Towards a New Status for the Midwifery Profession in Ontario

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The approach of modern medicine to preventing and combating disease is increasingly technological and interventionist. A growing number of commentators argue that when this philosophy is applied to childbirth, which is not a disease but a normal life process, the experience can be made demeaning and even dangerous to mother and child. Midwifery, which takes an holistic approach to childbirth, offers an alternative to medical care. However, the regimes of civil and criminal liability in Ontario — as elsewhere — are hostile to the midwifery profession. In the first part of her article the author outlines the objections of the medical profession to midwifery, and challenges medicine's principal argument that midwifery is unsafe by presenting evidence to the contrary from several countries. The author then examines the legal status of midwifery in Ontario. She notes that practitioners face the preliminary obstacle that the profession is regarded anachrostically as the unlawful practice of medicine. Moreover, the standard of care applied for the purposes of criminal and civil negligence is derived almost exclusively from medical opinion, which, because of its technological bias, is inappropriate for judging the competence of midwives. The result is that midwives are deprived of the freedom to practice their profession, and individuals are deprived of the right to choose the type of prenatal care they consider desirable. The author concludes by examining and criticising recent attempts at legislative reform.

Afin de prévenir et combattre la maladie, la médecine moderne adopte une approche de plus en plus technologique et interventionniste. Or la naissance d'un enfant cst un événement naturel et non une maladie. De plus en plus d'observateurs soutiennent que lorsque l'approche médicale moderne gouverne une naissance, il en résulte une expérience dégradante, voire même dangereuse pour la mère et l'enfant. Les sages-femmes avec leur approche holistique de la naissance offrent une alternative aux soins médicaux. Cependant les régimes de responsabilité civile et criminelle, en Ontario comme ailleurs, sont hostiles à la profession de sage-femme. Dans la première partie de son article l'auteure présente les objections de la profession médicale à la pratique des sages-femmes. Elle réfute l'argument à l'effet que l'accouchement par sage-femme est dangereux en démontrant qu'un tel accouchement comporte peu de risques dans les pays où il est bien pratiqué. L'auteure étudie ensuite le statut juridique de la profession de sage-femme en Ontario et note que l'on regarde anachroniquement cette profession comme une pratique illégale de la médecine. De plus, tant pour la négligence criminelle que civile, le « standard of care » utilisé est tiré de l'opinion médicale qui, à cause de ses préjugés technologiques, est incapable de juger de la compétence des sages-femmes. Il en résulte que les sages-femmes se voient dénier le droit de pratiquer leur profession et que les futurs parents se voient dénier le droit de choisir le type de soins prénataux qu'ils croient préférables. Enfin, l'auteur examine et critique les tentatives récentes de réforme du droit en ce domaine.

Synopsis

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> *And I said of medicine, that this is an art which considers the constitution of the patient, and has principles of action and reasons in each case.*
> Plato: *Gorgias*

Introduction

Midwifery, which takes an holistic approach to childbirth, is becoming increasingly accepted as an alternative to medical delivery, which many view as excessively technological in its approach to what is essentially a natural life process. If midwifery is to be integrated into our prenatal healthcare system, the civil and criminal legal regimes which govern the practice of medicine will have to be modified to take account of the approach to practice which differentiates the midwife from the medical doctor.

In order to understand the contemporary controversy over the acceptance of midwifery in western society, the historical context of both medicine and midwifery must first be examined. That is the subject of the first part of this paper. Although such a vast subject can only be briefly canvassed here, the contrast between the ethic of the science of medicine and the ethic

of the practice of midwifery is central to an understanding of the issues involved in the movement towards alternative birthing methods. As Part II of the paper reveals, this contrast in approach has yielded different outcomes and success rates for medicine and midwifery. Part III canvasses issues of civil and criminal liability as they relate to the practice of midwifery in its present unregulated form, and discusses further issues which will arise if midwifery is legally recognised. An important focus of inquiry is the relationship between the individual's right of self-determination and the rights imputed to the foetus.

Part IV assesses the present political status of midwifery in Ontario, and proposes criteria for regulation.

I. Philosophies of Childbearing

As far as is known, the practice of midwifery,[1] meaning the assisting of a person throughout childbearing and her process of birthing a child, has existed throughout all cultures and across all times, and the profession has been almost exclusively dominated by women.[2] It was not until the twentieth century, and only in western societies, that the process of childbirth was moved to a hospital environment as a matter of course to be controlled by the practice of medicine. This transition occurred extremely quickly by historical standards. In 1900 less than 5% of births occurred in hospitals and most were attended by midwives, but by 1972 over 98% of births took place in the hospital.[3] Although the medicalization of childbirth is only a very recent phenomenon limited both in historical and cultural dimension, the predominant contemporary social presumption in North America is that pregnancy and childbirth are medical conditions that can only be appropriately and safely dealt with by qualified medical practitioners.

If one accepts, however, that pregnancy and childbirth are natural processes, as well as being psychologically, emotionally, and socially significant life occurrences, it becomes clear that the ethic of medicine as a science

[1]Interestingly, the difference in philosophy between the two disciplines is manifested in the meaning of their nominate terms. The word midwife comes from the Old English meaning "with" (mid) "woman" (wife), and is "a woman who assists women in childbirth" or who "assists in a creative process". Obstetrics, on the other hand, is "the branch of medical science concerned with childbirth and ... treating women ... in childbirth". See *Random House College Dictionary*, rev. ed. (New York: Random House Inc., 1984). Midwifery considers childbirth a creative process whereas medicine considers it a pathology to be treated.

[2]J. Litoff, *American Midwives* (London: Greenwood Press, 1978) at 3.

[3]R. Hubbard, "Legal and Policy Implications of Recent Advances in Prenatal Diagnosis and Fetal Therapy" (1982) 7 Women's Rights L.R. 201 at 202. See also D. Evenson, "Midwives: Survival of an Ancient Profession" (1982) 7 Women's Rights L.R. 313 at 315.

focussing almost singularly on biological and physiological pathology[4] is inadequate to cater to all aspects of the childbirth experience. As one obstetrician and proponent of midwifery has stated:

> Doctors are trained to look after disease, not to facilitate the normal. The continuous care a midwife delivers is something which a doctor is totally incapable of.[5]

For the medical profession, the command of an esoteric body of knowledge brings with it the power of an unquestioned control over the health of others; those outside the medical sphere (including members of the legal profession) defer to medical opinion and expertise. Simultaneously with the granting of power over health care to the medical profession, the power and autonomy of the individual over her or his physical health is lost. The patient becomes the passive object of the doctor's expertise, the physiological terrain on which the physician's work is performed. This form is manifested in the context of childbearing; the patient lies supine, possibly anaesthetized, feet in stirrups. The physician "delivers"[6] the child, and may do so by use of forceps, induction or Caesarean section. Due to the emphasis of the profession on medicine as a biological science, the physical aspect of the process in the hospital context becomes paramount, at the expense of the quality of childbirth as an emotional and psychological life experience. In contrast, the philosophy of midwifery is to recognise the significance of the experience of bringing a newly created human being into the world, and attempt a supportive rather than a usurpative approach to the birth process by assisting the individual to deliver her child instead of delivering it in her place.[7]

The transfer of the care and assistance of persons in childbirth from midwives to the medical profession has been documented to be essentially the result of an historical conflict between the two professions:

> What is so astounding about the rise of male professionals over female healers is that it was not a process which resulted from changes in medical science.

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[4]See H. Fabrega, *Disease and Social Behaviour* (Cambridge: MIT Press, 1974) at 1; L. Eisenberg & A. Kleinman, eds, "Clinical Social Science" in *The Relevance of Social Science for Medicine* (London: D. Reidel, 1981) at 1ff; R.H. Bannerman, "Traditional Medicine in Modern Health Care Services" (1980) 6 Int. Rel. 731.

[5]M. W. Enkin, as quoted in J. Powis, "The Quiet Revolution" (1981) 77:2 The Canadian Nurse 26 at 26.

[6]As one mother and lay midwife phrased it, "I *gave* birth. I wasn't delivered. The difference [is] between doing and being done to." S. Arms, *Immaculate Deception* (Boston: Houghton Mifflin Co., 1975) at 211.

[7]B.A. McCormick, "Childbearing and Nurse-Midwives: A Woman's Right to Choose" (1983) 58 N.Y. Univ. L. Rev. 661 at 668.

> Rather, it was the result of a political battle — in which the right to a medical monopoly was the prize — that was fought long before the development of modern scientific techniques.[8]

The result of this has been a legally regulated and recognised practice of medicine, but not midwifery. However, the debate between the professions of midwifery and medicine over the competence of midwives to practice has continued through to the present day. The medical community actively continues to discourage midwifery practice,[9] and as recently as 1975, the position of the American College of Obstetricians and Gynecologists on childbirth was stated as follows:

> Labor and delivery, while a physiologic process, clearly presents potential hazards to both mother and fetus before and after birth. These hazards require standards of safety which are provided in the hospital setting and cannot be matched in the home situation.[10]

In Ontario, there are presently three major factions on the issue of the appropriate mode of regulation and integration of midwives into the health care system. These are represented by the views of midwives themselves, of nurses, and of physicians. The Position Statement[11] of the College of Physicians and Surgeons of Ontario, which is primarily directed towards enunciating the duties of physicians, "discourages" their involvement in home births:

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[8]Community Task Force on Maternal and Child Health, *Childbearing Families and the Law: Midwifery Law* (Winnipeg: Community Task Force on Maternal and Child Health, 1981) at 3 [hereinafter Community Task Force]. See also Litoff, *supra*, note 2, and Evenson, *supra*, note 3. Others contend that "it is quite clear that this legislation [prohibiting midwifery] is best understood as directed to the protection of children and, to a lesser extent, their mothers and which had the ancillary effect of creating a professional monopoly... ." J.M. Eekelaar & R.W.J. Dingwall, "Some Legal Issues in Obstetric Practice" (1984) J. of Social Welfare L. 258 at 263. Apparently, however, the "protection of children" among the lower class, immigrant and rural populations was not a major concern, as the practice of midwifery among these groups has been tolerated by both the medical and legal professions throughout the 20th century. K. Yagerman, "Legitimacy for the Florida Midwife: The Midwifery Practice Act" (1982) 37 U. of Miami L. Rev. 123 at 128. Moreover, there is evidence directly supporting the "battle for monopoly" theory. For example, when the first bill to regulate midwifery in England was introduced in the legislature, several MPs opposed it, one of them explaining that "he had received representations from medical men stating that the passage of this Bill would deprive them of much legitimate practices which they at present enjoyed." See B. Cowell & D. Wainwright, *Behind the Blue Door: The History of the Royal College of Midwives 1881-1981* (London: Cassell, 1981) at 23.

[9]*Ibid.* at 221; Evenson, *supra*, note 3 at 314-15.

[10]As quoted in G.J. Annas, "Legal Aspects of Homebirths and Other Childbirth Alternatives" in D. Stewart & L. Stewart, eds, *Safe Alternatives in Childbirth* (Chapel Hill: NAPSAC, 1976) 161 at 161. See also below, text accompanying notes 87ff.

[11]College of Physicians and Surgeons of Ontario, "Out of Hospital Births — Position Statement", *College Notices*, January 1982.

> The College of Physicians and Surgeons of Ontario believes that out of hospital births should be discouraged because of the additional risks to the mother and the baby .... The risks to both the mother and the child are greatly reduced when the baby is born in a hospital .... [T]he perinatal mortality rate for home deliveries in Great Britain is more than 60% higher than the overall rate. The College firmly believes that the safeguards afforded by the hospital greatly outweigh any personal dissatisfaction with some hospital procedures.[12]

The College quotes no source in its statement for the statistics cited,[13] which are contrary to the bulk of available data on perinatal and maternal mortality rates. This data is discussed below.

The role the physicians' group proposes for midwives is a minimal one, serving only to support physician medical care in a hospital setting.

This type of system was proposed as early as 1970 by Professor R.D. Fraser in a report commissioned by the then Ontario Government Committee on the Healing Arts. The report amounts to the insulting suggestion that midwives could best be utilized as a cheap labour resource to perform the mundane procedures requiring only a marginal level of competence, in order to reduce the workload of physicians:

> [A] midwife could save two-thirds of a physician's time in examining a normally pregnant woman. This time could be increased if an obstetrician had a midwife working with him and if the midwife performed the lower-level competence services during the office visits that the doctor supervised. ... The physician usually is too busy to chat with the patient, and the patient sometimes shows a reluctance to talk freely with the physician about her problems. This is partly because he is generally a male, and partly because she feels foolish when she reveals her naivete to a person of his assumed stature. The role thus falls to other types of personnel ....
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> There is a vital gap here that could be filled by a midwife ....[14]

After analyzing certain statistics, Frazer concludes that tremendous savings would accrue if a midwife were paid approximately one third of a physician's salary and performed services requiring a lower level of com-

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[12]*Ibid.*

[13]Interestingly, the College stated that "[t]he data contained in this policy statement was provided to the College on a confidential basis by the Royal College of Physicians and Surgeons of Great Britain." Jane Ross, Executive Assistant to the Registrar of the College of Physicians and Surgeons of Ontario, in a letter to the author dated 22 March 1985. This author can perceive no rationale for applying the concept of "confidentiality" to what are presumably objective statistics. On the contrary, it is accepted practice in the scientific community that the legitimacy of statistical evidence and conclusions drawn therefrom arises from *disclosure* of the sources of data and methods used to compile them. One can only conclude that where this objective information is subjectively kept "confidential", the legitimacy of the evidence is at least questionable. See further, *infra*, note 59 and accompanying text.

[14]R.D. Fraser, *Selected Economic Aspects of the Health Care Sector in Ontario* (Toronto: Queen's Printer, 1970) c. 8 at 174ff.

petence, such as taking the mother's height, weight, temperature and blood pressure, and standing by during the period of labour, which can last as long as eighteen hours or more.

Clearly the "vital" role of "chatting" with the expectant mother throughout her pregnancy and sitting with her during hospital labour at one third a physician's salary would satisfy the interests of neither mothers nor midwives. The view that midwives should hold only a minor supportive role as determined by and under the supervision of a physician is prevalent throughout the medical profession. This model does not account for midwives' legitimate interest in practicing as a skilled profession, and fails to deal with the range of problems inherent in physician and hospital care that are the concern of those who would prefer to elect midwifery care.[15]

The second model is that proposed by the nursing profession. The position of the College of Nurses of Ontario was recently stated as follows:

> The College's present position is that midwifery should be recognized as a health care specialty based on nursing preparation, with additional formal training in maternity and infant care .... The nurse midwife would collaborate with physicians and other health care professionals.[16]

There are several problems with this system that have been revealed by the experience of the United States, where nurse-midwifery is the predominant form of regulated midwifery.[17] Most states have legislated significant restrictions on nurse-midwives practicing in accordance with the ethic of midwifery, such as a prohibition on attending home births, a requirement of physician supervision, and either a restriction of nurse-midwifery care to the hospital setting or denial of hospital admitting privileges for nurse-midwives.[18] These restrictions on midwifery practice can have further ramifications. In some states where midwifery was legalized only in the hospital setting, people have defied the law and turned to lay midwives for service at home births. On the other hand, *denial* of hospital privileges to nurse-midwives has also given rise to conflict, and there has been at least one successful antitrust action by nurse-midwives on this basis against a hospital in the U.S.[19] Nor have pressures on doctors not to col-

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[15]See below, part II.

[16]"Midwifery Gives Birth to Many Issues" (1985) 10 College of Nurses of Ontario Communique 1 at 1.

[17]Although the American statutes regarding midwifery and practice of medicine vary from state to state, most require midwives to hold a degree in nursing and a diploma from a college for nurse-midwives, to pass an examination and be licensed or certified, generally with the American College of Nurse-Midwives.

[18]See McCormick, *supra*, note 7 at 705.

[19]*Nurse Midwifery Associates* v. *Hibbett*, 549 F.Supp. 1185 (D.Tenn. 1982).

laborate with nurse-midwives or to perform home births ceased following the institution of regulated midwifery.[20]

> Many doctors ... feel constrained by threats to their malpractice insurance; there is also pressure from disapproving peers. In truth, most malpractice insurers will not cover a physician who assists at home births, and some physicians have lost their hospital admission privileges through participation in home births.[21]

These conflicts reveal the unworkability of forced collaborative practice when hospitals or physicians are given the last word.

Although the College of Nurses of Ontario would accept out-of-hospital births, it believes that these should be allowed only for "low-risk" individuals in "birthing centres" staffed by both nurses and physicians, and like the College of Physicians and Surgeons it too discourages home birth.[22] Thus despite the fact that home birth has been shown to be beneficial for normal childbirth, this option would be precluded if midwifery were made a nursing specialty, since nurse-midwives do not approve of home births.[23] Furthermore, a "birthing centre" staffed with physicians and nurses would hardly fulfill the ethic of midwifery, and smacks suspiciously of being a euphemism for what is really another form of regular hospital care. As Evenson describes the practises of nurse-midwives in such birthing centres in the United States,

> one of the distinguishing characteristics of the nurse-midwife is that, unlike lay midwives, she is institution-oriented by training and thus pathology-oriented, making her more disposed toward medical intervention. But even if she were not, institutional directives leave her little room to exercise her own best judgement in individual cases ... despite statistical evidence that well over 70% of all births involving healthy women will not require medical intervention of any kind, birthing centres frequently screen out as many as half of those women who apply, and a third of those who are initially accepted.[24]

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[20]The American College of Obstetricians and Gynecologists has asserted that home birth is tantamount to "child abuse", and has called on all physicians to deliver more babies in order to stop the growth of nurse-midwifery practice. See Evenson, *supra*, note 3 at 324.

[21]R.G. Devries, *Regulating Birth: Midwives, Medicine and the Law* (Philadelphia: Temple University Press, 1985) at 49.

[22]College of Nurses of Ontario, "Guidelines For Registered Nurses Providing Care to Individuals and Families Seeking Alternatives to Childbirth in a Hospital Setting" (November 1983) at 3.

[23]The American College of Nurse-Midwives has also taken a formal position against home births. See M.F. Forrest, "Natural Childbirth: Rights and Liabilities of the Parties" (1978-79) 17 J. Fam. L. 309 at 330.

[24]Evenson, *supra*, note 3 at 323. Devries confirms that the establishment of close institutional relationships with medical personnel alters the midwife's style of practice, and several studies "document that the formal ties between doctor and midwife necessitated by licensure result in the more frequent resort to physician assistance by midwives." Devries, *supra*, note 21 at 107 and 111.

Finally, the third approach to the regulation of midwifery is that taken by the Ontario Midwives Coalition (now the Ontario Association of Midwives) in support of a profession of "direct-entry midwifery,"[25] whereby an individual may be directly trained as a midwife without specifically having been trained in nursing or medicine. The proposal is generally one for three to four years training and education, and there is good reason to expect that this should be sufficient for independent practice.[26] Certainly a comparison to medical training makes any contention that such training be required for childbirth attendants seem unwarranted, in view of the following observation:

> Any physician may attend a birth. Students in California medical schools, however, receive only three to nine weeks obstetrical training, and it is possible to graduate from medical school without any clinical training in obstetrics.
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> ....
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> Most lectures received by the medical students were on complications in birth and how to treat them .... The medical students received only one lecture on the conduct of normal pregnancy....[27]

The recommendations of the Ontario Association of Midwives[28] set out comprehensive means of ensuring ongoing education and competence in the profession, and even include an "Informed Choice Agreement" for mothers selecting midwifery services.[29] The proposal describes a three year course of education, encompassing such diverse subjects as biology, caring, counselling, psychology, communication, cultural values, client education, sociology and environment. This reflects a multifaceted theory of health care, as an art, a science and a social phenomenon. Completion of the course of study would yield "a diploma or degree through a course of instruction in an accredited school of midwifery as approved by the College of Mid-

[25]Ontario midwives favour the use of this terminology rather than that of "lay midwifery" to avoid negative connotations associated with the latter, which may imply an untrained, non-specialist individual.

[26]See Evenson's comparison of direct entry and nurse midwifery training, *supra*, note 3 at 314.

[27]J.J. Tachera, "A 'Birth Right': Home Births, Midwives, and the Right to Privacy" (1980) 12 Pacific L.J. 97 at 113-14. In Ontario, students in their last year of medical school get four weeks rotation in each area as a "clinical clerk" in which they would get exposure to a delivery room but would not perform a delivery. Beyond this, exposure depends on where the student desires to specialise. Those specialising in family practice get four weeks further exposure during internship and another eight during residency. Women's College Hospital in Toronto has proposed to increase this amount in 1987 to twelve weeks. Again, however, *any* physician is legally "qualified" to attend a birth. This seems particularly unwarranted when compared to the extensive education midwives undergo.

[28]The proposals were communicated to the Ontario Legislature in submission to the Health Professions Legislation Review Committee. See below, text accompanying note 149.

[29]Midwives Coalition, Third Brief to the Committee (October, 1985) Appendix 6.

wives."[30] The group also proposes a mandatory refresher course and examination for those members who have not practiced in at least five years, and every one to three years a member must furnish proof of continuing education. The conduct of the profession would be overseen by a College of Midwives, independent of the medical profession.

The Association also proposes that midwives be responsible for the screening of clients for risk factors and physician referral, under a complex five-level set of screening standards now in use. The system requires consultation with other professionals when certain indicators are present:

> [R]isk level "5" is "high risk" and requires specialist attention, while risk levels 1-4 require differing levels of monitoring and assessment in accord with other risk factors. Under OAM standards additive risk assessments over 3 require consultation with peers.[31]

In the result, although the one point of agreement among the three opposing camps in Ontario is that midwifery should be regulated by some standard, each group desires a professional monopoly over normal pregnancy and childbirth care, and their views as to the extent and nature of the education desirable differ accordingly.

II. The Case For Midwifery

A. Midwives and Doctors

In recent years, much statistical research has been undertaken, by those both within and without the medical profession, to determine the relative competence of midwives and physicians, and the value and efficacy of obstetric practices and techniques. The compiled statistical data[32] assessing relative success are based primarily on maternal mortality rates and perinatal prematurity and mortality rates, and are resolved overwhelmingly in favour of midwifery practice,[33] since such rates have been shown to be either comparable for both professions or lower for midwives. In countries where midwifery is extensively used, perinatal mortality rates have been better than for countries relying more heavily on physician and hospital births.

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[30]Ontario Association of Midwives, First Brief to the Committee (December 1983).

[31]Midwives Coalition, Second Brief to the Committee (June 1984) at 39. See pages 36-41 for an outline of the standards used. There are a total of twenty-five categories of grouped risk factors; five levels for each of five stages of care, i.e. historical risk, prenatal risk, labour and delivery risks, postpartum maternal risks and postpartum risks to the child.

[32]The bulk of data has been obtained since the 1960s, after the revival of midwifery practice in the form of the profession of nurse-midwifery, and thus is not necessarily restricted to lay midwifery practice.

[33]Evenson, *supra*, note 3 at 315.

For example, a 1973 study in Holland, where midwives attended 37% of all births and 67% of home births (which constituted over half of all births), the infant mortality rate was the third lowest worldwide at 1.15%, whereas that of the United States, a country with one of the most sophisticated and advanced levels of medical technology, was 1.77%.[34] Several comparative studies within the United States have yielded similar results.[35] This statistical evidence may be legitimately questioned[36] on the ground that midwives generally attend normal low-risk births and refer cases with complications to qualified medical practitioners, both as a matter of general practice among lay midwives and as a matter of legislative requirement for nurse-midwives. The fact that physicians and hospitals are dealing with a greater proportion of higher risk births may adversely affect their success rate. However, results are comparable for all studies undertaken, and there is little or no conflicting data. Furthermore, most such studies were performed by the medical profession itself so there can be little allegation of bias. Most importantly, other studies that control for these risk factors have revealed the same or better outcomes, favouring midwifery practice.

The studies which best illustrate the favourable outcomes produced by midwifery are those involving the institution of midwifery programs in circumstances previously dominated by physicians. The most compelling evidence for the effectiveness of midwives arose from two studies of the temporary introduction of a midwifery program in a California hospital for the years 1960 through 1963 to relieve a medical manpower shortage.[37] The neonatal mortality rate which for 1959 had run at 2.39%, fell to 1.03% during the program. When obstetrician manpower increased, the California Medical Association succeeded in terminating the program. After reinstitution of obstetrical care, the neonatal mortality rate rose to 3.21%, more than triple the rate of that under midwifery care. Similarly, the 11% prematurity

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[34]Tachera, *supra*, note 27 at 101.

[35]The results of many of these studies are reviewed in the literature. See, *e.g.*, H.M. Caldwell, "*Bowland* v. *Municipal Court* Revisited: A Defense Perspective on Unlicensed Midwife Practice in California" (1983) 15 Pac. L.J. 19 at 25; S. Tom, "Nurse-Midwifery: A Developing Profession" (1982) 10 Law, Med. & Health Care 262; Tachera, *supra*, note 27 at 100; G.A. Hoff & L.J. Schneiderman, "Having Babies at Home: Is it Safe: Is it Ethical?" (1985) 15 Hastings Ctr. Rep. 6:19 at 6:20.

[36]C. Slome *et al.*, "Effectiveness of Nurse-midwives: A Prospective Evaluation Study" (1976) 124 Am. J. of Obs. & Gyn. 177 at 178.

[37]T.A. Montgomery, "A Case for Nurse-Midwives" (1969) 105 Am. J. of Obs. & Gyn. 309; B.S. Levy, F.S. Wilkinson & W.M. Marine, "Reducing Neonatal Mortality Rate with Nurse-Midwives" (1971) 109 Am. J. of Obs. & Gyn. 50. See also Caldwell, *supra*, note 35 at 26.

rate fell to 6.4% during the midwifery program, and rose again to 9.8% after its termination.[38]

A review of the available data makes it clear that midwifery is not only an adequate method of birth care, but is arguably a safer and more effective form of care for normal childbirth than is standard physician care. It will be seen that the statistical evidence that supports this conclusion can be a useful tool before forums such as courts and the legislature in the process of legitimizing midwifery in the legal context.

B. Home Birth and Hospital Birth

In addition to general statistical evidence supporting the benefits of midwifery care, there is significant evidence regarding specific hospital practices that leads compellingly to the view that midwifery is a preferable form of care, and that hospital care is in fact a poorly adapted means of dealing with normal childbirth.

From its inception, the practice of dealing with childbirth as a matter of medical specialization has produced a range of iatrogenic problems. It was not until the latter part of the nineteenth century that antisepsis was discovered[39] and thus that the practice of treating various patients in succession had contributed to maternal and infant infection, and was largely the cause of the rampant epidemic of puerperal fever which existed throughout that century.[40] It has been observed that even today institutional obstetric care can contribute to increased rates of maternal and infant infection,[41] due to the high bacteria level present in hospitals. In contrast, home births are less likely to result in infection because mothers have developed immunity to bacteria in their homes.[42]

The development of sophisticated technology in obstetrics has also contributed to increased complications. Even such simple hospital practices as the invariable use of the supine position (sometimes with the demeaning device of arm straps) are inapposite to childbirth. Other positions are more

[38]Dempkowski, "Future Prospects of Midwifery in the United States" (1982) 27 J. of Nurse-Midwifery 9; see also J. Widhalm Doyle, "Midwifing the Addescents at Lincoln Hospital" (1979) 24:4 J. of Nurse-Midwifery 27; and similar additional studies reviewed in Slome, *supra*, note 36; Tom, *supra*, note 35; Evenson, *supra*, note 3; Levy, Wilkinson & Marine, *supra*, note 37; Montgomery, *supra*, note 37.

[39]This occurred through application of the work of Louis Pasteur and Joseph Lister to obstetrics. See Litoff, *supra*, note 2 at 19.

[40]Hubbard, *supra*, note 3 at 206.

[41]Caldwell, *supra*, note 35 at 24. Caldwell cites two studies, one indicating infection rates to be four times higher in the hospital than at home, the other showing that infection rates for obstetric surgery actually increased by 26 for the period of 1975 to 1978.

[42]Tachera, *supra*, note 27 at 102.

conducive to effective use of the abdominal muscles, and throughout most of the world a crouching position is most commonly adopted for delivery.[43] In addition, the hospital practice of requiring bed confinement during labour has adverse physiological effects, including increased need for medication, prolongation of labour and increased abnormal foetal heart rates.[44]

While more interventionist obstetric procedures such as the use of forceps, drugs, episiotomies and Caesareans can be beneficial when used where necessary, they also carry inherent risks of damage. Persuasive evidence has recently been adduced showing that such techniques are overused and in large measure unnecessary, particularly for normal births.[45] Time constraints and the issue of allocation of hospital resources mean that labour may be induced or accelerated by mechanical or chemical means, not in the interest of the health of the mother or child, but to economise on hospital staff time and resources and make facilities available for other births. The risks associated with excessive use of interventionist procedures are borne out in fact. In the United States between 1915 to 1930 the infant death rate from birth injuries actually increased. Two separate reports found the causes for this increase to be "lack of prenatal care and excessive operative procedures, often improperly performed."[46]

In recent years, attention has been focused on the alarmingly high rate of Caesarean births, which in North American hospitals exceeds that of anywhere else in the world. A 1979 report of the U.S. Department of Health, Education and Welfare found that "Caesarean section is associated with a maternal mortality rate 3 to 30 times that found among vaginally delivered

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[43]See, *e.g.*, Bannerman, *supra*, note 4 at 743. Yagerman, *supra*, note 8 at 137 observes that "the disadvantages of [the supine] position, one adopted for the convenience of the delivering attendant, are now widely accepted. The position alters the normal fetal environment, creating distress to the child, decreases the intensity of contractions, and obstructs the normal process of childbearing."

[44]D. Haire, "Improving the Outcome of Pregnancy Through Increased Utilization of Midwives" (1981) 26 J. of Nurse-Midwifery 5 at 6, cited in McCormick, *supra*, note 7 at 691.

[45]Perhaps the most convincing evidence against interventionist hospital procedures is contained in a study by Mehl, which controlled for risk factors and matched for comparability 1046 mothers in homebirth with 1046 in hospital birth. The study found

> marked differences in the use of invasive obstetric procedures between the two groups. In the hospital group, the caesarean section rate was three times higher (8.2 versus 2.7 percent); forceps were used much more often (30.6 versus 1.2 percent); and birth injuries were increased (3 versus 0 percent). Episiotomics were performed almost routinely in the hospital group as opposed to the homebirth group (87.4 versus 9.8 percent), but tbere were still more lacerations in the hospital group.

See L. Mehl, "Scientific Research on Childbirth Alternatives: What it Tells Us About Hospital Practice" in Stewart & Stewart, *supra*, note 10 at 171-208, reviewed by Hoff & Schneiderman, *supra*, note 35 at 20.

[46]Evenson, *supra*, note 3 at 316. The studies were performed by the New York Academy of Medicine and the White House Conference on Child Health and Protection.

mothers."[47] Caesarean section also produces increased risks of foetal death due to respiratory distress syndrome.[48] The extensive use of foetal heart monitors has compounded these problems. Studies suggest that "electronic fetal monitors are not accurate predictors of fetal stress. False stress indications increase the likelihood of Caesarean section which results in greater mortality and morbidity."[49] The same study reveals that utilization of foetal monitoring devices also carries risks of injury to both mother and foetus, including perforations of the uterus or placenta and lacerations to the foetus.[50]

Virtually all drugs carry with them possibilities of side effects, and the general medical and ethical problem surrounding the use of drugs for which the effects may be unknown also has a place in obstetrics. One need only recall the disastrous effects of the use of such drugs as thalidomide and DES, prescribed to prevent miscarriage or for the "symptom" of morning sickness, to realise that the benefits of such intervention are at least questionable.[51] The problem of drug usage is particularly exacerbated in the context of pregnancy, since the complex and intricate process of foetal development, and thus the effects of drugs thereon, is still not well understood by biologists.[52]

A final consideration on this issue is that of the psychological and social elements in the process of childbearing. It takes little imagination in view of the foregoing survey to observe that hospital childbirth does not enhance the quality of the experience of bringing another human being into life, and the consensus of available evidence appears to be that midwifery is preferable in this respect.[53] Anecdotal evidence of women having experienced

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[47]U.S. Dept of Health, Education & Welfare, *Cost and Benefits of Electronic Fetal Monitoring: A Review of the Literature*, DHEW Pub. No. 79-3245 (1979), cited in *Evenson, supra*, note 3 at 319 [hereinafter H.E.W.].

[48]"Study of Respiratory Distress Syndrome in Newborns Revealed", *The [Chicago] Tribune* (10 February 1982) 1, cited in Evenson, *supra*, note 3 at 319.

[49]H.E.W., *supra*, note 47.

[50]*Ibid.*

[51]These are not rare occurrences. There are many drugs for which the detrimental side effects have outweighed the benefits of reducing risks by causing severe damage to newborns. Stilboestrol, for prevention of miscarriage, can cause vaginal cancer in the offspring; Synthetic progestin, also for prevention of miscarriage, results in masculinized female babies; some anticonvulsant drugs have resulted in facial clefts; and Aminopterin, a cancer treatment drug, can cause severe cranial and nervous system deformities. See E.W. Keyserlingk, "The Unborn Child's Right to Prenatal Care (Part I)" (1982) 3 H.L.C. 10 at 15.

[52]See Hubbard, *supra*, note 3 at 209.

[53]A. Thaiss, "Clients' Perceptions of Physicians' and Midwives' Prenatal Care" (1980) 80 Am. J. Nursing 684. The survey "shows that client satisfaction with prenatal care provided by midwives surpassed satisfaction with physicians, particularly on the question of confidence." See Evenson, *supra*, note 3 at 321.

both hospital and midwife assisted homebirths shows a preference for the latter.[54] Interventionist practices of hospitals can serve to minimize personal fulfillment of the birthgiving experience, and may even generate adverse physiological consequences. Standard hospital procedures such as shaving the pubic area and requiring an enema before birthing have proven unnecessary, even detrimental, to physiological health,[55] and further serve to dehumanize and to demean the experience of giving birth. At least one study has attributed the more favourable prematurity and mortality rates of home birth in part to "a general lack of fear and other maternal stresses usually present in hospital birth."[56] Furthermore,"hospital policies may prevent a husband from being with his wife during childbirth, require the woman to remain in bed throughout labour, or separate the mother from her newborn within minutes of birth."[57] Families have no choice but to comply with such policies since, although they have been challenged in the American courts several times on constitutional grounds, judges have consistently held them to prevail over patients' rights and interests.[58]

Despite large quantities of detailed evidence showing the dangers associated with hospital procedures and the benefits of midwife-assisted births, coupled with a distinct lack of evidence[59] to the contrary, proponents of medicalization continue to assert the necessity of hospitalization for child-

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[54]See Arms, *supra*, note 6, and S. Kitzinger, "Women's Experiences of Birth at Home" in S. Kitzinger & J.A. Davis, eds, *The Place of Birth* (Toronto: Oxford University Press, 1978) at 135.

[55]Yagerman, *supra*, note 8 at 136 notes several studies that show that pubic shaving increases the risk of postpartum infection, indicating that the practice may in fact be detrimental rather than simply benign.

[56]See Caldwell, *supra*, note 35 at 25.

[57]McCormick, *supra*, note 7 at 672. Several studies have shown that the policy of separating mother and child at birth may interfere with "maternal-infant bonding", and have long-term negative physiological and emotional effects. J.A. MacFarlane, D.M. Smith & D.H. Garrow, "The Relationship Between Mother and Neonate" in Kitzinger & Davis, *supra*, note 54 at 185; and Yagerman, *supra*, note 8 at 137.

[58]See *Hulit* v. *St. Vincent's Hospital*, 520 P.2d 99 (Mont. 1974), *Fitzgerald* v. *Porter Memorial Hospital*, 523 F.2d 716 (7th Cir. 1975) and *Baier* v. *Woman's Hospital Foundation*, 340 So.2d 360 (1st Cir. 1977). Because constitutional rights protect only against state action, such suits are generally ineffective.

[59]Indeed, after a reasonably diligent search, this author could find absolutely no data supporting the contention that for health outcomes medicine is superior to midwifery. Devries notes that one study done by the ACOG is frequently referred to by physicians "as proof that infant death in home births was two to five times greater than in hospital birth", but he further observes that the data are questionable and states that "the study is referred to by innumerable physicians, but not once have I been able to locate a reference to its place in publication." Devries, *supra*, note 21 at 134 and 168. See also M. Tew, "The Case Against Hospital Deliveries: The Statistical Evidence" in Kitzinger & Davis, *supra*, note 54 at 55.

birth.[60] However, a general social trend in recent years to question the infallibility of medical judgment has led to an increased willingness on the part of the public to reject the contention that hospital care is necessary for childbirth, and to move towards alternative and more fulfilling methods of maternity care. In view of the fact that midwifery care appears on the evidence to be more in the interest of public health than hospital care, this progression should be encouraged. It should be emphasized, however, that this does not mean medical obstetrics no longer has a place in the care of women undertaking pregnancy and childbirth. While midwifery services should be provided to the public to meet the demand for more satisfying forms of birth care and, as discussed, there is much evidence revealing the objective health benefits of midwifery, a health care system incorporating both obstetrics and midwifery should be designed in such a way that each service is utilized where appropriate. A distinction should be made between the normal, healthy process of pregnancy and childbirth, which should be dealt with by the practice of midwifery, and disease or illness complications that may arise in or affect the natural childbearing process, which should be dealt with by the medical profession. Although this distinction is perhaps not easy to make in practice, it is nevertheless a crucial one. We have seen that historically it has been the clouding of this distinction that has led to the excessive use of highly interventionist medical practices detrimental to the health interests of the normal individual.

III. Legal Status of Midwifery in Ontario

A. The Unlawful Practice of Medicine

Although midwifery is still practiced throughout most of the world in lay form and is the predominant form of birth care, it can now be legally practiced in most industrialized countries only if licensed or certified. The heavy regulation of the health professions, which became the norm between 1900 and 1930, contributed to the demise of the traditional lay midwife[61] by requiring medical education and licensing to practice. Although there are a few countries, notably Sweden, Finland, Holland[62] and England, in

[60]See, *e.g.*, U.K., Standing Maternity and Midwifery Advisory Committee, *Report on Domiciliary Midwifery and Maternity Bed Needs* (London: HMSO, 1970) ("The Peel Report") as cited in Tew, *supra*, note 59 at 55.

[61]Litoff, *supra*, note 2 at 141.

[62]Sweden, Finland and Holland use midwifery services extensively and generally have the best infant mortality rates worldwide. See Community Task Force, *supra*, note 8 at 4. The obstetrician/midwife debate occurred in Holland in 1880, when it was decided that home births should be encouraged, since they were statistically substantially less dangerous than hospital births. Midwifery has since been the predominant form of birth care, although ironically Dutch physicians are now arguing for greater hospital care. See G.J. Kloosterman, "The Dutch System of Home Births" in Kitzinger & Davis, *supra*, note 54 at 85.

which midwifery has survived the industrial era as the normal practice for childbirth, widespread interest in reviving the practice of midwifery in North America did not reach substantial levels until the 1960s. In the United States throughout the 1960s and 1970s, many states introduced legislation regulating midwifery practice as public interest in "natural childbirth" methods increased.[63] However, by this time the medical profession already had a firm stronghold on the management of childbirth and birthing procedures. Perhaps because of the relatively late date at which legal recognition of midwifery in the United States occurred, most states did not institute regulation of lay midwifery as an independent profession (which is the case in most other countries), but rather a compromise was reached in the development of the "nurse-midwife", a professional having a full education as a registered nurse, and additional education in the specialty of midwifery. The emphasis on the practice of nurse-midwifery rather than lay midwifery developed at the same time as interest in independent nurse practitioners was growing.[64]

In contrast to both the recent American expericnce and to the situation in England, where midwifery has been regulated since 1902,[65] the provinces of Canada at present have sparse or no legislation providing for the regulated practice of midwifery. A recent report notes that "of the two hundred and ten countries in the World Health Organization, only eight, including Canada, are without systematic provision for support by a midwife during normal childbirth."[66] Most provinces bar the practice of obstctrics or midwifery by anyone other than a licensed physician.[67] However, Newfoundland has a *Midwifery Act* allowing for regulation of midwifery practice, and New Brunswick has no restriction nor regulation of the practice of midwifery at all.[68] Nevertheless, because large portions of Canada are mostly rural with little access to full medical services, the practice of midwifery has survived in remote areas through traditional means as well as through Outpost Nurs-

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[63]Hubbard, *supra*, note 3 at 203.

[64]See also N. Baker, "Entrepreneurial Practice for Nurses: A Response to Hershey" (1983) 11 Law, Medicine and Health Care 257; N. Hershey, "Entrepreneurial Practice for Nurses: An Assessment of the Issues" (1985) 11 Law, Medicine and Health Care 252; M.A. Wolfe, "Court Upholds Expanded Practice Roles for Nurses" (1984) 12 Law, Medicine and Health Care 26.

[65]See J. Finch, "Paternalism and Professionalism in Childbirth - I" (1982) 132 New L.J. 995.

[66]Community Task Force, *supra*, note 8 at 1. The other seven countries are Venezuela, Panama, New Hebrides, El Salvador, Dominican Republic, Columbia and Burundi. The World Health Organization, of which Canada is a member, is a proponent of promoting traditional health practices such as midwifery and fostering integration of such practices with Western medical techniques. See Bannerman, *supra*, note 4 at 745-47.

[67]Community Task Force, *supra*, note 8 at 5.

[68]*Ibid.*

ing.[69] Several Canadian nursing schools offer diplomas in maternal care adjunct to the Outpost Nursing program, and since 1962 the University of Alberta has received recognition for certification from the Central Midwives Board of England and Scotland for nurses who undertake its "Advanced Practical Obstetrics" course.[70]

In Ontario, no legislation exists for the practice of midwifery as a distinct profession. No person may practice medicine unless licensed to do so by the Council of the College of Physicians and Surgeons of Ontario (*Health Disciplines Act*, R.S.O. 1980 c. 196, section 52), and section 45(1)(f) of the *Health Disciplines Act* states that the "practice of medicine includes the practice of surgery and obstetrics." Because the Council governs the requirements for the issuing of licenses, it could issue licenses for the practice of midwifery to those not holding a medical degree, but it has not done so.[71] Section 67(1) of the Act makes it an offence to engage in the practice of medicine if not licensed, and section 67(2) makes explicit reference to the practice of midwifery:

> [A]ny person not licensed under this Part who takes or uses any name, title, addition or description implying ... that he is recognized by law or otherwise as a ... licentiate in ... midwifery, or who assumes, uses or employs ... any affix or prefix indicative of such titles or qualifications as an occupational designation relating to the treatment of human ailments or physical defects or advertises or holds himself out as such, is guilty of an offence ... .

The section thus precludes an individual from professing that she or he is qualified to practice midwifery. The phrase "by law or otherwise" would probably preclude practice even solely on the basis of having had experience, regardless of any assertion of legal or professional qualifications. Although it might be argued that assistance in childbirth does not fall within the category of the "treatment of human ailments or physical defects,"[72] this

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[69]J. Hurlburt, "Midwifery in Canada: A Capsule History" (1981) 77 The Canadian Nurse 2:30 at 2:30.

[70]*Ibid.*

[71]Community Task Force, *supra*, note 8 at 18.

[72]An argument that the "practice of medicine" does not include midwifery was successfully made on this basis in *Banti* v. *State*, 289 S.W.2d 244 (1956). In *Bowland* v. *Municipal Court*, 18 C 3d 479, 556 P.2d 1081, 134 Cal. 630 (1976), the court came to the opposite conclusion, holding that midwifery was included because pregnancy is a "physical condition" within the meaning of the California statutory definition of "practice of medicine". Of greater relevance in Ontario, since "practice of medicine" is left largely undefined by the *Health Disciplines Act*, is *Commonwealth* v. *Porn*, 82 N.E. 31 at 31, 196 Mass. 326 (1907), where it was held in the absence of statutory definition that "the practice of medicine does not appertain exclusively to disease, and obstetrics as a matter of common knowledge has long been treated as a highly important branch of the science of medicine." This view is supportable in Ontario by the reference to midwifery in s. 67(2) of the *Health Disciplines Act*, as well as by the fact that "practice of medicine" is defined to include obstetrics, in s. 45(1)(f).

proscription is disjunctive from the prior proscription against holding oneself out as a practitioner of midwifery and thus is a separate basis of liability.

Under the *Health Disciplines Act*, there exist only two exceptions to the prohibition in section 52 against practicing medicine if unlicensed, and these are set out in subsection (2):

> For the purposes of subsection (1),
> (a) rendering first aid or temporary assistance in an emergency without fee; or
> (b) the administration of household remedies by members of the patient's household,
> shall be deemed not to be engaging in the practice of medicine.

Neither exception is of much assistance to an individual desirous of practicing midwifery, since the emergency requirement of the first would not contemplate the ongoing care involved in the practice of midwifery,[73] and it further precludes the charging of a fee. Although midwifery might be determined to fall within the "household remedies" definition of the second exception,[74] delivery of such care is restricted to members of the household. It thus seems clear that, contrary to the view that midwifery in Ontario is "neither legal nor illegal,"[75] a midwife could conceivably be prosecuted for the mere practice of her profession. However, this has apparently not yet occurred, and instead, midwifery practice has received a certain level of tolerance by the medical profession and acceptance by the community.

B. Criminal Liability

Aside from being subject to penalty under the *Health Disciplines Act* for practicing midwifery in Ontario, liability to criminal conviction is also possible for both the individual practicing midwifery and the individual bearing the child, in certain circumstances. Of greatest relevance is the case of *R.* v. *Marsh*[76] which held that a birth attendant has a duty toward a foetus

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[73]Similar emergency exemptions in American statutes have been interpreted to be inapplicable to planned home births; *Bowland* v. *Municipal Court*, *supra*, note 72. See also Caldwell, *supra*, note 35 at 31.

[74]A similar exception in the *California Business and Professional Code*, § 2144, allowing for "the domestic administration of family remedies" was held not to encompass lay midwifery, in *Bowland* v. *Municipal Court*, *supra*, note 72 at 1087.

[75]See *e.g.*, L. Hossie "The midwives' battle for self-rule" *The [Toronto] Globe and Mail* (12 November 1985) A7.

[76](1979), 2 C.C.C. (3d) 1, 31 C.R. (3d) 363 (B.C. Co. Ct). Of peripheral relevance are sections 216 and 590 (infanticide), 221 (killing unborn child in act of birth) and 226 (neglect to obtain assistance in childbirth) of the *Criminal Code*, R.S.C. 1970, c. C-36 [hereinafter *Criminal Code*]. Without going into detail, however, all three offences require some form of intent, bad motive or condition where the mother's "mind is ... disturbed" (s. 216), and thus have no particular relevance to the practice of midwifery *per se*.

for the purposes of section 203 of the *Criminal Code*, causing death to a "person" by criminal negligence. The Court held that a foetus was a "person" within the meaning of this section, notwithstanding section 206 of the *Criminal Code* which states that a child becomes a "human being" for the purposes of the Act "when it has proceeded, in a living state, from the body of its mother... ." The court stated at page 9:

> For the purposes of the issue before the court it is not necessary to define the precise moment at which an embryo becomes a person. It is sufficient to say that the living foetus within the body of its mother and apparently a normal, vital and vigorous foetus, developed as a full-term child and in the very process of being born, was a person, within the meaning of s. 203 of the *Criminal Code*... .

In making this statemcnt, the court left open the possibility that a duty to the foetus as a "person" for the purposes of section 203 may in fact extend further back than the moment of birth. Presumably, the Court's reasoning could equally apply to section 204 of the *Criminal Code*, which proscribes causing bodily harm by criminal negligence in comparable wording. It should be noted that these sections are of general application and thus, of course, apply equally to all persons, including licensed physicians, who administer health care to a person during pregnancy or childbirth. They have particular relevance to midwifery, however, due to its present ambiguous legal and professional status. Section 198 of the *Code* requires a "duty to have and use reasonable knowledge, skill and care" of those undertaking to administer "medical treatment."[77] Since the acceptable standard of care is likely to be that established by expert witnesses from the medical profession, it is much more probable that a midwife would be held to have failed to meet the level of care required by the *Criminal Code.*

These sections could also be interpreted to apply to mothers who choose other than standard hospital procedures for childbirth care, if such a choice is held to amount to "criminal negligence"[78] in the circumstances. However, Annas cites a small body of common law cases supporting the proposition that a mother's duty towards her child for the purposes of the criminal law does not begin until *after* birth.[79]

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[77]If midwifery is defined as "medical treatment", it is likely that midwives would be held to the standard of care of the medical profession at present, but possibly to the standards of the profession of midwifery in the event that legislation regulating such a profession were passed. Similarly to s. 198, s. 45 absolves from criminal responsibility those undertaking "surgical operations" if the operation is performed with "reasonable care and skill" and its performance is reasonable in the circumstances.

[78]S. 202 defines "criminal negligence" as showing "wanton or reckless disregard for the lives or safety of other persons".

[79]Annas, *supra*, note 10.

It is also possible that the reasoning of the court in *R.* v. *Marsh* might be applied to other sections of the *Code* which define offences against "persons". Of particular relevance is section 197 of the *Criminal Code* which states, in part, that:

> (1) Every one is under legal duty
>
> ....
>
> (c) to provide necessaries of life to a person under his charge if that person
> (i) is unable, by reason of detention, age, illness, insanity or other cause, to withdraw himself from that charge, and
> (ii) is unable to provide himself with the necessaries of life.
>
> (2) Every one commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse, the proof of which lies on him, to perform that duty, if
>
> ....
>
> (b) with respect to a duty imposed by paragraph (1)(c), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.

Were a foetus at term to be defined as a "person" within the meaning of this section in accordance with *R.* v. *Marsh*, it seems likely that it would also be defined to be "under the charge" of at least its mother and possibly also of a birth attendant, and a foetus is clearly "unable to provide himself with the necessaries of life." To this extent it is possible that both a mother and a birth attendant would be under a legal duty for the purposes of this section. "Necessaries of life" can include medical care[80] and, if in the context of childbirth this is interpreted as referring to standard hospital medical procedures, a midwife might be criminally responsible, for example, for failure to use forceps, or a mother on a more general basis for failing to obtain "medical care" during pregnancy and childbirth, to the extent that she chooses midwifery services instead. The section has a broader range of liability than that discussed in *R.* v. *Marsh* (criminal negligence causing death), since it requires only failure to perform a duty that is "*likely* to cause the health of that person to be endangered permanently" [emphasis added].

Because midwifery involves an ethic of non-intervention, an individual's choice of this method generally includes an election to forego several types of "medical treatment", and this is complicated at the moment of childbirth by the presence of the foetus.[81] A mother's election to forego a Caesarean section, for example, may be limited in the criminal law by the extent to which such a procedure is necessary to preserve the life or health

[80] *R.* v. *Brooks* (1902), 9 B.C.R. 13, 5 C.C.C. 372 (S.C.).

[81] Eekelaar & Dingwall, *supra*, note 8.

of the foetus. Where the life of the foetus is in danger, the mother's refusal of a procedure may be analogous to impeding its rescue by the midwife or physician. Section 241 of the *Criminal Code* provides that:

> Every one who
>
> ....
>
> (b) without reasonable cause prevents or impedes, or attempts to prevent or impede any person who is attempting to save the life of another person,
>
> is guilty of an indictable offence ....

However, application of this section again depends on whether a foetus is defined as a "person". As well, it may be that the mother's interest in protecting her own health and safety is "reasonable cause" for refusing such a procedure pursuant to the section. In this respect it is interesting to note that section 221 defining the indictable offence of killing an unborn child in the act of birth provides an exemption in the interests of the mother:

> (2) This section does not apply to a person who, by means that in good faith, he considers necessary to preserve the life of the mother of a child, causes the death of such child.

This indicates that the mother's interest may in some circumstances prevail over those of the foetus for the purposes of the criminal law.[82]

A conflict may exist between a birth attendant's respective duties under the criminal law towards mother and foetus. If the birth attendant insisted on a procedure for the benefit of the foetus, she might be liable to the mother for assault (sections 244 to 245.3). Although section 45 absolves from criminal responsibility those performing reasonable and skilled operations, its effect is limited to operations performed on a person "for the benefit of that person" and thus would be of no avail where the operation is performed on an individual for the benefit of her foetus.

C. Civil Rights and Liabilities

The position of the midwife in tort law is complicated by several factors. The first of these is the ambiguous legal status of midwifery. Under the present legal regime, in which midwifery is essentially the unlawful practice of medicine, it is possible that the practice of midwifery would *per se* constitute a failure to discharge the duty of care.[83]

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[82]This perspective is also evident elsewhere. K.M. Weiler & K. Catton, "The Unborn Child in Canadian Law" (1976) 14 Osgoode Hall L.J. 643, observe at 647 that in the *Criminal Code*'s "abortion provisions a preference is expressed for the extant life of the mother over the potential life of the unborn. When the mother's right to health or life is threatened by the continued life of the fetus, she has the right to defend herself by having its existence terminated."

[83]See I.T. Gordon, "The Birth Controllers: Limitations on Out-of-Hospital Births" (1982) 27:1 J. of Nurse-Midwifery 34.

Both midwife and mother are subject to liability for negligence, the mother to her foetus, and the midwife to both mother and foetus, for damage caused prior to or during delivery.[84] It seems likely that in negligence cases midwives at present, if not held to be negligent by the mere practice of their profession, would at least be held to the standards of care set by the medical profession for pregnancy and childbirth care.

Accordingly, liability could result if it is shown that damage could have been prevented by the use of standard obstetric technology or procedure, since it is common practice for courts to exhibit deference to the opinion of the medical profession. Courts have often stated that they will not "second-guess" medical judgment, even in cases where the particular judgment is disputed on medical standards:

> [T]he dispute within the medical profession ... is not one that should be resolved by substituting our judgement for the professional judgement of the staff of defendant hospital.[85]

Devries aptly describes the judicial deference to professional judgment of physicians as "medical hegemony".[86] His lucid sociological analysis of this phenomenon is worth quoting at length:

> [A]reas ruled by the law must be "justiciable" — that is, the arrangements of nonlegal institutions must be understood in legal terms in order for laws to regulate them .... Many nonlegal institutions, including medicine, have developed highly specialized bodies of knowledge that prevent penetration by legal institutions without some technical guidance .... [T]he counsel of medical experts helps determine the outcome of legal decisions related to health care. (This ... is of particular import for midwifery where obstetricians and other physicians have enormous *de facto* power over legislation and adjudication concerning midwives ... .)
>
> ....

[84]It is possible that a midwife could avoid liability to the mother by raising the defence of voluntary assumption of risk, to the extent that the mother *elected* to use her services, if the risks were disclosed. However, in the event of damage to the foetus, an argument of assumption of risk is unlikely to succeed. The defence of assumption of risk has been used to argue against maternal liability to the foetus on the basis that "a person bestowing a benefit — in this case the mother bringing the child into the world — should not be held to the same high standard of care to the child-beneficiary as would a stranger." E.W. Keyserlingk, "The Unborn Child's Right to Prenatal Care (Part II)" 3 H.L.C. 31 at 37, describing an argument in "The Impact of Medical Knowledge on the Law Relating to Prenatal Injuries" (1962) 110 U. of Penn. L. Rev. 554. This view would likely not hold sway in Canadian law, which requires full disclosure of the risks and a clear voluntary acceptance of them, requirements which could not, of course, be satisfied in the case of a foetus.

[85]*Fitzgerald* v. *Porter Memorial Hospital*, *supra*, note 58 at 721 (Per Stevens J.).

[86]Devries, *supra*, note 21 at 149.

> [L]egal officials who make medical decisions let themselves be influenced by culturally dominant medical views. In ... modern societies, allopathy has been accepted as the orthodox mode of medical treatment. The elevation of allopathy — reflecting a basic trust in the progress of science and the benefits of technology — is the result of political and economic competition among various styles of medicine that occurred earlier in this century.... [C]onsequently, legal decisions in the legislatures and courts exhibit a bias toward allopathic practice.[87]

The likelihood that courts will defer to medical opinion is exacerbated in the case of midwifery by open policy statements against midwifery or practices associated with it made by professional medical organizations, which serve to reinforce the view that the practice of midwifery is *per se* negligent. Both the College of Physicians and Surgeons of Ontario and the College of Nurses of Ontario have made such policy statements, the former threatening its members with professional misconduct if they assist or collaborate with midwives and, stating that "it does not consider home births to be safe or in the patient's best interest,"[88] and the latter stating that home birth should be "limited to those situations where adequate physician involvement is ensured."[89] The American College of Obstetricians and Gynecologists (ACOG) has gone even further by stating that "home delivery is maternal trauma and child abuse!"[90] The fact that courts are likely to accept such medical opinion over the opinion of midwives is even more disconcerting when it becomes clear that these opinions may be particularly unjustified. According to Gordon,

> [i]n a dramatically biased research undertaking, ACOG has decided to collect "genuine scientific data ... which will ultimately convince those who are willing to listen." They have established a registry to receive reports of preventable maternal deaths associated with home delivery because the existing data indicate a *lower* than expected maternal mortality rate for women giving birth at home. An ACOG news release stating that "79 babies died last year in California associated with home delivery that would not have died in hospitals" does little to enhance their credibility as unbiased researchers. The California State Department of Health Statistics cited by ACOG did not differentiate between planned and unplanned out-of-hospital births, so that at least 67% of the out-of-hospital stillbirths represented precipitous, unplanned and/or premature deliveries.... Thus despite the claims of ACOG to the contrary, the

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[87]*Ibid.* at 11-12.

[88]College of Physicians and Surgeons of Ontario, "Nurse-Midwives", *College Notices* (January 1982).

[89]College of Nurses of Ontario, *Guidelines for Registered Nurses Providing Care to Individuals and Families Seeking Alternatives to Childbirth in a Hospital Setting* (November 1983) at 1.

[90]W. Pearse, (ACOG Executive Director), "Home Birth Crisis", ACOG Newsletter (1977), as quoted in Gordon, *supra*, note 83 at 35.

> California data cannot be used to evaluate the safety of planned births in a non-hospital setting.[91]

As we have seen, it is not at all clear that medical standards should invariably be the benchmark for assessing whether negligence has occurred. The evidence discussed earlier shows that midwifery care and home birth are at least as safe for normal birth as medical care. This observation emphasizes that courts should not necessarily apply a medical standard of care *post facto* on the presumption that it is a superior form of care. Rather, midwifery must be recognized as an adequate and acceptable form of care, both legally and medically, such that questions of negligence in a midwife-assisted birth can be analyzed with reference to standards of that profession on its own terms. To facilitate this form of analysis on the part of the courts, midwifery should be established as a legally regulated profession. With a statutory scheme in place setting norms of practice for midwifery, a reference point for evaluating negligence in the case of a midwife would be established, and a mother would not be negligent merely for selecting this form of health care. Professional regulation would also serve to lend credibility to the philosophy of midwifery and allow it to acquire the *de jure* legitimacy it deserves, based on its *de facto* legitimacy established by the statistical evidence.

However, establishing midwifery as a legally regulated profession does not fully secure the status of midwives in tort law. Several other issues regarding the duties of midwives in the context of pregnancy and childbirth generally, and in the context of a rapidly developing technology in the area of obstetrics specifically, serve to obscure the legal position of both mothers and their midwives. It is useful as an introductory note to outline briefly these issues.

One complication is that unlike the paradigm two-party tortious event, there are necessarily three parties involved in the context of pregnancy and childbirth: midwife, mother and foetus. The result of this triad relationship is a conundrum of rights and duties that is not easily resolved for the purposes of tort law. The fact that mother and foetus constitute a single *physical* entity can be a source of conflict if a midwife is burdened with a separate legal duty to each. Another focus of conflict is the mother. Her duty of care towards the foetus may conflict with her rights of autonomy and interests in her own health, which may in turn conflict with either of the duties of the midwife towards the mother or the foetus. These complexities are further exacerbated by the expansion of medical technology in the area of obstetrics. As birth technology in the area of prenatal diagnosis and therapy advances at an increasingly rapid pace, the law is responding by expanding the duties of both mothers and their birth attendants towards

[91]Gordon, *supra*, note 83 at 37.

foetuses. Expanded duties indicate corresponding rights, and there is a rapidly growing body of literature on the issue of according certain legal rights to foetuses, particularly with the development of such new causes of action as "wrongful life" and "wrongful birth."

The introduction of midwifery in this context acts as a countervailing trend since its non-technological approach is an antithesis to this developing body of law. The burgeoning trend to accord rights to foetuses that may dictate greater technological intervention during pregnancy and birth on behalf of the foetus would clash on a legal level with the proposed right of midwives to practice according to their professional ethic, and the right of the individual to select midwifery as a mode of health care. On a policy level, if midwifery is to become a legally recognized and regulated profession, the integrity of its philosophical approach to health care independent of the medical ethic must be maintained. The approach of midwifery is an holistic one, emphasizing a natural birth and de-emphasizing interventionist procedures. To this extent it must somehow be justified against the present medical and legal trend to promote greater intervention in the pregnancy and childbirth process, and thereby establish foetal rights.

As the law dealing with the rights and duties of various parties in relation to pregnancy and childbirth is just beginning to develop, particularly in Canada, many questions are still unsettled and much of the jurisprudence is in a state of conflict and flux. However, a comprehensive review of the law and the legal literature reveals the issues set out above.

In addition to the paradigm negligence cause of action which encompasses actions for prenatal or even preconception injury,[92] the courts have begun to recognise new causes of action in tort which create onerous duties of care towards the mother and foetus prior to and during pregnancy and childbirth. American courts have recognized a cause of action for "wrongful birth," an action by the parents for the birth of a child following faulty birth control or sterilization due to negligence, or the birth of a *naturally* defective child which might have been avoided by abortion if the duty to inform of

[92]In *Grodin* v. *Grodin*, 301 N.W.2d 869 at 870, 102 Mich App. 396 (1980) the court found a mother liable for dental damage to her child caused by use of tetracycline during pregnancy on the basis that the "mother would bear the same liability for injurious, negligent conduct as would a third person". See B.M. Knoppers "Modern Birth Technology and Human Rights" (1985) 33 Am. J. Comp. L. 1 at 27. *Renslow* v. *Mennonite Hospital* 351 N.E.2d 870 at 874, 40 Ill. App. 3d 234 (1976), aff'd 367 N.E. 2d 1250, 67 Ill. 2d 348 (S.C. Ill., 1977) recognized a preconception injury to the mother consequent to the child on the basis that "[t]here has been no shred of showing that defendants could not reasonably have foreseen that the teenage girl would later marry and bear a child and that the child would be injured as the result of the improper blood transfusion."

certain risks had been fulfilled or adequate detection techniques used.[93] These cases put a higher onus on birth attendants to use available techniques to detect abnormalities, which is a push towards greater utilization of interventionist technology. A few American courts have allowed a cause of action for the companion tort of "wrongful life," an action brought by the defective child on his or her own behalf, again for negligently caused failure to abort. The most notable of these is *Curlender* v. *Bio-Science Laboratories*,[94] which allowed the child damages for a defective life caused by inadequate testing and counselling for Tay-Sachs disease. This new body of case law again tends to impose a duty on physicians and midwives to attempt painstakingly to detect defects, indicating that prevailing state of detection methods in the area of obstetrics should be used in order to discharge the duty of care. To this extent, the use of midwifery techniques may be considered negligent. Furthermore, because in the case of wrongful life actions the cause of action belongs to the child, the mother may also be subject to a duty of care, forcing her to opt for more meticulous detection methods than midwifery would afford.

However, Canadian law has not yet gone this far. When faced with wrongful birth actions, Canadian courts have accepted that a cause of action exists but have assessed only nominal damages for the parents, rejecting the idea that a child could be anything less than an overall benefit to parents[95] where an unwanted child resulted from a negligently performed sterilization procedure, and even terming the very idea of such damages "grotesque".[96] There has apparently been no case of a successful wrongful life action yet in Canada. In *Cataford* v. *Moreau*,[97] the cause of action was rejected on the grounds that it was impossible to assess damages by comparing the situation after birth with not having been born at all.

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[93]See, *e.g.*, *Moores* v. *Lucas*, 405 So.2d 1022 (Fla. Dist. Ct. App. 1981), a failure to diagnose and/or warn of an inheritable disease; *Phillips* v. *United States*, 508 F.Supp. 544 (D.S.C. 1981), 575 F.Supp. 1309 (D.S.C. 1983), negligent genetic counselling on Down Syndrome; and *Naccash* v. *Burger*, 223 Va. 556, 290 S.E.2d 825 (1982), erroneous labelling of blood in Tay-Sachs test, as cited in Knoppers, *supra*, note 92 at 4, note 19. Again, viability serves as the limiting factor in this cause of action. *Wallace* v. *Wallace*, 421 A.2d 134 (N.H. 1980) held that a pre-viable foetus cannot be the subject of a wrongful death action, and *Vaillancourt* v. *Medical Center Hospital of Vermont Inc.*, No. 4-80 (Mc. Nov. 5, 1980) that a viable foetus can be the subject of such an action whether or not born alive. See Keyserlingk, *supra*, note 51 at 20.

[94]165 Cal. 477, 106 Cal. App. 3d 811 (1980). See also *Harbeson* v. *Parke-Davis Inc*, 656 P. 2d 483, 98 Wash. 2d 460 (1983) and, in part, *Turpin* v. *Sortini*, 643 P.2d 954, 31 Cal. 3d 220 (1982). The cause of action for wrongful life was rejected in England in *McKay* v. *Essex Area Health Authority* [1982] 2 W.L.R. 890, [1982] 2 All E.R. 771 (C.A.).

[95]*Cataford* v. *Moreau* [1978] C.S. 933, 114 D.L.R. (3d) 585 .

[96]*Doiron* v. *Orr* (1978), 86 D.L.R. (3d) 719 (Ont. H.C.). It should be cautioned that this approach may have been a result of the fact that both cases involved the birth of *healthy* children, and it is possible that the courts will react differently to the birth of a *defective* child.

[97]*Supra*, note 95.

As previously noted, a child clearly has a cause of action for injuries negligently sustained by it prior to birth, indeed perhaps prior to conception, and this holds for Canada as well.[98] This action would lie against both mother and midwife or physician. As the *Family Law Act* provides:

> 65. No *person* shall be disentitled from bringing an action or other proceeding against another for the reason only that they stand in the relationship of parent and child.
>
> 66. No *person* shall be disentitled from recovering damages in respect of injuries incurred for the reason only that the injuries were incurred before his birth. [emphasis added][99]

These provisions imply, by their use of the word "person", that the cause of action exists only for someone who has already been born. Indeed, Canadian courts, consistent with a more conservative approach than American courts have taken, tend to emphasize that birth is a prerequisite to legal rights in the area of prenatal and preconception torts.[100] For example, although the right of action for prenatal torts was recognized as early as 1923 in *Smith* v. *Fox*,[101] the court stipulated that the right to damages arose once the precondition of live birth was satisfied.[102] Similarly, in *Montreal Tramways* v. *Lêveillê* the court held that a right of action for prenatal injuries existed if the foetus was "born alive and viable."[103]

Although it is arguable as a matter of pragmatics alone that live birth is necessary in order to bring an action in court on one's own behalf, the emphasis Canadian courts place on this requirement tends to preclude the attachment of rights to a foetus prior to birth. Indeed, the courts, while allowing the right of action after birth, have specifically refrained from de-

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[98]*Duval* v. *Séguin* [1972] 2 O.R. 686, 26 D.L.R. (3d) 418 (H.C.), aff'd [1974] 1 O.R. (2d) 482 , 40 D.L.R. (3d) 666 (C.A.).

[99]S.O. 1986, c. 4.

[100]This conservative approach may also explain the reluctance of Canadian courts, in contrast to American courts, to accept the actions of wrongful life and wrongful birth.

[101](1923) 3 D.L.R. 785 (Ont. H.C.).

[102]The court in *Smith* v. *Fox*, *ibid.*, also rejected a claim by the father as "next friend" of the foetus before its birth which underscores the reluctance to accord rights to the unborn. On the issue of prenatal injury, see Knoppers, *supra*, note 92 at 7, and Weiler & Catton, *supra*, note 82 at 651ff.

[103][1933] S.C.R. 456 at 464, [1933] 4 D.L.R. 337. This implies the further requirement in civil law that the foetus be viable *after* birth (i.e. birth and immediate death would preclude the cause of action).

ciding that a foetus has juridical status.[104] Moreover, a clear statement on this issue was made in *Borowski* v. *A.G. Canada*,[105] which decided that a foetus is not protected by the *Charter* on the basis that

> it is the prerogative of Parliament, and not the Courts, to enact whatever legislation may be considered appropriate to extend to the unborn any or all legal rights possessed by living persons. Because there is no existing basis in law which justifies a conclusion that foetuses are legal persons and therefore within the scope of the term "everyone" utilized in the *Charter*, the claim of the Plaintiff must be dismissed.[106]

Thus, while the door has been left open in the U.S. to accord legal personhood to the foetus, it is arguable that in Canada at least, a foetus generally has no protection under the law except upon birth. This would mean that a mother's selection of midwifery services during pregnancy rather than obstetrical services could not be interfered with on the purported grounds of protecting the interests of the foetus.

Nevertheless, the recent U.S. case law on wrongful birth and life, as well as that involving the more accepted torts of prenatal and preconception negligence, has given rise to a vehement discussion on foetal rights in both the Canadian and American literature. The argument that a foetus should have certain legally recognized rights has led to the contention that the state should not only establish a right of action in tort *post facto*, but should intervene *during* pregnancy and childbirth to protect foetal rights. The Family and Children's Law Commission of British Columbia has stated, for example, that

> once a woman has decided to bear the future infant, the laws of the province should emphasize individual responsibility to provide the infant [sic, foetus][107]

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[104]For example, *Duval* v. *Séguin*, *supra*, note 98. Weiler & Catton, *supra*, note 82, observe at 654 that the court in *Duval* v. *Séguin* was able to find a cause of action arising only upon birth by relying on the doctrine of *Donoghue* v. *Stevenson* [1932] A.C. 562 (H.L.) that damages (manifested after birth) need not coincide in time with the tortious act (before birth). The fact that courts have recognized this cause of action does not necessarily imply that the foetus has a legal personality since, as *Duval* v. *Séguin* points out, the damages compensated are those suffered during the injured life *since* birth. Furthermore, the wrong is not necessarily one committed against the foetus since it may, as in the case of preconception torts, be inflicted before the foetus even comes into existence.

[105](1983) 4 D.L.R. (4th) 112 (Sask. Q.B.), aff'd (1987) 56 Sask. R. 129 (C.A.).

[106]*Ibid.* at 131. On the other hand, recall that *R.* v. *Marsh*, discussed *supra*, note 76, decided that at least for the purposes of the criminal law, a foetus may be a "person in some instances."

[107]It is technically incorrect to refer to a foetus as an "infant" or even as an unborn "child" as several writers are wont to do, since it does not accord with the dictionary definition of these words and tends to presuppose the personhood and hence legal status of the foetus, which is at best unclear in law. As W.W. Watters *et al.* have noted, the "medical term fetus is more dispassionate and hence more compatible with a legalistic form of reference. If we use the word fetus, people are free to attach whatever value to that word they choose .... We do not call a seed an ungerminated flower nor an acorn an unsprouted oak tree; why should we call a fetus an 'unborn child'?". "Response to Edward W. Keyserlingk's Article: The Unborn Child's Right to Prenatal Care" (1983) 4 Health L. in Can. 32 at 34.

> with the kind of pre-natal care that will prevent unnecessary jeopardy to the child .... [I]f a woman requires frequent pre-natal visits for medical surveillance in order to detect and prevent complications that would lead to premature birth or some other predisposition to disease in the future child, it seems irresponsible for her to allow other considerations to take precedence over such a requirement for health care.[108]

The Commission accordingly recommended dispositions be made to place the mother under a supervision order in such situations. The proposition that courts should intervene during pregnancy to decide what is in the best interest of the foetus is often based on an analogy to child protection. This analogy was accepted in the United States, where several courts have held that a foetus can be a child for the purposes of child neglect statutes.[109]

In Canada a court has appointed a guardian *ad litem* for an 18 week foetus under a child protection statute while the father sought an injunction to prevent its abortion.[110] Canadian courts have also awarded custody of foetuses to provincial Child Welfare Agencies in two recent decisions. In the first,[111] the Ontario Provincial Court awarded three months temporary custody, ruling that there were grounds to believe that there was a substantial risk to the foetus' health or safety under section 47(3) of the *Child and Family Services Act, 1984*.[112] The court found that the homeless mother refused to seek medical assistance necessary for the delivery of the child. More recently, a B.C. provincial court judge ruled after the fact that child care authorities were entitled to apprehend custody of a foetus in order to enable a doctor to perform a caesarean section the mother had refused.[113] The court also awarded permanent custody of the child, which had by the

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[108]British Columbia, Royal Commission on Family and Children's Law, *Report V: The Protection of Children* (Vancouver, March 1975) at 65, as cited in Weiler & Catton, *supra*, note 82 at 649.

[109]See, *e.g.*, *Re Baby X*, 97 Mich.App.111, 293 N.W.2d 736 (1980), *Hoener* v. *Bertinato*, 171 A.2d 140 (N.S. 1961). Indeed, Keyserlingk notes that one such case (*People* v. *Yates*, 298 P. 961 (1931)) involved a child support section of a statute that explicitly deemed an "unborn child" to be a person for the purposes of that section. See Keyserlingk, *supra*, note 51 at 18ff; and M. W. Shaw, "Conditional Prospective Rights of the Fetus" (1984) 5 J. Legal Med. 63 at 89.

[110]*Re Simms and H* (1979), 106 D.L.R. (3d) 435 (N.S. Fam. Ct).

[111]*Re Children's Aid Society of City of Belleville, Hastings County and the Unborn Child of L.T. and G.K.* (1987), 59 O.R. (2d) 204, 7 R.F.L. (3d) 191 (Prov. Ct).

[112]S.O. 1984, c. 55.

[113]*Re Baby Boy R.* (3 September 1987), Vancouver 876125 (B.C. Prov. Ct). The court also awarded permanent custody of the child, which had by the time of the hearing been born, to child care authorities after finding that the mother was unable to care adequately for the child.

time of the hearing been born, to child care authorities after finding that the mother was unable to care adequately for the child.[114]

It is possible under this approach that the use of midwifery services could be precluded entirely. As Shaw observes:

> Although there has been a movement for the use of midwives and home deliveries, it is possible that a physician might see a strong medical indication for a hospital delivery if the risks of lack of medical attendance and emergency equipment were high. If a mother refused such assistance, she could be liable for fetal neglect.[115]

On the other hand, it is arguable that child protection statutes are an inappropriate tool in the context of midwifery, since they are intended to apply only in severe cases of neglect and since they are applied stringently by the courts. As Keyserlingk observed, with respect to the former Ontario *Child Welfare Act* (now Part III of the *Child and Family Services Act, 1984*):

> It cannot bring into play any degree of child protection only because someone establishes that someone else than the parents or a parent could do a *better job or the best job* for a child, that is, "The criteria underlying the definitions provided for in s. 20 should not be based on what is in the best interests of the child but rather what is necessary to raise the child's standard of care back to an acceptable minimum level".
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> ....
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> [I]t is always possible for parents, physicians and others to do a better job for the unborn. Will forgetting a single prenatal checkup, taking a cigarette too many times one day ... be potential occasions for ... a Family Court to decide that the unborn child is in need of protection ... ? Of course not."[116]

If this interpretation is correct, it seems clear as a general proposition that midwifery services constitute at least an "acceptable minimum level" of care for the foetus and as such could not be subject to scrutiny under child welfare statutes.

Even without the aid of such statutes, the literature and some cases have proceeded solely on the basis of a foetal rights argument and the state interest in the unborn. But a continued progression of increased maternal duties and foetal rights corresponding to advances in medical science, be-

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[114]Two other Canadian cases, *Chapman* v. *Canadian National Railway Co.* (1943), 52 O.W.N. 47, aff'd 52 O.W.N. at 297 (C.A.) and *Gidding* v. *Canadian Northern Railway Co.* [1920] 2 W.W.R. 849 (Sask. C.A.), found the foetus to be the subject of compensation legislation and, while not directly on point, leave open the avenue of treating the foetus as a person for some purposes in private law. See Weiler & Catton, *supra*, note 82 at 650.

[115]Shaw, *supra*, note 109 at 89.

[116]Keyserlingk, *supra*, note 84 at 32, quoting J. Wilson, *Children and the Law* (Toronto: Butterworths, 1978) at 49. See also *Re Brown* (1975), 9 O.R. (2d) 185, 21 R.F.L. 315 (Co. Ct) and B.M. Dickens, "Legal Responses to Child Abuse" (1979) 12 Fam. L.Q. 1 at 24.

yond that presently established by the case law, would lead to what at least one group of writers has termed an "Orwellian nightmare."[117] For example, Robertson argues that

> far reaching intrusions on the mother's body and freedom of action for the benefit of the unborn child may legitimately follow [from the case law]. Women, for example, might then be forced to deliver by cesarean section. They may also be prohibited from using alcohol or other substances harmful to the fetus during pregnancy, or be kept from the workplace because of toxic effects on the fetus. They could be ordered to take drugs such as insulin for diabetes, medications for fetal deficiencies, or intrauterine blood transfusions for Rh factor. Pregnant anorexic teenagers could be force-fed. Prenatal screening and diagnosis procedures, from amniocentesis to sonography or even fetoscopy, could be made mandatory. And, in utero surgery for the fetus to shunt cerebroventricular fluids from the brain to relieve hydrocephalus, or to relieve the urethral obstruction of bilateral hydronephrosis could also be ordered. Indeed, even extra-uterine fetal surgery, if it becomes an established procedure, could be ordered, if the risks to the mother were small and it were a last resort to save the life or prevcnt severe disability in a viable fetus.[118]

Keyserlingk further cites as a cause of defects the mother's age.[119] If, as he and others suggest, duties should be imposed on mothers according to risk factors as they become known, individuals might be denied the right to procreate[120] during certain risky age ranges, if it is deemed negligent to do so.

These suggestions are not entirely far-fetched. Several courts have ordered mothers to submit to medical procedures during pregnancy that they had chosen not to undergo, in the interest of the foetus. In *Jefferson* v. *Griffin Spalding County Hospital Authority*[121] an individual near term who refused surgery on religious grounds was ordered to undergo a sonogram and, if "considered necessary by the attending physician to sustain the life of the child,"[122] a caesarean section. The court held that the state's interest

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[117]Watters *et al.*, *supra*, note 107 at 32.

[118]J.A. Robertson, "The Right to Procreate and in Utero Fetal Therapy" (1982) 3 J. Legal Med. 333 at 357-59.

[119]Keyserlingk, *supra*, note 51 at 12.

[120]This observation is important since it indicates that imposing such duties on persons could bring us full circle to direct conflict with the right to procreate at all, which in the U.S. is a legally recognized right, established as an element of the right to privacy as early as *Griswold* v. *Conneticut*, 381 U.S. 479 (1965) and developed into the right to reproductive privacy in *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972) and *Roe* v. *Wade*, 410 U.S. 113 (1973).

[121]274 S.E.2d 457, 247 Ga. 86 (1981) [hereinafter *Jefferson*].

[122]*Ibid.* at 460. 331 F.2d 1010, certiorari denied. See also *Jones* v. *President of Georgetown College, Inc.* 377 U.S. 978 (1964) where a blood transfusion was ordered. Another case, from Colorado, where the ordering of a caesarean section is discussed by W.A. Bowes & B. Selgestag, "Fetal versus Maternal Rights: Medical and Legal Perspectives" (1981) 58 Obstet. & Gynecol. 209.

in the foetus, which it described as a "child," and "a human being fully capable of sustaining life independent of the mother,"[123] overrode the interests of the mother. Similarly, in *Raleigh Fitkin-Paul Morgan Memorial Hospital* v. *Anderson*, the court ordered an individual seven months pregnant to undergo a blood transfusion, again if considered "necessary in the opinion of the physician in charge"[124] because "the unborn child is entitled to the law's protection."[125] Indeed in one case, a schizophrenic, seven months pregnant, was civilly committed in the purported interest of the protection of her foetus.[126]

It can be seen that if the case law continues to develop to the point suggested by the literature, the individual's autonomy would be severely limited. More specifically, her right to select the particular mode of health care she deems appropriate for her pregnancy and parturition would become heavily restricted. This has significant ramifications for the practice of midwifery in two ways. First, because midwifery is presently considered an "alternative" form of health care, particularly as it is not legally recognized in Ontario, it could, in view of the case law, be considered a generally inadequate form of health care, and thereby inhibit midwives' ability to practice. Second, the selection of midwifery involves a choice to forego the majority of extraordinary or interventionist procedures, such as amniocentesis or sonography during pregnancy, and use of foetal monitoring equipment or Caesarean section during childbirth. The decision to opt out of these procedures brings the right of the mother to do so into conflict with her developing duty at law to utilize these procedures in the interest of the foetus.

In the result, if midwifery is to survive as a feasible health care option, midwives and mothers must be protected against legal intervention precluding the option of a "natural' child birth. Further, if midwifery is to become legally regulated, the ensuing legal and political sanction of this

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[123]*Ibid.* at 459. See also *supra*, note 109.

[124]201 A.2d 537 at 538, 42 N.J. 421 (1964) [hereinafter *Raleigh Fitkin-Paul*].

[125]*Ibid.* Interestingly, in both *Jefferson* and *Raleigh Fitkin-Paul*, it could be argued that despite their emphasis on the personhood of the foetus, the courts' concern also lay with the health of the mother since doctors had testified that there was a significant risk of death to both foetus *and* mother without the procedure in question. Indeed, the court in *Raleigh Fitkin-Paul* at 538 noted that "the welfare of the child and the mother are so intertwined and inseparable that it would be impracticable to attempt to distinguish between them ... ." In both cases the mother's interest, at least in respect of health, paralleled rather than conflicted with that of the foetus and hence, as Robertson notes with respect to the *Jefferson* case, "the court was able to avoid ruling on whose health interests should prevail ... ." J.A. Robertson, "Procreative Liberty and the Control of Conception, Pregnancy and Childbirth" (1983) 69 Va L. Rev. 405 at 446.

[126]P.H. Soloff, S. Jewell & L.H. Roth, "Civil Commitment and the Rights of the Unborn" (1979) 136 Am. J. Psych. 114, cited in Robertson, *ibid.* at 446.

profession must somehow be reconciled with the countervailing trends in tort law.

Several arguments can be made to support the individual's right to use midwifery services. The foetal rights argument, which restricts the mother's capacity to opt for such services by subordinating her right of self-determination to rights imputed to the foetus, must first be rebutted.

Foetal rights arguments rest on two assumptions: first, that the mother and the foetus are separate entities with separate collections of rights; and second, the mother, by freely choosing to bear the child has, by implication, consented to abandon the right of self-determination in so far as that right is in conflict with the rights imputed to the foetus. Pregnancy is viewed as a passive donation of one's body with the necessary consequence that one loses rights in favour of those of the foetus, rather than an active process in which one retains autonomy and control. For example, Robertson argues that

> [t]o impose on the mother the duty to undergo surgical delivery where it is necessary to save the child's life or prevent it from being injured is not unreasonable when she has chosen to lend her body to bring the child into the world.[127]

Both elements of the foetal rights theory are fundamentally flawed.

The most serious error of foetal rights arguments is the failure to acknowledge the position of the mother in relation to the foetus, a position in which the foetus is necessarily subordinate. The foetus right up until birth subsists only as a part of its mother's body, and the development of sophisticated technology does not change this scenario. As long as the foetus is a part of its mother's body, the fact that it is capable of living outside it is irrelevant when the mother's body must be invaded to get access to the foetus in order to protect its "rights." To this extent, the foetus is subordinate to the individual bearing it, and subject to her power of autonomy. As Hubbard observes:

> It makes no sense, biologically or socially, to pit fetal and maternal "rights" against one another. Indeed, legal "rights" do not offer a proper framework for assessing the situation of a pregnant woman and her fetus. As long as they are connected, nothing can happen to one that does not affect the other.... It is

[127]Robertson, *supra*, note 125 at 456. Robertson's argument results in a virtual loss of the individual's right of control over the course of her pregnancy and to protect her bodily integrity. He decides that it follows from the available American case law that an individual should have no right to refuse a procedure benefitting her foetus unless it presented an "undue risk to her life or health" (at 445). Since by definition no doctor could rationally or responsibly recommend a procedure entailing "undue risk" no case could arise in which the mother's right to bodily integrity could have any effect on the outcome.

> *her* right ... precisely *because* the fetus is part of her body. To argue "rights" of the fetus *versus* those of the mother ignores this organic unity and substitutes a false dichotomy.... As long as a fetus is attached to the pregnant woman, her body maintains its life and her body wall bars access to it.[128]

Hubbard concludes:

> When physicians and judges become guardians of "fetal rights" mothers *and* fetuses lose, because their respective "rights" cannot be sorted out any better than their respective biology.[129]

The second assumption in a foetal rights argument is the theory that the mother, by choosing to have the child, has by implication consented to subordinate her rights to certain rights imputed to the child. Any theory which infers consent to abandon civil rights and liberties as fundamental as the freedom from intrusion on the body should be viewed with suspicion: if consent were freely and consciously expressed, there would be no need to infer it. Implied consent can be imposed acquiesence. Moreover, it is possible to rebut implied consent by demonstrating that the person in question was merely responding to an imperative.

Bearing children today is largely a matter of choice, but is also a function of one's biological existence and an event that is extremely significant to both the individual and society. As a matter fundamental to the survival of the human race and necessarily adjunct to a woman's existence, it should not under any circumstances result in a loss of rights or control over one's body. The significance of the choice and power to bring another human into the world, both to society and to the individual, must be perceived in order to avoid hastily establishing foetal rights at the expense of maternal rights.

But the foetal rights theory, which underlies the above legal developments does not allow for a logical or coherent sorting out of the respective positions of mother and foetus for the purpose of protecting both independently in any given medical situation, and the *de jure* subordination of the foetus must follow from its *de facto* biologically subordinate position. Hubbard's analysis reveals not only that the individual should retain her rights of autonomy during pregnancy and parturition, but also that she is the only "patient" to whom the caregiver owes a duty.

Support for this position can be found in law, based on the right to security of the person and to refuse medical treatment, and the right to informed medical decision-making. There is some basis in the American case law for a general right to refuse medical treatment. For example, the court in *In re Melideo*[130] upheld a Jehovah's Witness' refusal of a blood

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[128]Hubbard, *supra*, note 3 at 215-16.
[129]*Ibid.* at 217.
[130]390 N.Y.S.2d 523 (1976).

transfusion and stated that "every human being of adult years and sound mind has a right to determine what shall be done with his own body and cannot be subjected to medical treatment without his consent.[131] Indeed, a few cases have allowed parents to refuse treatment for their child,[132] and yet there are many more that deny parents this right both, as we have seen, in the context of pregnancy and after birth.[133] As the law in this area is unresolved, an argument on this basis alone would be likely inconclusive, particularly since little or none of the case law is Canadian.

Nevertheless, an argument for a general right to refuse treatment is reinforced by the right to bodily integrity or security of the person, particularly since this right is now constitutionally protected by section 7 of the *Charter*.[134] Although a right to bodily integrity has not been clearly articulated, it is not unknown to the law. Regan documents a historical judicial aversion to imposing physical invasions or risks on persons in general and, in the context of an argument for abortion rights, analogizes a woman's

[131]*Ibid.* at 52. See also *Re Osborne,* 294 A.2d 372 (1972) and *Re Brooks' Estate,* 205 N.E.2d 435, 32 Il. 2d 338 (1965), blood transfusion refusals; *Superintendent* v. *Saikewicz,* 370 N.E.2d 417 (Mass., 1977), chemotherapy refusal; *Re Guardianship of Richard Roe, III,* 421 N.E.2d 40 (Mass., 1981), refusal of psychotropic drugs; and *Youngberg* v. *Romeo,* 102 S.Ct. 2452 (1982), freedom from unreasonable bodily restraint protected, cited in McCormick, *supra,* note 7 at 692. Annas maintains that "[t]he general rule is that an adult patient who is both conscious and mentally competent has the legal right to refuse to allow any medical or surgical procedure to be performed on his body." G. Annas, *The Rights of Hospital Patients* (New York: Sunrise Books, 1975) at 79, as quoted in Forrest, *supra,* note 23 at 320.

[132]*Re Phillip B.,* 156 Cal. Rptr. 48 (1979). In discussing the case of *Re Hofbauer,* 393 N.E.2d 1009 (Ct. App. 1979), Shatten & Chabon, "Decision-Making and the Right to Refuse Lifesaving Treatment for Defective Newborns" (1982) 3 J. Leg. Med. 59 at 65 write that "[i]n refusing to order chemotherapy against the parents' wishes, the court of appeals stated that it would accord great deference to the parents' choice of physician and mode of medical therapy as long as there was some support for their choice among medical authorities." This would seem to articulate a broader right to *determine* the form of treatment in contrast to the right to *refuse* treatment, and thus would be some support for the individual's right to opt for midwifery services.

[133]For a thorough review of this case law see Shatten & Chabon, *supra,* note 132 at 65ff. In Canada, *Re D* (1982) 30 R.F.L. (2d) 277 (Alta Prov. Ct) held that the state's right to protect the child's health prevailed over the parents' freedom of religion as Jehovah's Witnesses under s. 2 of the *Canadian Charter of Rights and Freedoms* to refuse a blood transfusion to their child.

[134]Although the rights in s. 7 were originally thought to afford only procedural ("due process") protection, the recent Supreme Court of Canada decision in *Reference Re s. 94(2) of the Motor Vehicles Act* [1985] 2 S.C.R. 486 is some indication that s.7 rights may be treated as substantive. Knoppers, *supra,* note 92 at 25, points out further that "[i]t could be argued that the right to beget, irrespective of the means, would fall under the 'liberty' interest of article 7."

position in pregnancy to that of a samaritan,[135] concluding that "imposing invasion and hardship for the benefit of a third person is flatly inconsistent with our nation's fundamental traditions."[136] Indeed, forcing an individual to undergo treatment for the benefit of her foetus is analogous to imposing on her a duty of rescue, a notion which is clearly unaccepted in Anglo-Canadian jurisprudence: the obligation is moral not legal.[137] Although several writers have argued that the interest to be protected (here the health of the foetus) should be weighed against the intrusiveness or degree of harm involved in the invasive medical technique,[138] the law in some instances has been loathe to impose even minor physical invasions. For example, in paternity cases, where the significant interest of the child's financial future is at stake, courts have refused to order an individual to undergo a blood test under the *Children's Law Reform Act*,[139] instead requiring consent to the procedure or holding that the "personal rights" of the individual prevail.[140]

The right to determine the course of one's health care is also supported by the law of battery,[141] still extant in Canada in the medical context.[142] The mother's capacity to bring an action in battery means that she always has the right to refuse a medical treatment physically consequent upon her body, which would include virtually any procedure for the benefit of the foetus, since her consent is required before medical personnel can physically touch her person. Shriner's argument that the mother's interests override any foetal interests is essentially one based on the law of battery:

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[135]Regan argues that

> the woman should not be compelled to subordinate her interests to those of the fetus.... There is a conflict of interest between the woman and the fetus, and someone is going to lose.... The point is that our law generally resolves this conflict in favour of the potential samaritan. When a woman is pregnant, it is the fetus that needs aid and the woman who is in a position to give it. If the conflict between the woman and the fetus is to be resolved consistently with the resolutions of the most closely analogous cases, the woman must prevail.

D.H. Regan, "Rewriting *Roe* v. *Wade*" (1979) 77 Mich. L. Rev. 1569 at 1610.

[136]*Ibid.* at 1620.

[137]The position has been maintained as recently as 1971 in *Horseley* v. *McLaren* (1971), [1972] S.C.R. 441, 22 D.L.R. (3d) 545.

[138]See Robertson, *supra*, note 118 at 335. Dickens notes for example that this weighing process is evident in the case law regarding a parent's right to determine medical treatment of her child. B.M. Dickens, "The Modern Function and Limits of Parental Rights" (1981) 97 L.Q. Rev. 462 at 484.

[139]S.O. 1977, c. 41.

[140]See *Re H and H* (1979), 25 O.R. (2d) 219, 9 R.F.L. (2d) 216 (H.C.) and *Re Rhan* (1979), 27 O.R. (2d) 210 (Co. Ct). In *Rhan* the court held that in the circumstances the alleged father's right to privacy prevailed.

[141]Battery is the tort of intentional touching of one's person in some manner without his or her consent.

[142]*Reibl* v. *Hughes* [1980] 2 S.C.R. 880, 14 D.L.R. (3d) 1, 33 N.R. 361.

> A woman is plainly a person; a fetus' status is not so clear. A woman's undoubted personhood carries with it the ancient and well-nigh sacred right that no one may touch her body without her consent. Hence, she may refuse surgery for any reason, or for no reason at all. A fetus, however, for a variety of perfectly natural reasons, may never even be born.[143]

The law on informed consent in the medical context is also of great relevance in determining the individual's right to control her pregnancy and parturition. Health care providers have a duty to inform their patients of the nature and risks of medical procedure and to acquire their consent to such procedures before performing them, or else they risk liability in negligence.[144] According to Dickens,

> [t]he purpose is to serve and to maximize the patient's autonomy. The patient must be permitted to exercise autonomy, furthermore, regarding not only the selected method of treatment, but particularly regarding the determined goal of treatment. Goals relate to the patient's preferred lifestyle and philosophy, rather than to the more limited issue of selection between medical management modalities ... .[145]

The result of the legal requirement of informed consent is that although health care personnel may advise and recommend the course of health care, the ultimate right to *determine* the appropriate health care, even in the context of pregnancy, should lie with the individual. As Shriner writes,

> [t]here is no acceptable alternative to requiring the woman's consent to surgery, and the obstetrician's role must remain one of informing, counselling and persuading in the difficult but fortunately infrequent, situation[s] ... .[146]

It is arguable that the requirement of informed consent or informed choice, particularly in view of its purpose according to Dickens, above, means a mother should have the right to decide whatever is in her own best interests (and those of her foetus), even if considered medically irrational.[147]

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[143]T.L. Shriner, "Maternal versus Fetal Rights — A Clinical Dilemma" (1979) 53 Obstet. & Gynecol. 518 at 518, as cited in Hubbard, *supra*, note 3 at 211.

[144]*Reibl* v. *Hughes*, *supra*, note 142; *Hopp* v. *Lepp* [1980] 1 S.C.R. 192, 112 D.L.R. (3d) 67, 13 C.C.L.T. 66; *White* v. *Turner* (1981), 31 O.R. (2d) 773, 120 D.L.R. (3d) 269, 15 C.C.L.T. 81 (Ont. H.C.).

[145]B.M. Dickens, "The Modern Law on Informed Consent" (1982) 37 Mod. Med. Can. 706 at 706. Dickens rightly maintains that the term "informed consent" is inappropriate in implying too limited a patient participation (his argument is based on *Reibl* v. *Hughes*, *supra*, note 142). Instead a term such as "informed decision-making" would be more appropriate since it puts the power to decide where it should reside, with the patient.

[146]See Hubbard's discussion of Shriner's work in Hubbard, *supra*, note 3 at 211.

[147]As Dickens, *supra*, note 145 at 707 states, "Although the informing physician must initially focus upon what is material to an exercise of prudent, reasonable decision-making, it must be borne in mind that a patient's autonomy permits exercise of choice in an unreasonable or irrational way.

....

[A]utonomy serves an individual's wishes, rather than the person's interests."

However, the courts take a more objective than subjective approach to the patient's judgement,[148] and as we have seen this in general means a heavy reliance on medical judgement.

In developing the law on informed choice in the context of pregnancy and parturition, it is crucial that the courts recognise that questions regarding the health care management of the mother and foetus, which deeply affect fundamental legal and moral rights of the person, are more appropriately decided by the mother than the medical profession. Unfortunately, courts have a tendency to view medical testimony as empirically unquestionable rather than as fallible opinion that serves only as evidence.[149] But differing opinions within the medical profession as to whether a procedure is warranted will be found in almost any case, and we have seen that the contemporary medical opinion as to the "benefits" of certain procedures is by no means infallible and has not infrequently been proven wrong by the passage of time and new data.[150] This fact alone serves as a legitimate basis for refusing those procedures one deems undesirable in the interests of one's own health. Even now a debate rages in the literature about the appropriateness of novel prenatal procedures, while courts are simultaneously ordering those very procedures. One writer, after reviewing the courts' avid acceptance of new medical procedures, concludes that "this shift ... is proceeding more rapidly and encompassing larger areas of recovery than can be justified in light of the existing uncertainty and flux of medical knowledge."[151]

The limited number of cases on the issue already reveal the flaws in medical judgement:

> [P]hysicians' predictions of harm to the foetus [are not] as reliable as judges might tend to believe. In both the Georgia and Colorado cases [where courts ordered the mother to undergo Caesarean section] ... the doctors' alarm proved disproportionate. The Georgia woman had a successful vaginal delivery despite her doctor's insistence that it was a 99% impossibility ... and the fetal monitor

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[148]In the context of a negligence action, the court in *Reibl* v. *Hughes, supra,* note 142 held that the question is one of what a reasonable, informed person in the patient's circumstances would have done, closing off the ability of a patient to act subjectively (i.e. objectively unreasonably) if she is to later sustain an action in negligence. (In effect she has assumed the risks.) The court also held that expert medical evidence is still pertinent to establish causation and the nature and risks involved in the ailment and its various forms of treatment.

[149]See *supra,* note 88 and accompanying text.

[150]See above Part I.

[151]"The impact of Medical Knowledge on the Law Relating to Prenatal Injuries" (1962) 110 U. of Penn. L. Rev. 554 at 598, as quoted in Keyserlingk, *supra,* note 84 at 34.

> in Colorado proved to have exaggerated the potential damage to the fetus from the delayed delivery.[152]

The acknowledgement that medicine is not a precise science provides a good argument for putting in the hands of the individual the right to decide her own destiny upon disclosure of the best information that the medical profession can provide.

The law on informed consent and battery, particularly against the backdrop of the *Charter*'s fundamental freedoms, including security of the person, provide justification for a system in which the health care provider's duty is owed solely to the mother, to inform her of the health prospects of her and her foetus, and in which the final decision is hers. This framework allows for a more coherent form of analysis and avoids the dilemmas that arise under a "foetal rights" analysis:

> If [the physician] accedes to the mother's wishes and the child is born dead or defective, he faces potential civil or criminal liability for neglecting his duty to the unborn child.
>
> ....
>
> The physician has an independent duty to assure the well-being of the child, a duty that the mother cannot waive. Yet if the physician insists on the cesarean section out of a fear of legal liability or concern for the unborn child, he risks a civil or criminal action brought by the mother for assault and battery... .[153]

Instead, under the above proposal, the health care provider's duty is satisfied by proper disclosure and proper performance of procedures decided upon by the mother, who could sue for negligent performance of either of these duties. The foetus is adequately protected by a postnatal right of action for prenatal injuries now present in our law for the negligence of either mother or health care attendant, including that flowing from the attendant's negligent failure to advise the mother adequately.[154] However, in view of the above conclusion that maternal rights to refuse treatment prevail, it would be necessary that this cause of action extend only to acts of mis-

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[152]See Hubbard, *supra*, note 3 at 214, citing Berg, "Georgia Supreme Court Orders Caesarean Section-Mother Nature Reverses on Appeal" (1981) 70 J. Med. Assn. of Ga. 451, and G.J. Annas, "Forced Caesareans: The Most Unkindest Cut of All" (1982) 12:3 Hastings Ctr Rep. 16.

[153]Robertson, *supra*, note 125 at 456.

[154]This proposed approach is similar though not identical to the present English approach under the *Congenital Disabilities (Civil Liability) Act* of 1976, in which the health care attendant has a duty only to the mother and the postnatal child's right of action lies only against the attendant for breach of duty to the mother. For a broader analysis of this statute, see Eekelaar & Dingwall, *supra*, note 8 at 264-70.

feasance and not to nonfeasance.[155] This protects maternal rights to autonomy and to use of midwifery services by recognizing as a general proposition that there are valid reasons for choosing non-intervention as a course of dealing for pregnancy. Allowing "nature to take its course" is a legitimate choice based on the evidence reviewed above. As this decision is within the rational range of choices, a mother cannot be forced to undertake any of the available modes of medical intervention, all of which carry their own risks to both mother and foetus, to avoid the risks inherent in pregnancy itself.

Although the law has become fraught with anomalies and inconsistencies for situations in which a foetus is involved, the proposed approach seems most consistent with our primary legal precepts and helps to clarify the conflicting rights and duties involved. The child is protected after birth for positive acts of negligence against it prior to birth, the duty of the health care practitioner is clarified, and the autonomy of the individual to determine the course of her health care is preserved. Finally, a basis for the legal and political legitimacy of the midwifery profession would thereby be settled.

IV. Political Status in Ontario: Models of Regulation

In spite of, or perhaps because of, the fact that the present law in Ontario effectively prohibits midwifery, the issues of the right of midwives to practice and of the public to have access to their services have become increasingly significant within the last few years. This heightened interest in midwifery is in part due to a desire to improve "fragmented, unco-ordinated and sometimes inadequate"[156] delivery of maternal health care services, and the recognition that "midwifery services are essential in remote areas because of the shortage of physicians."[157] Recent evidence indicates that even in urban areas in Ontario the availability of maternal health care provided by the medical profession is decreasing because of the growing cost of malpractice insurance experienced in the past year. Obstetricians' premiums increased to $2,900 in 1985 from $1,950 in 1984 and family physicians' premiums, which stood uniformly at only $500 in 1984, increased to $1,200 for those who practiced obstetrics while remaining at $550 for those who

[155]Although the law as we have seen is unsettled on this point, the proposition would not be inconsistent with mainstream judicial thought. Keyserlingk, *supra*, note 51 at 12 who says that "the emphasis to date in doctrine, jurisprudence and statutes, as regards the unborn, has been on *positive* acts of negligence rather than negligent *omissions*."

[156]Canadian Nurses' Association, "Statement on the Nurse Midwife" (1978) as cited in Community Task Force, *supra*, note 8 at 7.

[157]Community Task Force, *supra*, note 8 at 10. Statement based on a report of the Sub-Committee on Perinatal Health of the Ontario Council of Health.

did not.[158] These increases have apparently caused a reduction in the number of doctors willing to perform obstetrics and indicate that there will be an increasing market for midwives' services in Ontario, already overburdened by demand.

There is also a growing realization in Ontario that the costs of maternity care would be greatly decreased under a system of midwifery practice. Evidence from the United States indicates that this would be the case.[159] In Ontario, with a provincial health insurance plan, this would mean substantial savings to taxpayers.

In response to increased interest in the provision of midwifery services, Bill 48, which would establish midwifery as an independent self-governing health profession, was introduced into the Ontario Legislature in April, 1984, by New Democratic Party MPP David Cooke. The bill was supported by both the Liberal Party and NDP but did not progress to a vote, because it was considered premature until further studies assessing the impact of regulated midwifery on the present health care system were made.[160] In particular, it was thought best to await the findings of the Health Disciplines Legislative Review Committee, which had been established in 1983 to report on the proposed legalization of several new health disciplines in Ontario.

Less than a year after these events, public attention was focused on midwifery through the media coverage of an Ontario coroner's inquest into the death of Daniel McLaughlin-Harris, a baby delivered with the assistance of midwives on Wards Island in Toronto, who died shortly thereafter from hypoxia. Although the inquest did not make any finding of legal responsibility on the part of the midwives, it became a highly politicized forum for assessing the merits of midwifery.[161] After a lengthy hearing, on 17 July 1985, the coroner's jury made several recommendations, the primary ones being that midwifery be legally regulated in Ontario, covered by OHIP and subject to compulsory malpractice insurance.[162] However, on 18 July 1985, the Health Ministry issued a press release stating that it did not intend to

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[158]T. Tedesco, "MDs said less willing to deliver babies" *The [Toronto] Globe and Mail* (11 July 1985) M3.

[159]Evenson, *supra*, note 3 at 320, states that the average cost of midwifery services in 1979 was $800 as compared with $1200 to $2000 for obstretricians, and Yagerman, *supra*, note 8 at 139, observes that a study of South Florida for 1981 indicated the costs of hospital care ranged from $800 to $1000. The average cost for midwifery care was $500.

[160]Bill 48, 4th sess., 32nd Legislature, Ontario, 33 Elizabeth II, 1984. See *Hansard Official Report of Debates* (Ontario), 32nd Leg., 4th Sess., 1984 at 3747-55.

[161]See L. Hossie, "Opposing philosophies at issue in midwife delivery inquest" *The [Toronto] Globe and Mail* (1 July 1985) A14.

[162]See the verdict of Coroner's Jury serving on the inquest into the death of Daniel McLaughlon-Harris held June 24 to July 17, 1985 at 5-8.

recommend that the practice of midwifery in Ontario be licensed until a study was done, despite the recommendations of the coroner's jury.

Several months later, in January of 1986, the Health Disciplines Legislative Review Committee made its recommendations confidentially to the Health Minister, who subsequently announced that midwifery was to become a legally regulated profession.[163] The mode of regulation was not revealed. At present, the question to be decided is how to integrate midwives into the existing health care system, and a Task Force has been set up by the Health Ministry for this purpose. The mandate of the Task Force was to determine such issues as the appropriate type of education and qualifications for midwives, the appropriate setting for the profession's practice, and the most functional relationship between midwives and doctors, and its report has just been released at the time of this printing. Its findings should serve to inform the determination of the nature and form of legal regulation, and for this reason its mandate is of significant import to midwives. Unfortunately, not one midwife was assigned to the Task Force despite the fact that theirs is the very profession in question. Instead it was composed of representatives from professions more peripherally involved; Toronto lawyer Mary Eberts (Task Force Chairman), Alan Schwartz, coordinator of the predecessor Health Professions Legislation Review, Dr. Rachel Edney, former president of the Canadian College of Family Physicians, and Kathryn Kaufman, associate professor at McMaster University School of Nursing.[164] The intent was to keep the Task Force "neutral" which, while perhaps true of individual members, is ostensibly not the case on a representative level. Midwives along with the rest of the general public were entitled to make submissions to the Task Force for its consideration.

In structuring a scheme for the regulation of midwifery, it is useful to review Bill 48.[165] The bill is entitled "An Act to establish Midwifery as a Self-Governing Health Profesion," and would have amended the *Health Disciplines Act* by adding Part III-A to establish the profession of midwifery independently from other health professions such as medicine and nursing. The responsibility for determining the standards of knowledge and skill as well as the standards of qualification for the practice of midwifery would have been granted by section 67b to a body called the College of Midwives of Ontario, analogous to the present College of Physicians and Surgeons of Ontario which goverus the practice of medicine, and the Council of the

[163]This significant step unfortunately went largely unnoticed since it occurred at the height of Ontario's "extra-billing" controversy, which stole most of the headlines.

[164]See B. Walker, "Midwife services to get legal status legislature told" *The [Toronto] Star* (24 January 1986) A4.

[165]Bill 48 was preceded by Bill 31, which was withdrawn due to a drafting error. See *supra*, note 160.

College would control the granting, revoking and standards of licencing in comparable fashion. Section 67m provided for the establishment of a Discipline Committee to deal with complaints and allegations of professional misconduct or incompetence.

Although the bill would not have completely resolved the conflict among the professions of medicine, nursing and direct entry midwifery, it appears to have been directed in favour of proponents of direct entry midwifery. No requirement of physician supervision was made, and this would have successfully eliminated the problem prevalent in American jurisdictions of midwives being unable to provide services to clients in non-hospital environments due to physicians' reluctance or inability to participate. It has already been noted that the requirement of physician supervision in other jurisdictions has yielded a host of problems restricting effective practice, such as physicians participating in midwifery being refused hospital admitting privileges or denied malpractice insurance by their insurance companies.[166] Such measures have prevented nurse-midwives from obtaining the physician supervision required in order to practice. In addition, physicians are put under much pressure from their own profession not to attend home births or engage in co-operative practice with nurse-midwives, and fear that such practice will be considered professionally negligent and thereby increase their malpractice liability. The Ontario bill would have largely alleviated these problems by keeping physicians and midwives primarily separate rather than interdependent.

Commentators in American jurisdictions have also noted problems with nurse-midwives being denied health insurance coverage,[167] making their services unappealing to consumers. This problem should not arise in Ontario, since the *Health Insurance Act* allows for coverage for services delivered by both physicians and other persons lawfully entitled to render insured services, which would include midwives in the event that they become regulated.[168]

By leaving the determination of what constitutes sufficient qualification to practice midwifery up to the Council of the College (section 67f(e)), the bill would arguably have left open the possibility of requiring a nursing degree to practice, effectively establishing a profession of nurse-midwifery

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[166]See Evenson, *supra*, note 3 at 322.

[167]See McCormick, *supra*, note 7 at 676ff.

[168]See *Health Disciplines Act*, S.O. 1974, c. 47, s. 1(b), s. 45(1)(b), s. 50, s. 52(1). It is also interesting to note that the *Canada Health Act*, S.C. 1984, c. 6, s. 2 allows for federal contributions to provincial health insurance plans, including services rendered by lawfully entitled practitioners, and home care service. A statutorily created regulatory system for midwifery would entitle the profession to this additional source of funding for provincial insurance covering maternity care.

rather than lay midwifery. This route, however, would likely have been precluded by the stated purpose of the bill, which was to "establish midwifery as an *independent*, self-governing health profession along the lines of medicine and nursing" (emphasis added). Furthermore, section 67d provides that the composition of the Council be 18 to 25 members of the College of Midwives, and non-members sitting on the Council must be lay persons since they cannot be registered or licensed under "any other Act governing a health practice," so that the interests of medicine or nursing would probably not have been represented by the Council in its setting of regulations.

Nevertheless, the possibility of certain conflicts between the medical and midwifery professions is left open, due to the failure of the bill to define clearly the realm of health care allocated to each profession. Midwifery is defined in section 67a(1)(f) of the proposed bill as follows:

> "practice of midwifery" means the supervision, care and counselling of women before, during and after pregnancy and labour, and includes,
> (i) conducting normal deliveries independently,
> (ii) caring for the newborn,
> (iii) taking preventative measures,
> (iv) detecting abnormal conditions in mothers and the newborns,
> (v) obtaining medical assistance,
> (vi) taking emergency measures in the absence of medical assistance, and
> (vii) providing counselling and education to the community concerning health, preparation for birth and parenthood, family planning and child care.

Although the provision for "conducting normal deliveries *independently*" [emphasis added] is progressive in that the requirement of physician supervision stipulated by many other jurisdictions is absent, no definition of what constitutes "normal delivery" is given. In view of the radically different approaches to childbirth taken by the medical profession and the profession of midwifery, it is likely that their respective definitions of "normal delivery" will also differ. Because there is no requirement of physician supervision the *responsibility* for "detecting abnormal conditions in mothers and the newborn" is given to midwives, but this reveals nothing about what is to be the *standard* of normalcy. As Evenson notes:

> Most midwives would agree that where there are serious health risks, such as diabetes or high blood pressure, or where there is evidence of complicating factors, the clients should be referred to a physician. But there is a substantial difference of opinion as to what is "normal" .... Practitioners differ on what is a normal length of labour, the age of the mother as related to risk, and whether breech presentations *must* be delivered by Caesarean section.[169]

In the event of an allegation of negligence or professional incompetence, a heavy burden may be put on the midwife if medical opinion is used as

[169]Evenson, *supra*, note 3 at 323.

the source for the definition of what is a normal condition of pregnancy and childbirth. However, the use of a standard risk-determination system such as that proposed by the OAM above might help to alleviate this problem by serving as a reference point before a court or tribunal.

As the bill also gave the responsibility of "obtaining medical assistance" to midwives, the determination of the appropriate circumstances for summoning medical assistance would have posed problems similar to those just discussed. Although the Council of the College of Midwives would have been given power by the bill to establish professional standards for midwives, such standards would not necessarily be those that would be applied by a court in the event of an allegation of criminal or tortious negligence. As the bill said nothing about the place in which care is to be provided, this issue becomes crucial for midwives undertaking to deliver care at home births. It has been seen that representatives of the medical profession consistently oppose home birth as a dangerous practice. Depending on the approach to standards taken by the College of Midwives itself, participation in home births might have amounted to professional misconduct under the bill, making the midwife subject to disciplinary action.

The general tendency of courts to defer to the opinion of the medical profession, on which a substantial body of case law has been built,[170] may thus work to the detriment of midwives and this problem was not resolved by the bill. In this respect the statistical data discussed above would be highly pertinent in supporting an assertion before the courts of more objective standards of care and professional practice.

V. Conclusion

The irony of the social reduction of the pregnancy and childbirth process into a mere medical episode over the course of recent western history has become apparent in recent years. The loss of the traditional midwife in our society has been an unfortunate event in terms of both health interests and sociocultural values. The recent introduction of Bill 48 into the Ontario Legislature signals a revived interest in making the experience of pregnancy and childbirth more fulfilling for the individual, as well as evidencing its deserved social significance. The proposed legislation appeared to balance interests correctly by making midwifery an independent profession with its own educational requirements, while imposing on it the onus of determining occasions for the propriety of medical intervention, and for these reasons is an important progressive step.

[170]See, *e.g.*, *Lustig* v. *The Birthplace*, 27 ATLA L. Rep. 87 (Wash. Co. Ct 1983) in which a wrongful death action against nurse-midwives succeeded on "expert evidence" that the decedent should have been referred to a physician.

While this form of legal regulation could not by itself resolve the tort and criminal issues involving midwives, it would help to alleviate the formal bias in our legal and health care systems to rely on physician care as a matter of course by legitimizing the practice of midwifery. The issues in tort and criminal law must be sorted out by the courts once midwifery is regulated. However, statutory regulation is still a long way off. In the interim, Ontario midwives can best serve their interests as health care innovators by continuing to educate the public on the merits of midwifery care, in order to dispel the image of midwifery as a "fringe" or "alternative" form of health care and allow for full integration into the health care delivery system. Pay Hayes, writing in 1971, succinctly described this concern:

> On the one hand, if the midwife is given value only as a poor substitute for the doctor, there will be rejection and poor use of her skills. On the other hand, if she is introduced as a clinical specialist in her own sphere and allowed to function in a way that expresses her special field of knowledge, acceptance and utilization would be assured.[171]

This insight dictates the solution of independent professional regulation for midwives, in order to achieve the goal of comprehensive, quality health care services for the residents of Ontario.

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[171]P. Hayes, "Midwives? In Canada? Let's Hope So!" (1971) 67:7 Canadian Nurse 19.