) to 14(4)–pass; Clauses 14(5) to 16(2)–pass; Clauses 17 to 19(1)–pass; Clauses 19(2) to 21(3)–pass; Clauses 21(4) to 22(1)–pass; Clauses 22(2) to 23(1)–pass; Clauses 23(2) to 25(1)–pass. Clauses 25(2) to 26.

Mr. Chomiak: Mr. Chairperson, am I correct to assume from the drafters of this legislation that most of these provisions are similar to those in the other practicing acts of the other professions, most notably the recent amendments to The Medical Act, to The College of Physicians and Surgeons act? Just in general, is that correct?

Mr. Praznik: Yes, Mr. Chair, I understand they are almost identical. The only variances would be anything that fits specifically with the practice of midwifery.

Mr. Chairperson: Clauses 25(2) to 26–pass; Clauses 27(1) to 28(1)–pass; Clauses 28(2) to 32(1)–pass; Clauses 32(2) to 34(2)–pass; Clauses 34(3) to 35(4)–pass; Clauses 36(1) to 36(5)–pass; Clauses 36(6) to 39(1)–pass; Clauses 39(2) to 41–pass; Clauses 42 to 43(1)–pass; Clause 43(2)–pass; Clauses 43(3) to 44(2)–pass; Clauses 44(3) to 45(2)–pass; Clauses 45(3) to 47(2)–pass; Clauses 47(3) to 49–pass; Clause 50(1)–pass; Clauses 50(2) and 51(1)–pass; Clauses 51(2) to 52–pass; Clauses 53(1) to 54(2)–pass; Clauses 54(3) to 55(2)–pass; Clauses 56 to 58(2)–pass; Clauses 58(3) to 60–pass; Clause 61(1) to 61(5)–pass; Clauses 61(6) to 65–pass; Clauses 66 to 67(2)–pass; preamble–pass; table of contents–pass; title–pass. Bill be reported.

Committee Changes

Mr. Helwer: Mr. Chairman, I wonder if I could have leave to make a change on the committee for tomorrow morning.

Mr. Chairperson: Is there leave for committee changes for tomorrow morning? [agreed]

Mr. Helwer: I move, with leave of the committee, that the honourable member for St. Norbert (Mr. Laurendeau) replace the honourable member for Pembina (Mr. Dyck) as a member of the Standing Committee on Law Amendments effective Friday, June 13, at 10 a.m., with the understanding that the same substitution will also be moved in the House to be properly recorded in the official records of the House.

Mr. Chairperson: Agreed? [agreed]

The committee, by the way, will sit tomorrow at 10 a.m. to consider Bill 55. There will be further hearings to that bill as well as clause-by-clause consideration.

Committee rise.

COMMITTEE ROSE AT: 10:29 p.m.

WRITTEN SUBMISSIONS PRESENTED BUT NOT READ

Re: Bill 7.

I am Joyce Slater and for the recent birth of my daughter I was attended by a midwife in a hospital. My baby was in a breech position and consequently was delivered by an obstetrician with excellent technical expertise. However, while I do not doubt the dedication and sincerity of the doctor and labour and delivery staff, I found their views on birth to be vastly different from the views of my midwife. The view of the hospital staff appeared to reflect the rigid protocol of the institution in which they worked while those of the midwife were much less controlling and appreciative of individual circumstances.

During my three-day tenure as a maternity patient, I experienced the authority of the medical bureaucracy–I saw too much power concentrated in one individual, the obstetrician; I saw nursing staff afraid of doctors, therefore unable to advocate for patients; I experienced staff with little or no training in labour coaching and breast-feeding; and I experienced a "cookbook" approach to birth which did not involve me as an active participant.

My midwife offered alternatives and choice, allowing my husband and myself to make informed decisions. She advocated for my wishes, which had been previously discussed, when I was unable to express them. During my prenatal care, she spent generous amounts of time answering my many questions, rather than the hurried five-minute "check-up" at the obstetrician's office. In fact, it was the midwife who discovered my baby to be in a breech position, not the doctor. I also credit the fact that I did not have to have a cesarean section primarily to my midwife and her sound judgment.

We live in a world of "what if" when it comes to obstetrics. "What if something goes wrong . . ." Women have been sold this fear by the medical establishment, to the extent that most believe there is only one safe choice for birth–the doctor and the hospital. Well, I would like to turn this around and ask: What if women were allowed to be active participants in their own pregnancy and delivery? What if women were given choice and empowerment during the birthing process? My experience with midwifery gave me options I would not have otherwise been given, and I believe I had a safer, healthier birth as a result. I fully support the establishment of midwives as an autonomous profession in Manitoba.

Joyce Slater
Private Citizen

* * *

The Parkland Status of Women is a branch of the Manitoba Action Committee on the Status of Women and is located in Dauphin, Manitoba. As a feminist organization, we are concerned that the legalization and the implementation of midwifery in the province of Manitoba is carried out in a way that supports women's choices and provides for equitable birthing options for women and their families.

We, at the Parkland Status of Women, support the Midwifery Implementation Council's recommendations to your government. The Midwifery Implementation Council's approach to midwifery show a respect for the needs of women and the need of midwives. Should their recommendations be accepted, we feel Manitoba will be well on its way to providing a safe and comprehensive service to Manitoba women.

We are pleased to see that provisions have been made for the establishment of a governing body of midwives to oversee this profession. The College of Midwives is necessary in establishing autonomy within the profession of midwifery. Midwives are best qualified to govern themselves as they cannot be seen as an extension of the medical model. Birth is a normal life experience, and although there will be some exceptions, it is midwives who are the experts in the "normal" and it is up to them to identify boundaries, limitations and skills assessments of those individuals who will work in the field of midwifery and call themselves midwives. We concur with the recommendations that midwifery be an autonomous profession.

Midwifery in this province has existed for many years and has proven itself to be in demand insofar as it has been available. For women who did not live close to a midwife or who could not find one in their area, this often meant disappointment and frustration. Now, as women begin to see the government move towards the legislation of midwifery and the forthcoming certification of midwives, it is extremely important to provide rural women with the same opportunities to access as those who live in the cities. Accessibility to midwives must be available simultaneously in both rural and city communities. As demand for midwifery service increases with the city limits, special provisions may become necessary in order to assist midwives in upgrading and practising in rural communities. Those provisions should include community education, midwifery friendly hospitals, and job sharing within close catchment areas.

Other provinces which have already regulated midwifery or implemented midwifery services have admitted to problems which impeded the quality of service that was available. In particular, the province of Ontario was unsuccessful in certifying adequate numbers of midwives to meet demand. We stress the importance of providing rural midwives with opportunities to upgrade their education without leaving their communities. Assisting rural communities in providing upgrading skills for midwives as well as support for the implementation of midwifery services is an important necessity. Encouraging rural individuals

to pursue the profession of midwifery must be supported concurrently with opportunities to practise and be educated outside of the city.

Providing all women with access to midwives, as their primary caregivers, will certainly require the government to include midwifery care as an insured, core service. All women who request this type of care must have access to it regardless of their income level. The experience of birth and empowerment through birth is not to be measured in dollars and cents. Healthy, confident mothers and families are often the result of midwifery care. Women are seeking more support and assurance in their lives as birthing mothers and primary caregivers for their family. Birth as a normal life event for women has transformed women's lives and strengthened countless families. Certainly, no one should be denied this experience because of monetary reasons. However, it should be noted that midwifery care will save the health care system a great deal of money.

One of the most contentious issues for many is the issue of a woman's right to where she will birth, with home birth included as one of the options. As a cornerstone in the strength of this legislation, place of birth, including home birth, protects and promotes women's personal choices. Making sure this choice is available for women must be a priority in this legislation. Midwifery without personal choice restricts a woman's opportunity to accept responsibility, impedes her intuition, has the potential to depress the experience of personal empowerment and may create hostilities. I am personally convinced of the need to provide women with a variety of birth settings, including home birth. As a home birth parent of five children, I cannot conceive of a midwifery service void of this option. Additionally, as was stated earlier, the experience of birth has a far-reaching effect for the entire family. When midwives begin to practise in a variety of settings, it will be important to provide different settings for different women. Ideally many women may choose environments such as alternative birthing centres and clinics as they make the transition from the hospital model of care to the midwifery model of care.

Still unresolved is the amalgamation of traditional midwifery with certified midwifery and the consequences and/or benefits that are inherent in this change. There are a lot of concerns that traditional midwifery as we know it will not be recognized, nor allowed to continue under the auspices of the certified program of midwifery. Some of our concerns include: Will there be provisions for alternative forms of treatment between midwife and birthing mother? Will midwives be given ample time to create meaningful trust relationships with their clients? Will midwives be welcome to practise as they have been without obligation to embrace and/or provide medical procedures, such as the use of Dopplers or the use of drugs and other medical interventions? Will they be pressured to adopt these and other measures because of their challenging role of helping birthing women both in and out of the hospital? Many traditional midwives have viewed their intuition and instinct as having an essential bearing in the art of midwifery. Will there be provisions for them to continue in this manner? Traditional midwives have an inherent knowing of birth as a natural life event. They should not be forced into a role of medicalized intervention.

In closing, we urge this government to consider these crucial issues and include the recommendations as they have been put forward by the Midwifery Implementation Council. We applaud the government of Manitoba in seeking to decriminalize and implement midwifery in the province. Women who help future parents discover their own resources both before birth and after are making a tremendous contribution to our communities and our future. These women are midwives and they deserve to be recognized, encouraged and listened to.

Rosemary Friesen, Administrative Co-ordinator
Parkland Status of Women, Branch of the Manitoba Action Committee on the Status of Women Dauphin, Manitoba

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Submission of The College of Physicians and Surgeons of Manitoba re: Bill 7, The Midwifery and Consequential Amendments Act

Home Birth: Bill 7 does not specify site of delivery, however, previous discussions with the Midwifery Implementation Council (MIC) and a review of the proposed guidelines for home birth indicates the MIC's

intent to support the option of home birth. The MIC is aware that the College of Physicians and Surgeons remains opposed to planned home deliveries. There is no way to predict a low-risk delivery until after the delivery is over, thus planned home delivery potentially puts both the mother and the infant at unnecessary risk. As well, the geographical, environmental and resource situation in Manitoba, including rapid emergency transportation, are unsuited to planned home deliveries. The MIC repeatedly compares Manitoba to the Netherlands and other high population density countries of Europe, which MIC claims supports the "safety" of home births, a comparison which is entirely inappropriate and illogical. Currently, the best place to manage all untoward situations is the hospital or birthing centre setting. Quebec, which is a more appropriate analogy to Manitoba, plans to limit the practice of midwifery to a hospital setting and prohibits planned home births by midwives (copy of draft legislation attached).

It is respectfully submitted that Bill 7 prohibit home delivery and restrict deliveries to centres wherein the most optimal care can be given.

Section 2(3) Midwife as primary health care provider: Section 2(3)(c) specifies consultation for "conditions that arise during pregnancy." This provision should be expanded to include conditions of the newborn up to six weeks of age.

Section 4(1) Representation as a midwife: The term midwifery should not be exclusive to registered midwives as many physicians were originally licensed to practise medicine, surgery and midwifery and should be able to display the certificates of registration that were issued by the College of Physicians and Surgeons of Manitoba without fear of being charged with practising midwifery without a licence by the College of Midwives.

Regulations to The Midwifery Act: The College of Physicians and Surgeons has not had the opportunity to review the final version of the proposed regulations, and therefore we wish to reiterate our concerns:

(1) Accreditation: Many of our concerns relate to the lack of definition of the specifics of the training program/accreditation process. For example, Bill 7 allows a midwife to provide care for an infant up to six weeks of age. Who will be training midwives to care for infants, especially with respect to the recognition of important neonatal conditions? How will their knowledge of pediatric medicine be assessed and by whom?

(2) Guidelines for discussion, consultation and transfer: The list of criteria for mandatory consultation is inadequate in that it fails to deal with pre-existing medical conditions. Schedule I(A) of the Quebec "Draft Regulation" is an example of a more comprehensive list. In addition, consultation should be mandatory if there is a history of one previous cesarean section, rather than the criteria of "> 1 lower segment cesarean section" as stated in the draft guidelines (refer to Quebec Schedule I(B)).

(3) Site of birth: The Midwifery Act should restrict practice to approved settings which by regulation should be defined to be hospital or approved birthing centre (previously outlined on page 1).

All of which is respectfully submitted.

Kenneth R. Brown, M.D., Registrar
College of Physicians and Surgeons of Manitoba

Draft Regulation
Medical Act
(R.S.Q., c. M9)

Professional Code
(R.S.Q., c. C-26)

Physicians
Rules respecting study and practice of obstetrics by midwives

Notice is hereby given, in accordance with sections 10 and 11 of the Regulations Act (R.S.Q., c. R-18.1), that the Bureau of the Collège des médecins du Québec made the "Regulation on Rules respecting study and practice of obstetrics by midwives," the text of which appears below.

Pursuant to Section 95 of the Professional Code, this regulation will be examined by the Office des professions du Québec. Thereafter, it shall be

submitted, with the recommendation of the office, to the government which may approve it with or without amendment, upon the expiry of 45 days following this publication.

According to the college, the purpose of this regulation is "to set the standards of training and criteria of practice of obstetrics by midwives in a hospital with a view of encouraging a co-operation between midwives and other health care providers, notably: family physicians, obstetricians-gynecologists, pediatricians, to eventually allow the integration of the practice of midwifery in hospital settings."

Also according to the college, "for the public, this regulation will help assure the pregnant woman and her surrounding the availability of a secure delivery in hospital by a professional of her choice. Also this regulation will enable the midwife to obtain the co-operation and consultation with physicians and will integrate the midwife in a perinatal team working in an establishment and will assure her also an autonomous practice of normal obstetrics. This draft regulation has no impact on small or mid-size businesses or others."

Further information may be obtained from Dr. Adrien Dandavino, director of the Medical Education Department, Collège des médecins du Québec, 2170 boulevard René-Lévesque Ouest, Montréal (Québec) H3H 2T8: telephone number : (514) 933-4441, extension 302; fax number (514) 933-3112.

Any person having comments to make is asked to send them, before the expiry of the 45-day period, to the Chairman of the Office des professions du Québec complexe de la Place-Jacques-Cartier, 320, rue Saint Joseph Est, l'étage, Québec (Québec), G1K 8G5. These comments will be forwarded by the office to the Minister responsible for the administration of legislation concerning the professions. They may also be forwarded to the professional order that made the regulation, that is to say the Collège des médecins du Québec, as well as the persons, departments and agencies concerned.

Robert Diamant
Chairman of the Office
des professions du Québec

Regulation on Rules respecting study and practice of obstetrics by midwives

Medical Act
(R.S.Q., c M-9.s.19, 1 par., subpar. a)

Section I. Standards of Competence

1.01 The practice of obstetrics by a midwife in general and specialized hospital ("hospital centre") conditional to, notably, the obtention of a university midwifery diploma issued by a school of midwifery approved by the "Ministère de l'Éducation."

A school of midwifery is accredited by the "Collège des médecins du Québec" insofar as the training programme leading to the obtention of a university diploma has a minimal duration of 36 months and includes:

1) theoretical and practical courses as described in Schedule III;
2) clinical training periods in a hospital setting; and
3) examinations;

the whole allowing the holder of this diploma:

a) to inform and advise in the field of family planning;

b) to diagnose pregnancy, to monitor normal pregnancy and to conduct the necessary examinations during the development of a normal pregnancy;

c) to counsel and to have carried out or to recommend the necessary examinations for the early diagnosis of risk-prone pregnancies and of genetic anomalies respecting established guidelines;

d) to advise in the matter of lifestyle, of prenatal risks, in particular concerning various agents and environmental factors and to insure complete preparation for delivery, notably, concerning psychological, physical and sociocultural aspects;

e) to transfer the responsibility, if the case arises, to a family physician, to an obstetrician-gynecologist or to a pediatrician, according to the standards of care of the hospital centre if the pregnancy or the newborn present

a particular risk, as defined by the regulation respecting obstetrical and neonatal risks in Schedule I and Schedule II; and to co-operate with the attending physician to insure an appropriate follow-up of the mother and the child, notably, from a psychosocial standpoint;

f) to conduct a normal delivery in the hospital centre of a vertex presentation, including, if necessary, an episiotomy and, in an emergency situation, to conduct the delivery of a breech presentation;

g) to examine and to take care of the newborn and to take all measures if need be and, if the case arises, to perform immediate resuscitation;

h) to provide appropriate care to the mother, to assess normal postpartum progress, to counsel regarding the best care of the newborn;

i) to provide care as prescribed by physicians;

j) to draw up the written reports inherent to the practice using the forms approved by the hospital centre, particularly the common provincial obstetrical chart;

k) to administer or to prescribe substances or drugs according to a list approved by the hospital centre;

l) to provide the usual care to the newborn on the condition that he is examined by a physician within the first 24 hours.

2.01 Among activities listed under Section 1.01, only the conduct of a normal delivery, the initial examination of the newborn and the administration of medication and substances, must be done in a hospital centre.

Section II. Standards of Training

3.01 A candidate for the practice of obstetrics by midwives must:

a) have a university training given by a school of midwifery approved by the "Ministère de l'Éducation du Québec" and the "Collège des médecins du Québec";

b) obtain such a midwifery diploma after a teaching programme, a clinical training in a hospital centre and an examination leading to an accredited university diploma in midwifery, the whole not less than 36 months duration;

c) succeed the examination required by the "Collège des médecins du Québec";

d) hold the status of permanent resident and have an adequate knowledge of the French language as defined by the "Office de la langue française";

e) abide by the rules of the Code of Ethics of physicians applicable to the practice of obstetrics by midwives.

3.02 The examination required from a candidate includes the following methods of evaluation: written, oral (clinical), practical.

3.03 This examination must include the following subjects as defined in Schedule III:

a) general subjects;

b) thorough knowledge of specific subjects relating to activities of midwifery;

c) mastering of practical and clinical components;

d) legislative, ethical and organizational aspects of the practice of obstetrics by midwives.

3.04 To be eligible for the examination, a candidate must hold a diploma issued by a school of midwifery recognized in accordance with paragraph a of section 3.01 or have successfully completed an equivalent training.

3.05 The candidate who holds a diploma issued by a school of midwifery situated outside Québec and recognized by the International Confederation of Midwives and by the World Health Organization (WHO) may obtain an equivalence for this training making him eligible for the required examination, if it is in accordance with paragraph b of article 3.01 of the present regulation and if the training has been satisfactorily completed.

Schedule I Obstetrical Risks

A) Diseases which may adversely influence the present pregnancy or delivery:

1. active tuberculosis;
2. anomalies of coagulation or thrombocytopenia;
3. diseases of the urinary tract;
4. high blood pressure;
5. insulin-dependant diabetes;
6. Addison's disease;
7. Cushing's disease;
8. Crohn's disease;
9. ulcerative colitis;
10. hyperthyroidism;
11. cervix amputation, conisation, uterus malformations;
12. submucosal myomectomy;
13. myomectomy of an intramural or interstitial myoma;
14. surgery of a perineal fistula;
15. anemia HB less than 100 g/liter, resistant to treatment;
16. cardiopathies;
17. previous history of thromboembolism;
18. respiratory insufficiency;
19. collagen diseases;
20. hepatic diseases;
21. neuromuscular diseases;
22. psychiatric diseases;
23. during pregnancy, seroconversion for the following infectious diseases: toxoplasmosis, rubella, cytomegalovirus and herpes;
24. seropositivity for HIV and HbSAg;
25. sexually transmissible diseases: gonorrhea, syphilis, chlamydia;
26. cancer;
27. subarachnoid hemmorrhage;
28. multiple sclerosis.

B) Risks related to obstetrical antecedents or gravidic pathology:

1. Rh incompatibility, platelet incompatibility, presence of immune antibodies;
2. cervical incompetence without previous history of normal delivery;
3. premature separation of a normally inserted placenta;
4. previous cesarean section without vaginal delivery after cesarean section;
5. shoulder dystocia;
6. child with an intrauterine growth retardation (>97" percentile) according to USHER's curve at the previous delivery.

C) Risks related to a disease occurring during the present pregnancy:

1. intake by the mother, during pregnancy, of medication, drugs or alcohol, having potential consequences on the fetus and the newborn;
2. gestational diabetes;
3. isoimmunization;
4. bleeding after 20 weeks of pregnancy;
5. threat of premature labour or cervical incompetence;
6. any anomaly described at echography;
7. hyperemesis gravidarum;
8. suspicion of an extrauterine pregnancy.

D) Diseases related to delivery:

1. signs of fetal distress;
2. premature rupture of membranes from 12 hours to 24 hours, without uterine contraction in a term pregnancy;
3. suspicion of chorioamniotis;
4. arrest of cervical dilatation;
5. arrest of fetal descent at delivery;
6. unusual blood losses during labour;
7. premature separation of a normally inserted placenta;
8. perception of a vessel on vaginal examination;
9. prolapse of umbilical cord;
10. placenta praevia;
11. 3" or 4" degree perineal laceration.

E) Postpartum diseases:

1. vulvar hematoma leading to voiding difficulty;
2. abscess of the perineal wound;
3. urinary retention;
4. severe infection;
5. puerperal psychosis;
6. phlebitis and risks of thromboembolism;
7. symptomatic anemia;
8. immediate or late postpartum hemorrhage;
9. retention of placenta during more than one hour;

10. suspicion of uterine rupture;
11. uterine inversion;
12. suspicion of partial retention of placenta;
13. subinvolution of the uterus resistant to treatment.

Annex II Neonatal Risks

1. a) APGAR ,<5, at one minute
   b) APGAR <7, at five minutes
   c) APGAR <9, at 10 minutes
2. newborn who had to be resuscitated: mask ventilation or tracheal intubation;
3. respiratory distress: inspiratory recession of the chest wall or tachypnea at 60/min or flaring of the nasal alae or grunting or apnea of more than 15 seconds duration;
4. central cyanosis;
5. persistent pallor > 60 minutes;
6. abnormal tears or cries;
7. jaundice in the first 24 hours of life;
8. jaundice requiring phototherapy according to the more recent criterions as defined by the Canadian Society of Pediatrics;
9. lasting jaundice > 14 days of life;
10. abnormal pigmentation;
11. generalized ecchymoses or petechiae;
12. single umbilical artery;
13. lethargy or hypotonia;
14. irritability or hypertonia;
15. intake by the mother, during pregnancy and lactation, of medication, drugs or alcohol, having potential consequences on the fetus and the newborn;
16. cardiac rhythm <100/min or >160/min;
17. obstetrical trauma;
18. anuria > 24 hours;
19. lack of passage of meconium >24 hours;
20. hypothermia or hyperthermia;
21. lasting thermic instability after 6 hours of life;
22. periumbilical crythema compatible with omphalitis;
23. rash other than neonatal crythema;
24. persistent tremor;
25. convulsions;
26. biliary vomiting;
27. diarrhea;
28. abdominal distention;
29. gastrointestinal bleeding;
30. weight loss >10 percent of the birth weight;
31. no resumption of birth weight 14 days after birth.
32. lasting strabismus;
33. bulging anterior fontanelle;
34. premature closure of sutures;
35. abnormal red ocular reflection;
36. unilateral or bilateral atresia of choanae;
37. palpable thyroid;
38. hepatomegaly > 2 cm under the costal margin;
39. palpable spleen;
40. palpable kidney;
41. abdominal mass;
42. cardiac murmur;
43. nonpalpable, weak or asymmetric femoral pulses;
44. hip instability;
45. luxable hips;
46. absence or anomaly of primitive reflexes;
47. testicular torsion or mass;
48. undescended testicle;
49. inguinal mass;
50. presence of tears during the first week of life;
51. purulent discharge from the eye with redness of the conjunctiva;
52. presence of hair at the spine level;
53. abnormal laboratory results;
54. any other neonatal disease not mentioned in this schedule, whatever the cause.

Schedule III Content of Training

A) General subjects:

Basic knowledge of:

1. anatomy and physiology;
2. general pathology;
3. bacteriology, virology, parasitology and mycology;
4. child care and pediatrics, primarily regarding the newborn growth and development;
5. hygiene, health promotion, prevention and early detection of diseases;
6. nutrition and dietetics, primarily regarding diet of the woman at all ages, of the newborn and of young babies;
7. obstetrical pharmacology and toxicology;
8. birth control and family planning;
9. ethics and professional legislation;
10. psychology and psychiatry, notably concerning familial dynamics;
11. sex education.

Basic elements of:

12. biophysics, biochemistry and radiology;
13. sociology and anthropology;
14. social and preventive health care and epidemiology;
15. research and teaching.

B) Thorough knowledge of specific courses relating to midwifery:

1. anatomy and physiology of reproduction;
2. embryology and fetal development;
3. basic genetics;
4. normal obstetrics;
5. abnormal obstetrics pathology;
6. gynecology and gynecological pathology;
7. preparation for delivery and parental role including the psychological and sociocultural aspects;
8. preparation of material for delivery, including the knowledge and use of technical equipment;
9. analgesia, anesthesia and resuscitation;
10. physiology and pathology of the newborn;
11. care and supervision of the newborn;
12. psychological, social and environmental factors relating to pregnancy;
13. basic ethics.

C) Mastering of practical and clinical components:

1. medical care procedures;
2. surgical care procedures;
3. obstetrical care procedures;
4. gynecological care procedures;
5. prenatal examination;
6. animation of sessions preparing parents for childbirth;
7. participation and advice in the area of family planning;
8. monitoring the course of normal and pathological pregnancies using all appropriate clinical procedures and examinations;
9. looking after women in labour using all appropriate clinical procedures and techniques including those favouring the process of labour and delivery;
10. normal delivery;
11. initiation of action in emergency obstetrical situations including the manual removal of placenta, internal examination of the uterus and the immediate resuscitation of the newborn;
12. undertaking of an episiotomy;
13. repairing episiotomy and 1 and 2 degree perineal lacerations;
14. examinations, care and monitoring of the normal mother and newborn;
15. care and monitoring of risk-prone women during and after delivery;
16. care and monitoring of the newborn with a pathology or requiring special care.

D) Legislative, ethical and organizational aspects of practice of obstetrics by midwives.